

Individual Enrollment Checklist

GHI

Thank you for using Health Plan One to obtain your Individual health insurance. Follow the steps below to finalize your enrollment.

Required Documentation for New York Individual insurance for GHI:

- Direct pay Application Coversheet – please complete subscriber section.
- Application Form – complete, sign, and date.

Effective dates are the first of the month. Paperwork must be submitted to Health Plan Plan by the 12th of the month for a first of the following month effective date.

Please send all forms to:

**Health Plan One
1000 Bridgeport Ave, 4th Floor
Shelton, CT 06484**

**Phone: 877-567-5267
Fax: 888-342-1612**



Direct Pay Application Coversheet

Medicare Supplement / Value Open Enrollment

| | | |
|----------------|--|-------|
| GHI Group No.: | | Code: |
|----------------|--|-------|

| | |
|---------------|-----------|
| Product Name: | Category: |
|---------------|-----------|

| General Agency | | <input type="checkbox"/> To Be Credentialed | | Selling Agent | | <input type="checkbox"/> To Be Credentialed | |
|----------------|--|---|---|-------------------------------------|------|---|---|
| GA No.: | | Override: | % | SA No.: | 751A | Commission: | % |
| Agent Name | | | | Agent Name | | | |
| | | | | Health Plan One | | | |
| Address | | | | Address | | | |
| | | | | 250 Pequot Ave, Fairfield, CT 06890 | | | |
| Telephone | | | | Telephone | | | |
| | | | | 877.567.5267 | | | |
| Fax | | | | Fax | | | |
| | | | | 203-319-4346 | | | |

| | |
|-------------------------|-------------------------|
| Subscriber Name : | Desired Effective Date: |
| | |
| Social Security Number: | |
| | |

NOTES:

| | | | |
|-------------------------|--|------|--|
| GA Authorized Signature | | Date | |
|-------------------------|--|------|--|



NON-GROUP APPLICATION FOR INDIVIDUALS NOT ELIGIBLE FOR MEDICARE (OPEN ENROLLMENT PLAN)

INSTRUCTIONS

- Please type or print firmly with ballpoint pen.
- This is an application for hospital coverage or hospital/medical coverage. It may be used to apply for new enrollment, or to change your type of contract. Complete this application if you or your spouse, or both, are not eligible for Medicare due to age. Your contract should be appropriate (Individual or Family) to your status as indicated below:
 - Individual - If you are unmarried, widowed, divorced, or legally separated and have no dependent children.
If you are married without dependent children, and your spouse is eligible for Medicare.
 - Family - If you are married, or if you are married with dependent children. If you are married and your spouse is eligible for Medicare, and you have one or more unmarried children under age 19, you should apply for a Family contract for you and your child(ren). Your Medicare-eligible spouse should apply for separate coverage using a Non-Group Medicare Supplement Insurance Application Form.
- If you are unmarried, widowed, divorced, or legally separated with one or more dependent children.
- If you have one or more unmarried dependent children under 19 years of age or unmarried, dependent full-time students under 23 years, complete only one application for Family coverage for yourself and your children.
- Please do not submit payment with this application. When the application is processed, a bill will be sent to you. You will also receive your contract(s), as well as a copy of your processed application, in a separate mailing. Your identification card will be sent to you after GHI receives your payment.
- All applicants must:
 - a. Complete, sign, and date the application where indicated.
 - b. Check the appropriate boxes for type of coverage and type of contract.
 - c. Return the completed application to:

GHI
P.O. Box 969
Patchogue, NY 11772

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

PRINT IN INK

| | | | | | | | | | | |
|---|-----------------------------|------|-----------|---|----------------------------|-----------------------|---|----------------------------------|--------------------------------|----------------------------------|
| 1. Please complete the following information for the applicant | | | | | | | | | | |
| Full Name of Applicant | | | | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | | Date of Birth (M/D/Y) | | Social Security Number | | |
| Home Address (P.O. Box is not acceptable) | | | | | Telephone Numbers Work: | | Home: Fax: | | | |
| City | | | County | | State | | Zip Code | | | |
| Mailing Address (If different from Home Address) | | | | | | | | | | |
| City | | | County | | State | | Zip Code | | | |
| Applicant Email Address | | | | Primary Language Spoken | | | Race/Ethnicity (See Codes Below) | | | |
| 2. Please complete the following spouse information | | | | | | | | | | |
| Full Name of Spouse | | | | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | | Date of Birth (M/D/Y) | | Social Security Number | | |
| Home Address (P.O. Box not Acceptable) | | | | | Telephone Numbers Work: | | Home: Fax: | | | |
| City | | | County | | State | | Zip Code | | | |
| Mailing Address (If different from Home Address) | | | | | | | | | | |
| City | | | County | | State | | Zip Code | | | |
| Spouse Email Address | | | | Primary Language Spoken | | | Race/Ethnicity (See Codes Below) | | | |
| 3. Please provide the following information for your current or prior health benefits plan. | | | | | | | | | | |
| Type of Plan | Name and Address of Insurer | | | Telephone Number of Insurer | | Name of Policyholder | | Policy I.D. Number | Effective Date of Prior Policy | Termination Date of Prior Policy |
| Hospital | | | | () | | | | | | |
| Medical | | | | () | | | | | | |
| 4. Do you intend to replace an existing accident and health insurance policy or coverage with the GHI Program you are now applying for? | | | | | | | | | | |
| <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, termination date of your other insurance / / . If yes, please check the type of plan you intend to replace. <input type="checkbox"/> | | | | | | | | | | |
| Hospital Insurance <input type="checkbox"/> Medical Insurance <input type="checkbox"/> Other (Please specify) _____ | | | | | | | | | | |
| 5. Is there a waiting period for pre-existing conditions under your existing plan? <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | | | | | |
| If yes, please indicate the effective date of your existing plan. / / . | | | | | | | | | | |
| 6. Please complete the information below for each unmarried dependent child under 19 years of age to be covered under the GHI Program. An unmarried dependent child will be covered until December 31 of the year he/she becomes 19. | | | | | | | | | | |
| Dependent Last Name | First Name | M.I. | DOB M/D/Y | Social Security Number | Sex | Relation-ship | Mailing Address (If different from above) | Race/Ethnicity (See Codes below) | Email Address | Telephone (Daytime) |
| | | | | | | | | | | |
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Race/Ethnicity Codes: (Optional) See explanation on reverse side

A = Asian B = Black or African American C = Caucasian O = Other
 I = Native American or Alaskan Native P = Native Hawaiian or Other Pacific Islander H = Hispanic or Latino

7. Please complete the information below for each unmarried dependent child between 19 and 23 years of age who is a full-time student in an accredited educational institution and who is to be covered under the GHI Program. Under programs that cover unmarried dependent students, a dependent student will be covered until December 31 of the year he/she becomes 23 or until he/she otherwise ceases to be an unmarried dependent student.

| Dependent Last Name | First Name | M.I. | D'OB M/D/Y | Social Security Number | Sex | Relation- ship | Mailing Address (If different from above) | Race/ Ethnicity (See reverse side) | Email Address | Telephone (Daytime) | Name and Address of School | Date of Graduation |
|---------------------|------------|------|---------------|---------------------------|-----|-------------------|--|---|------------------|------------------------|-------------------------------|-----------------------|
| | | | | | | | | | | | | |
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8. a. Are you eligible for group coverage that is comparable to the GHI coverage you are applying for in this application? No Yes
Please explain: _____

b. Have you been refused coverage under an employer health plan due to your age, sex, health status or occupation? No Yes
Please explain: _____

9. Has your health insurance coverage been terminated within the last 12 months due to nonpayment of premiums? No Yes

PLEASE READ THE BENEFIT DESCRIPTION OF EACH GHI OPEN ENROLLMENT PROGRAM OPTION IN THE GHI OPEN ENROLLMENT BROCHURE BEFORE MAKING YOUR SELECTION.

10. If you are a new applicant, or if you wish to add or change hospital coverage or hospital/medical coverage, please check the appropriate box below for the TYPE OF CONTRACT and TYPE OF COVERAGE requested. (The TYPE OF CONTRACT selected must be in accordance with your marital status, as outlined in the instructions at the top of the previous page.)

I am applying for (please check one box from each column): **SEE ATTACHED SHEET FOR APPLICABLE RATES.**

| Column A | Column B |
|-------------------------------------|--|
| <input type="checkbox"/> Individual | <input type="checkbox"/> Value Option (365-Day Hospital Program and Medical Program) |
| <input type="checkbox"/> Family | <input type="checkbox"/> 365-Day Hospital Only Program |

If you are applying for individual coverage, and if your spouse is eligible for Medicare, check here.

PLEASE DO NOT SUBMIT PAYMENT WITH THIS APPLICATION.

| 11. If you are presently enrolled under a GHI Direct Payment Hospital Program, please check the appropriate box below. | If you are presently enrolled under a GHI Direct Payment Hospital/Medical Program, check the appropriate box below. |
|---|--|
| <input type="checkbox"/> I wish to retain my present hospital coverage. | <input type="checkbox"/> I wish to retain my present hospital/medical coverage. |
| <input type="checkbox"/> I wish to change my present coverage from Individual to Family. | <input type="checkbox"/> I wish to change my present coverage from Individual to Family. |
| <input type="checkbox"/> I wish to change my present coverage from Family to Individual. | <input type="checkbox"/> I wish to change my present coverage from Family to Individual. |

12. When your application is processed, a bill will be sent to you with your contract(s).

THERE WILL BE AN 11-MONTH WAITING PERIOD FOR BENEFITS FOR ANY CONDITION FOR WHICH MEDICAL ADVICE, DIAGNOSIS CARE OR TREATMENT WAS RECOMMENDED OR RECEIVED DURING THE SIX MONTH PERIOD ENDING ON THE ENROLLMENT DATE OF COVERAGE. THIS WAITING PERIOD WILL BE REDUCED TO THE EXTENT THAT YOU ARE ENTITLED BY LAW TO A CREDIT FOR PRIOR CONTINUOUS CREDITABLE HEALTH COVERAGE.

IF YOUR CONTRACT IS TERMINATED BECAUSE YOU DID NOT PAY PREMIUMS, YOU CANNOT PURCHASE HEALTH INSURANCE FROM GHI FOR 12 MONTHS AFTER THE DATE OF TERMINATION.

I hereby apply for coverage of the type checked above. If this application is for a family contract, I have provided the names of my spouse, unmarried dependent children under 19 years of age (or who become 19 in this calendar year), and unmarried full-time student dependent children under age 23. I make this application on their behalf as well as my own. When the application is processed, coverage will be effective only if payment of the subscription charges is received in accordance with the invoice. I represent and understand that:

- A.** On my enrollment date, my existing contract(s), if any, will be canceled. Any remaining waiting period for pre-existing conditions under my existing contract will apply to the GHI contract for the same type of coverage. If I am currently covered under an individual contract and wish to change to a family contract for the same type of coverage, my enrollment date in the individual contract will be used to calculate my waiting period for pre-existing conditions. The waiting period for newly covered family members will be calculated from their enrollment date in the family contract. If I am currently covered under a family contract, and wish to change to an individual contract for the same coverage because of divorce, legal separation, annulment or death, my enrollment date in the family contract will be used to compute my waiting period for pre-existing conditions.
- B.** All statements and answers in this application are true to the best of my knowledge and belief. This application will be made part of my contract(s).

NOTE: BEFORE DATING AND SIGNING THIS APPLICATION, PLEASE MAKE SURE YOU HAVE ANSWERED ALL THE QUESTIONS. ALSO, BE SURE YOU HAVE CHECKED THE APPROPRIATE BOX FOR TYPE OF COVERAGE YOU DESIRE.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim concerning any materially false information, or conceals for the purposes of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation

Applicant's Signature (Do Not Print) _____ Date Signed _____

Applicant's Spouse's Signature (Do Not Print) _____ Necessary Only When Applying For Family Coverage _____ Date Signed _____

Why We Ask You for Race/Ethnicity Information

National studies show that differences in access to health care occur along ethnic lines. In our effort to ensure that everyone we serve receives appropriate care, GHI, along with other health insurers, is collecting data on ethnicity with the goal of improving access to care and outcomes for groups who often have poorer results and to improve customer service. Information will only be used by our Medical Department to improve access to needed care and will not be available to any other staff. Answering this question is voluntary.

GHI Web Site

For fast, convenient access to the latest claim status, eligibility, and benefits information, visit GHI's secure Web site at www.ghi.com. Available around the clock, the site offers provider listings, enables you to order ID cards, view an online Explanation of Benefits, access wellness information, and much more.

Translation Services

If English is not your primary language and translation services are needed when calling GHI Customer Service, a representative can help you.

(For GHI Office Use Only)

| | (Initials) | (Initials) |
|---|------------|------------|
| Date Application Issued | _____ | _____ |
| Date Application Received | _____ | _____ |
| Date Application Processed | _____ | _____ |
| Date, Contract and Copy of Application Sent | _____ | _____ |
| Type of Plan | _____ | _____ |
| Group Number | _____ | _____ |
| Category Number | _____ | _____ |
| Effective Date | _____ | _____ |