Mountain Health CO-OP
P.O. Box 5358
Helena, MT 59604
Direct- 406-447-9510
Fax: 406-447-5799

APPLICATION FOR INDIVIDUAL 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** **Guardian Social Security Number:**			
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 [ ] check to opt in for text messaging service	**Secondary Phone Number**	**Email Address**	

Race (Optional-check all that apply)

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

Benefit Plan Selection*(Select One)*:	[ ] Gold [ ] Silver [ ] Silver Option 2 [ ] Bronze Plus [ ] Bronze [ ] Bronze Expanded

Dependents to be insured *(Indicate all dependents to be insured under the policy.)*			
First Name	**Last Name**	**Date of Birth**	**Gender** [ ] Male [ ] Female

Due to the nature of information on this form: If you are faxing this form or have any administrative questions, please contact: 855-447-2900

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)

Plan Docs: [ ] Electronic [ ] Paper
Invoices: [ ] Electronic [ ] Paper
EOBs: [ ] Electronic [ ] Paper
Letter: [ ] Electronic [ ] 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 Mountain 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; (4) I will notify Mountain Health Cooperative if any statements or answers given in this application change prior to policy delivery; and (5) Any application received outside of open enrollment, as defined by the Affordable Care Act, must meet Special Enrollment Period Qualifications. I acknowledge that I have received the Outline of Coverage for the Coverage Plan I have selected.

I understand that polices offered by the Mountain 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 Mountain Health Cooperative. I understand that I must make my premium payments payable to the Mountain Health Cooperative.

I understand that I must give written notification, and pay any additional required premium, to Mountain 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 Mountain 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 Mountain 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

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