McLaren
HEALTH PLAN COMMUNITY

2020 McLAREN HEALTH PLAN COMMUNITY INDIVIDUAL APPLICATION (OFF MARKETPLACE ONLY)

Thank you for your interest in **McLaren Health Plan Community (MHP Community)** individual health plans!

MHP Community Individual coverage is a package of affordable, comprehensive HMO plans designed for individuals and families who are looking for health coverage options. Members must live in the areas MHP Community Individual coverage is offered, and cannot have health insurance through an employer or government-sponsored program.

The first step to becoming an MHP Community individual member is to complete this application by answering all questions, signing the application and sending it to MHP Community:

Attention: Sales Department
G-3245 Beecher Rd.
Flint, MI 48532.

You will receive notification within one to two weeks on the status of your application.

Paper applications must be received by the 15th of the month to be eligible for coverage on the first of the following month. Please complete the attached application for MHP Community individual coverage. This form is a legal document and must be completed in its entirety so that you and your family receive proper and timely coverage. An incomplete application will delay the application process and access to medical benefits. Please complete this form per the following instructions:

- **Application Information – Primary Applicant**
  This section is to be completed for the primary applicant. Complete all applicable blank spaces.

- **Applicant Information – List all individuals applying for coverage**
  In the spaces provided, indicate name, gender, birth date and social security number of all applicants. If you are requesting coverage for more than four dependent children, please include their information on a separate page.

- **Plan Coverage Selection**
  Please indicate your choice of benefit plan by checking the appropriate box.

- **Payment Options**[1]
  Please indicate if you would like to have your ongoing monthly premium deducted by Electronic Fund Transfer (EFT), or if you wish to receive a coupon booklet. If you wish to enroll in EFT, please complete the Electronic Payment Consent Form and return it with your application. You will receive confirmation from us informing you of the first date the EFT will begin. Funds will be transferred from your account on the first day of the

month. If you do not elect EFT, your first month's premium must accompany your application for coverage.

[1]***The first month's premium is due with the application. Your application will not be processed until we receive your first month's premium.***

- **Terms, Conditions and Authorization**
  Please read this section carefully before signing the application. The application must be signed and dated by the applicant, spouse, and any dependent children age 18 or older.

- **Non-Tobacco Use Affidavit**
  You are a "non-tobacco user" if you are not currently using, and have not used during the previous 30 days, any tobacco products, including cigarettes, cigars, chewing tobacco, pipe tobacco, snuff, dip, e-cigarettes or any similar tobacco-related product. For the purpose of this program, tobacco products do not include nicotine patches, nicotine gum or other items that are considered primarily tobacco cessation aids. If you have any questions, please contact Customer Service at 888-327-0671, TTY: 711.

- **Agent/Agency Verification**
  This section is to be completed by the Agent, **if applicable**.

  Note: *If you have any questions about this application or the process, call us at 888-327-0671, TTY: 711 or contact your agent.*

McLaren
HEALTH PLAN COMMUNITY

2020 MHP COMMUNITY INDIVIDUAL APPLICATION (OFF MARKETPLACE ONLY)

Mail completed application to: MHP Community
G-3245 Beecher Rd. Flint, MI 48532

Questions? Call 888-327-0671, TTY: 711 Fax: 810-600-7931

Coverage and Enrollment

Who will be covered by this plan?

☐ One adult (individual plan) ☐ Multiple people (family plan) ☐ Child only

Why are you applying?

☐ Open Enrollment (November 1, 2019 to December 15, 2019); *or*

☐ I have a qualifying event *(choose one):* ◯ Marriage ◯ Birth ◯ Loss of other coverage

◯ Other – please explain: _____

Applicant Information – Primary Applicant

Applicants Name:			Member ID:	Effective Date:
Street Address	City	State	Zip Code	County
Home Phone Number ( )	Work Phone Number ( )		Mobile Phone Number ( )	
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Do you reside in Michigan nine or more months each year? ☐ Yes ☐ No An applicant must reside in the MHP Community service area nine or more months each year to qualify.			

Are all applicants United States citizens or non-citizens lawfully present in the United States? ☐ Yes ☐ No

Applicant Information – List all individuals applying for coverage *(up to age 26)*

Name (Last, First MI)	**Gender**	**Birthdate** (mm/dd/yyyy)	**SS#** *(you must supply this unless you or a dependent are a non-citizen lawfully present in the US and do not have a social security number)*	**Primary Care Physician**	**Tobacco Usage**
Primary Name:	☐ M ☐ F				☐ Y ☐ N
Spouse Name:	☐ M ☐ F				☐ Y ☐ N

McLaren
HEALTH PLAN COMMUNITY

Continued, Applicant Information - List all individuals applying for coverage (up to age 26)					
Name: ☐ Dependent Child ☐ Stepchild ☐ Disabled Dependent*	☐ M ☐ F				☐ Y ☐ N
Name: ☐ Dependent Child ☐ Stepchild ☐ Disabled Dependent*	☐ M ☐ F				☐ Y ☐ N
Name: ☐ Dependent Child ☐ Stepchild ☐ Disabled Dependent*	☐ M ☐ F				☐ Y ☐ N
Name: ☐ Dependent Child ☐ Stepchild ☐ Disabled Dependent*	☐ M ☐ F				☐ Y ☐ N
** Disabled Dependent: Please complete the Disabled Dependent Form on page 11 and 12 of this packet.*					

Plan Coverage Selection

For plan details please visit McLarenHealthPlan.org

Please select the plan you wish to enroll in.

☐ McLaren Gold 1400 $1,400/$2,800 Deductible, 20% Coinsurance Total Out of Pocket Max $6,000/$12,000	☐ McLaren Bronze 6500 $6,500/$13,000 Deductible, 50% Coinsurance Total Out of Pocket Max $8,150/$16,300
☐ McLaren Silver Exchange $3,700/$7,400 Deductible, 20% Coinsurance Total Out of Pocket Max $8,150/$15,800	☐ McLaren Bronze Saver $6,900/$14,000 Deductible, 0% Coinsurance Total Out of Pocket Max $6,900/$14,000
☐ McLaren Silver 5000 $5,000/$10,000 Deductible, 30% Coinsurance Total Out of Pocket Max $8,150/$16,300	☐ McLaren Young Adult/Catastrophic $8,150/$16,300 Deductible, 0% Coinsurance Total Out of Pocket Max $8,150/$16,300

McLaren
HEALTH PLAN COMMUNITY

ELECTRONIC FUNDS TRANSFER (EFT) PAYMENTS

McLaren Health Plan Community (MHP Community) administers EFT payments for healthcare premiums in the following manner:

- On the first business day of every month, your monthly premium will be automatically debited from your designated checking or savings account.
- You must notify MHP Community of any changes to your designated account at least 15 days before the last day of the month.
- If there are insufficient funds in your account for the EFT to occur, you are responsible for any bank fees charged to MHP Community. You will also be responsible for paying the monthly healthcare premium in a manner other than EFT.
- MHP Community will only attempt the EFT once a month, on the first business day of the month.
- Please complete and sign the attached EFT consent form. Return the completed form to MHP Community by one of the following options:
    - **Mail:** Attn: Finance Dept.
      McLaren Health Plan Community
      G-3245 Beecher Road
      Flint, MI 48532
    - **Fax:** 810-600-7947
    - **Email:** MHPFinanceDepartment@mclaren.org
- MHP Community will send you a confirmation letter upon receiving your completed *EFT Payment Consent* form. The letter will confirm your request for your monthly premium payments to be made by EFT. Confirmation of the premium amount and the date of the first EFT will also be in this letter. Please continue to make your regular monthly premium payments until you receive this EFT confirmation letter.

If you have any questions regarding EFT payments, please call the MHP Community finance department at 810-733-9528, Monday – Friday, 8:30 a.m. – 5 p.m. (TTY: 711.)

Sincerely,

MHP Community Finance Department

McLaren
HEALTH PLAN COMMUNITY

EFT PAYMENT CONSENT

Member Name: _____

Contract #: _____ Phone Number: _____

Address: _____

_____

I, _____ (print name), give permission for the MHP Community finance department to electronically withdraw the amount owing for the monthly premium payment from the bank account I have listed below. I certify that I am a legal signer on this bank account and can authorize this type of payment. This EFT withdrawal will be completed monthly on the first business day beginning in the month I've chosen below. If there are not enough funds available on the first business day of the month to complete this transaction, I understand that I am liable to complete the monthly premium payment in a manner other than EFT. MHP Community reserves the right to revoke this agreement at any time.

Bank Name: _____ Bank Routing #: _____

Bank Account #: _____ ☐ Checking ☐ Savings

Month to begin EFT premium payments:

_____

Signature: _____ Date: _____

McLaren
HEALTH PLAN COMMUNITY

APPLICATION–MHP COMMUNITY INDIVIDUAL HEALTH PLAN

Applicant Name:

Terms, Conditions and Authorizations

By completing and signing this application for individual health insurance coverage, I agree to the following:

1. All information I have provided on this form is true to the best of my knowledge and belief and correctly recorded by me.
2. Any material misstatement in this application may result in denial of a claim and/or rescission of coverage. Once the application is submitted, I may be contacted by phone or e-mail by McLaren Health Plan Community (MHP Community) or its representative to complete the application process.
3. The effective date of coverage will be on the 1st of the month following approval by MHP Community. Evidence of approval will be based upon the issuance of ID cards and policy certificate. Coverage is contingent upon the timely and accurate premiums due and will be terminated if this condition is not met.
4. I certify that I meet all requirements for eligibility stated within this application including but not limited to:
    a. Michigan residency for nine or more months during the year.
    b. United States Citizen or have a valid social security number.
    c. No other health insurance coverage currently in place, except Medicaid.

Authorization to Send Email Messages and to Receive Electronic Documents
Periodically MHP Community sends out emails to our members providing them a newsletter, or to send information alerts/notifications or administrative reminders. MHP Community will not sell or give away your email information.

I authorize MHP Community to send periodic emails to me at the email address I have provided. I understand I may open emails on my cell phone and that charges from my cell phone provider may apply. MHP Community is in no way responsible for any fees charged to me by my cellular provider. I understand email is not a secure form of communication.

By signing this Application, I waive my right to receive a hard copy of my coverage documents. I agree that legal notices and communication (including coverage documents, renewal notifications and other documents related to coverage or rights under my policy) may be delivered electronically to the email address designated or posted to MHP Community's website, and not through U.S. mail. I can request paper copies of any documents at no cost. My consent to email or electronic communication may be canceled at any time without charge. To cancel your consent or request paper copies, contact MHP Community Customer Service at G-3245 Beecher Rd., Flint MI 48532. You can update your email address by calling Customer Service at 888-327-0671. To obtain electronic documents from MHP Community's website, please use commercially available web browsers. MHP Community's website contains

documents in PDF format. This may require Adobe Reader or other commercially available software to access.

Email address: _____

Applicant's Signature: _____

1. No contract waiver, modification or change of contract shall be binding upon MHP Community unless it is in writing and signed by an authorized officer of MHP Community.
2. I represent that neither I, my spouse, nor any dependent is receiving any form of reimbursement or compensation for this coverage from any employer.
3. I understand and agree that no agent, producer or broker has the authority: (i) to bind MHP Community by making promises regarding eligibility, benefits, or the issuance of a policy; (ii) to waive any answer or any portion of any answer to any question on this application or any information MHP Community requests; (iii) approve coverage; (iv) make or alter any contract on behalf of MHP Community; (v) waive or alter any of MHP Community's other rights or requirements.
4. I understand that, unless required by law, the completion of this application and submission of any estimated initial premium does not provide interim coverage.
5. I understand that, unless required by law, the completion of this application and submission of any estimated initial premium does not provide interim coverage.
6. If you have outstanding premium payments, you still owe the money and must pay it to MHP Community. For unpaid premiums in the past 12 months, any premiums paid under a new Certificate will be applied to what you owed under the prior Coverage. Once that amount is paid and the applicable premiums for the new Certificate are paid, MHP Community will activate Coverage (if you meet all of our eligibility requirements).

McLaren
HEALTH PLAN COMMUNITY

NON-TOBACCO USER AFFIDAVIT

Last Name	First Name	Middle Initial
Member ID	Home Phone	Work Phone

A tobacco user is defined as any person using a tobacco product, other than for religious or ceremonial use, four or more times per week within the past six months. Tobacco products include cigarettes, cigars, chewing tobacco, snuff and pipe tobacco.

Please check only ONE of the following choices:

Member

☐ **I am a non-tobacco user and, therefore, entitled to avoid the tobacco premium surcharge.**

Spouse

☐ **I am a non-tobacco user and, therefore, entitled to avoid the tobacco premium surcharge.**

Member

☐ **I do not qualify as a non-tobacco user and agree to pay the tobacco premium surcharge.**

Spouse

☐ **I do not qualify as a non-tobacco user and agree to pay the tobacco premium surcharge.**

You are a "non-tobacco user" if you are not currently using, and have not used during the previous 30 days, any tobacco products, including cigarettes, cigars, chewing tobacco, pipe tobacco, snuff, dip, e-cigarettes or any similar tobacco-related product. For the purpose of this program, tobacco products do not include nicotine patches, nicotine gum or other items that are considered primarily tobacco cessation aids. If you have any questions, please contact Customer Service at 888-327-0671, TTY: 711.

By my signature below, I certify that:

- All of the information I have provided on this affidavit is true and correct; and
- I understand that any misrepresentation of information on this certificate will subject me to the requirement to pay the tobacco surcharge for the current plan year; and
- I further understand that dishonesty or misrepresentation of information on this certificate may result in rescission of coverage.

_____ _____

Member Signature Today's Date

_____ _____

Spouse Signature Today's Date

[MHPC20141204]

McLaren
HEALTH PLAN COMMUNITY

I have personally read, understand and agree to the terms, conditions and authorization listed throughout this application.

_____ _____
Applicant's Signature Date Signed

_____ _____
Spouse's Signature Date Signed

_____ _____
Signature of Child age 18 Years or Older Date Signed

_____ _____
Signature of Parent/Legal Guardian for Child(ren) Date Signed

Agent/Agency Verification

All questions on this application have been completed by the applicant and the responses are true and accurate to the best of my knowledge.

Signature of Agent*:		Date:	
Name of Agent *(print name):*			
Agent/Agency Number:			
Address:	City:	State:	ZIP:
Phone Number:	Fax Number:		
Email Address:			

***Agent must contract with and be designated by MHP Community. Call Sales Support at 810-733-9530 for further information*.

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HEALTH PLAN COMMUNITY

DEPENDENT UNDER A QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

ELIGIBILITY

The child must:

- be under 26 years old; and
- be under court or administrative order (QMCSO) stating that his or her medical care is the Subscriber's; or
  Subscriber's spouse's legal responsibility.

Note: A copy of the QMCSO is required to enroll the child.

ENROLLMENT

The child may be enrolled at any time, preferably within 30 days of the date of the QMCSO. In addition:

- If the Subscriber/spouse does not apply, the child may be enrolled by the Friend of the Court or by the child's other parent or guardian through the Friend of the Court.
- The Subscriber parent may change from individual Coverage to family Coverage.
- If the parent that is required under the QMCSO to provide coverage for the child is not already a Subscriber or Member, that parent may enroll (if eligible) when the child is enrolled.
- Neither parent may disenroll the child from an active contract while the QMCSO is in effect, unless the child becomes covered under another plan, premiums have not been paid as required by the agreement, or the child is no longer eligible as a Covered Dependent.

EFFECTIVE DATE OF COVERAGE

- If MHP Community receives notice within 30 days of the QMCSO, coverage is effective as of the date of the QMCSO.
- If MHP Community receives notices after 30 days of the QMCSO, coverage is effective on the date MHP Community receives notice.

In order for MHP Community to make determination, please provide the following information:

Subscriber Information

Name: _____ Date of Birth: _____
Gender: _____ Marital Status: _____
Full Address: _____
Home Phone: _____Day Phone: _____

Dependent Information

Name: _____ Social Security Number: _____
Date of Birth: _____ Gender: _____ Marital Status: _____
Relationship to Subscriber: _____
Full Address: _____

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DISABLED DEPENDENT FORM

A Dependent child's Coverage terminates at the end of the calendar year in which he or she becomes 26 years old.

Exception: An unmarried, Dependent child who becomes 26 while enrolled in MHP Community and who is totally and permanently disabled may continue Coverage if all of the following apply:

- The Dependent child is incapable of self-sustaining employment because of mental or physical disability;
- The Dependent child relies on you for more than half of his or her support, as determined under Section 152 of the Internal Revenue Code, as amended;
- The Dependent child is unmarried; and
- The Dependent lives in the Service Area.

The Subscriber must submit to MHP Community the proof of this disability and dependence within 31 days of the child's 26th birthday. MHP Community may require annual proof of continued disability and dependence.

Note: A Dependent whose only disability is a learning disability or substance abuse does not qualify for Coverage after 26 under this exception.

Subscriber Information

Name: _____

Date of Birth: _____ Marital Status: _____

Full Address: _____

Gender: _____Home Phone: _____

Day Phone: _____

Dependent Information

Name: _____

Social Security Number: _____ Date of Birth: _____ Gender: _____

Marital Status: _____ Relationship to Subscriber: _____

Full Address: _____

A. Does the dependent reside with you? ☐ Yes ☐ No

B. Does the dependent rely one you for more than half of their support? ☐ Yes ☐ No

C. Is the dependent capable of self- sustaining employment? ☐ Yes ☐ No

   a. Currently employed? ☐ Yes ☐ No

D. Is the dependent currently receiving Social Security benefits? ☐ Yes ☐ No

   a. How many months has the dependent been receiving benefits? _____

E. Is the dependent covered by Medicare? ☐ Yes ☐ No

Treating Physician Information

Physician Name_____ Group Physician _____

Street Address _____ City _____ State _____ Zip Code _____

A. How long have you been treating the dependent? _____

B. What is the dependent's diagnosis or diagnoses which cause them to be disabled?

_____

C. Did the disability exist prior to the dependent reaching the age of 26? ☐ Yes ☐ No

D. When was the disability diagnosed? _____

E. Is the disability ☐ temporary or ☐ permanent?

Additional information

Please give MHP Community a letter with the following information signed by the treating physician: the dependent's diagnosis, the signs and symptoms of the condition, whether the dependent is capable of being self-supporting and if not, why the dependent is incapable of self-support. This information must appear on the physician or medical group's letterhead and be signed and dated by the physician. MHP Community reserves the right to request more information regarding the dependent, including but not limited to medical records.

Verification

The information I have given is true to the best of my knowledge. I have given MHP Community all the necessary and requested information. I know that my dependent's coverage may be denied if I have not given MHP Community all the needed information or if I have given MHP Community the wrong information. MHP Community may request more information to decide if my disabled dependent may be covered.

_____ _____

Subscriber's Signature Date Signed

[MHP20141222]

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INDIVIDUAL PEDIATRIC ESSENTIAL HEALTH BENEFIT ACKNOWLEDGEMENT

Applicant Name: _____

The undersigned Applicant understands that certain pediatric dental benefits are among the 10 categories of essential health benefits (EHBs) required under the Patient Protection and Affordable Care Act (PPACA). A failure to provide pediatric dental EHBs could result in the Applicant being non-compliant under PPACA. Applicant also understands that Qualified Health Plans (QHPs) purchased through MHP Community do not include the pediatric dental EHBs needed to comply with PPACA requirements and that they must be purchased through Delta Dental or through another carrier.

Applicant certifies that he/she either purchased the required pediatric dental EHB through Delta Dental, or a separate qualified dental plan that covers the required pediatric dental care through another carrier.

Applicant Signature _____ Date: _____

Are you using an Agent? _____ Yes _____ No

If Applicant has an Agent, Agent must complete the additional attestation:

As agent for the Applicant, in addition to the statement above, I also certify that this customer has purchased the pediatric dental essential health benefits needed to comply with PPACA requirements. I understand that failure to adhere to this certification can result in termination of my contract with MHP Community; nonpayment of commissions; or other penalties identified by MHP Community.

_____ _____

Agent Signature **Date**

_____ _____

Agent Name *(print)* **Date**