



Montana Health CO-OP

P.O. Box 5358
 Helena, MT 59604
 855-447-2900

**APPLICATION FOR INDIVIDUAL CONNECTED CARE COMPREHENSIVE
 HEALTH INSURANCE POLICY**

<i>Applicant Information-Applicant is the Proposed Policy owner</i>			
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) <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Mutually Defined <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Native American <input type="checkbox"/> Asian Pacific American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Black <input type="checkbox"/> Other Race or Ethnicity <input type="checkbox"/> Black (Non-Hispanic) <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Caucasian <input type="checkbox"/> Subcontinent Asian American <input type="checkbox"/> Hispanic <input type="checkbox"/> White (Non-Hispanic)			
<i>Benefit Plan Selection(Select One):</i>	<input type="checkbox"/> Gold <input type="checkbox"/> Silver <input type="checkbox"/> Silver Option 2 <input type="checkbox"/> Bronze Plus <input type="checkbox"/> Bronze <input type="checkbox"/> Bronze Expanded		
<i>Dependents to be insured (Indicate all dependents to be insured under the policy.)</i>			
First Name	Last Name	Date of Birth	Gender [] Male [] Female
Social Security Number	Relationship to Applicant [] Spouse [] Domestic Partner [] Dependent Child		

<i>Dependents to be insured</i> (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		
<i>Dependents to be insured</i> (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		
<i>Dependents to be insured</i> (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		
<i>Dependents to be insured</i> (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		
<i>Dependents to be insured</i> (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		
<i>Dependents to be insured</i> (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 Initial Binder 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.

ACH/EFT

Checking Account Number Name of Financial Institution Routing Number

CREDIT CARD

(Visa, MasterCard, Discover)

Credit Card Number Exp. Date Name on the Card Security Code

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

Representations-Owner Agreement

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 policies 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