Mountain Health CO-OP
1545 E Iron Eagle Dr Suite 101
Eagle, ID 83616
855-447-2900

APPLICATION FOR INDIVIDUAL ACCESS CARE COMPREHENSIVE HEALTH INSURANCE POLICY

Applicant Information-Applicant is the Proposed Policy owner			
First Name	**Middle Name**	**Last Name**	
Guardian *(if under 18 years of age)* **First name, MI, Last Name**			
Date of Birth (mm/dd/yyyy)	**Social Security Number**	**Gender** Male Female	
Mailing Address	**City**	**State**	**Zip Code**
Physical Address	**City**	**State**	**Zip Code**
Primary Phone Number	**Secondary Phone Number**	**Email Address**	

Race (Optional-check all that apply)

American Indian or Alaskan Native
Asian or Pacific Islander
Asian Pacific American
Black
Black (Non-Hispanic)
Caucasian
Hispanic
Mutually Defined
Native American
Native Hawaiian
Other Race or Ethnicity
Pacific Islander
Subcontinent Asian American
White (Non-Hispanic)

Benefit Plan Selection*(Select One)*:	Gold Silver Bronze Plus Bronze Expanded Bronze

Dependents to be insured *(Indicate all dependents to be insured under the policy.)*			
First Name	**Last Name**	**Date of Birth**	**Gender** Male Female
Social Security Number	Relationship to Applicant Spouse Domestic Partner Dependent Child		

Dependents to be insured *(Indicate all dependents to be insured under the policy.)*			
First Name	**Last Name**	**Date of Birth**	**Gender** Male Female
Social Security Number	Relationship to Applicant Dependent Child		
Dependents to be insured *(Indicate all dependents to be insured under the policy.)*			
First Name	**Last Name**	**Date of Birth**	**Gender** Male Female
Social Security Number	Relationship to Applicant Dependent Child		
Dependents to be insured *(Indicate all dependents to be insured under the policy.)*			
First Name	**Last Name**	**Date of Birth**	**Gender** Male Female
Social Security Number	Relationship to Applicant Dependent Child		
Dependents to be insured *(Indicate all dependents to be insured under the policy.)*			
First Name	**Last Name**	**Date of Birth**	**Gender** Male Female
Social Security Number	Relationship to Applicant Dependent Child		
Dependents to be insured *(Indicate all dependents to be insured under the policy.)*			
First Name	**Last Name**	**Date of Birth**	**Gender** Male Female
Social Security Number	Relationship to Applicant Dependent Child		
Dependents to be insured *(Indicate all dependents to be insured under the policy.)*			
First Name	**Last Name**	**Date of Birth**	**Gender** Male Female
Social Security Number	Relationship to Applicant Dependent Child		

Dependents to be insured *(Indicate all dependents to be insured under the policy.)*			
First Name	**Last Name**	**Date of Birth**	**Gender** Male Female
Social Security Number	Relationship to Applicant Dependent Child		

Dependents to be insured *(Indicate all dependents to be insured under the policy.)*			
First Name	**Last Name**	**Date of Birth**	**Gender** Male Female
Social Security Number	Relationship to Applicant Dependent Child		

Dependents to be insured *(Indicate all dependents to be insured under the policy.)*			
First Name	**Last Name**	**Date of Birth**	**Gender** Male Female
Social Security Number	Relationship to Applicant Dependent Child		

Do you have existing health coverage that you do not intend to replace with this policy?
Yes No

Has any person to be covered, who may legally use tobacco under federal or state law, used any tobacco product on an average of four or more times per week within the past 6 months (this does not include tobacco use for religious or ceremonial use)? Yes No If "Yes", please provide information below

Name	**Currently Using Tobacco Product(s) (Y/N)**	**Type of Tobacco Product Used**	**Willing to participate in a cessation program? (Y/N)**

Communication Preference: (Pick only one)

General:	Email	Paper	Phone
Invoices:	Email	Paper	
EOBs:	Email	Paper	
Letter:	Email	Paper	

Payment Method for <u>Initial Binder</u> Payments Only: You must submit a binder payment in full prior to the first day of your coverage to complete the effectuation of your policy. If you select to pay by Credit Card or Bank Account below, the full amount of your initial binder payment will be processed IMMEDIATELY upon submission. If you choose to pay by receiving an invoice first, select the Mail option below. Your invoice will be sent within 10 days of the completion of your enrollment by the communication preference selected in your application. ***Please consider using your checking or savings account and routing number to make your payment. This helps MHC contain costs, resulting in lower premiums for our members. Thank you.***

Checking Account Number	Name of Financial Institution	Routing Number
_____	_____	_____

CREDIT CARD

(Visa, MasterCard, Discover)

Credit Card Number	Card Type	Name on the Card	Security Code
_____	_____	_____	_____

If you would like an alternate payment method, please contact us at 406-447-9510

<u>Representations-Owner Agreement</u>

I agree that: (1) the statements and answers given in this application are true, complete, and correctly recorded to the best of my knowledge and belief; (2) this application will be part of the policy for which I apply; (3) I understand that the policy will be renewed on each policy anniversary date for a new 12-month period, unless I give written notification to Montana Health Cooperative to terminate the policy 60 days prior to the policy renewal date, or any other date on which I choose to terminate the policy; and (4) I will notify Montana Health Cooperative if any statements or answers given in this application change prior to policy delivery. I acknowledge that I have received the Outline of Coverage for the Coverage Plan I have selected.

I understand that polices offered by the Montana Health Cooperative do not offer pediatric dental coverage, and I may need to purchase a standalone dental plan in order to maintain full compliance.

I understand that preexisting conditions are not excluded under the Policy, and evidence of insurability is not required to be submitted for me or any of my dependents listed in this application to be insured under the Policy.

I understand that I will be billed by the Montana Health Cooperative. I understand that I must make my premium payments payable to the Montana Health Cooperative.

I understand that I must give written notification, and pay any additional required premium, to Montana Health Cooperative to add new eligible dependents under the Policy after the Policy is issued to me. Such notification and premium payment must be made in accordance with the terms and conditions of the Policy.

I hereby authorize Montana Health Cooperative to withdraw the **initial binder premium payment** from the financial institution and account named in the *Payment Method Section* of this application, if I selected this option of payment. I understand that this authorization will remain in effect until the financial institution has received and has had reasonable time to act on a written request from me to terminate this agreement. I understand that I can stop a withdrawal by notifying the financial institution at least three business days before the withdrawal is made. In the event of a withdrawal error, I must promptly notify the financial institution to preserve any rights I may have. I understand that I may direct my billing inquiries to Montana Health Cooperative.

No licensed insurance agent is authorized to: (1) make or modify contracts; (2) waive any insurer rights or requirements; and (3) waive any information the Insurer requests.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Signature of Applicant (Proposed Policyowner)	Date signed
Signature of Guardian *(if under 18 years of age*)	Date signed
State in which Policy will be Delivered	State in which Owner Signed Application
Signature of Licensed Insurance Agent	Date signed
Printed Name of Licensed Insurance Agent	Agent License Number