



Individual Enrollment Application

Phone: (855) 624-6463

Fax: (207) 402-3745

Mail Stop 100

PO Box 1121

Lewiston, ME 04243

Instructions: Complete this form if you are applying for an Individual or family health plan at Community Health Options. All questions must be completed before your request may be processed. If you have any questions, please contact your broker or call Health Options at (855) 624-6463.

Apply faster online

Apply faster online at www.healthoptions.org

What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants who need insurance)
- Policy numbers for any current health insurance

Why do we ask for this information?

We need this information to determine what coverage is available to you. We keep all the information you provide private and secure, as required by law.

What happens next?

Send your completed and signed application to:

Community Health Options

Mail Stop 100, PO Box 1121

Lewiston, ME 04243

Get help with this application

- Call Community Health Options at (855) 624-6463
- If you need help in a language other than English, call (855) 624-6463. Member Service will connect you with a translator for the language you need.
- TTY users should call 711.



2022 Individual Enrollment/ Change Form

PLEASE USE BLACK OR BLUE INK ONLY

Mail Stop 100, PO Box 1121
 Lewiston, ME 04243
 Fax: (207) 402-3745

If you have any questions, please contact Community Health Options at (855) 624-6463.

1. POLICY HOLDER INFORMATION		
Please check appropriate Item:		
<input type="radio"/> 2022 Open Enrollment – New Enrollment	<input type="radio"/> 2022 Open Enrollment – Renew Coverage	
<input type="radio"/> New Enrollment due to Life Event	<input type="radio"/> Change coverage due to Life Event	
If you qualify for a Special Enrollment Period or Life Event, select an event reason:		
<input type="radio"/> Marriage	<input type="radio"/> Loss of minimum essential coverage	
<input type="radio"/> Divorce	<input type="radio"/> Loss of Medicaid or CHIP	
<input type="radio"/> Birth or Adoption	<input type="radio"/> Loss of eligibility to health insurance subsidies	
<input type="radio"/> Turning 26 years of age	<input type="radio"/> Court Order	
<input type="radio"/> Relocation to a new ZIP code, county, or state	<input type="radio"/> Chapter 11 Bankruptcy	
<input type="radio"/> Changes to citizenship or immigration status	<input type="radio"/> Release from incarceration	
<input type="radio"/> Losing access to other coverage (e.g. employer coverage)	<input type="radio"/> Return from Military Service	
<input type="radio"/> COBRA expiration	<input type="radio"/> Other Qualifying Life Event _____	
Event Date: _____		
Policyholder's Name (Last/First/Middle Initial)		
Physical Address (Number and Street)		Apartment or Suite Number
City:	State:	Zip Code
Mailing Address (if different from physical address)		
Telephone numbers Home:	Work:	Marital Status [] Single [] Married
Email Address:		
<p>Supporting documentation is required for a Special Enrollment Period, or Life event. Failure to provide adequate documentation will cause delays in processing your enrollment changes. For more information about what types of supporting documentation will be accepted, please contact Member Services at (855) 624-6463</p>		

2. POLICY HOLDER AND FAMILY INFORMATION*

Please complete information for eligible family members you wish to cover, delete or change

Name(s) of Person(s) (Last, First, MI)	Relationship to You	Date of Birth (mm/dd/yy)	Gender	Social Security Number (SSN) xxx-xx-xxxx	Has this person been a smoker within the last 6 months?	Will this person have other health insurance coverage while this coverage is in effect?	Name of Other Coverage	Certificate/policy #
	Self		F / M		Y / N	Y / N		
	Spouse/ Domestic Partner		F / M		Y / N	Y / N		
	Dependent		F / M		Y / N	Y / N		
	Dependent		F / M		Y / N	Y / N		
	Dependent		F / M		Y / N	Y / N		
	Dependent		F / M		Y / N	Y / N		

Children may be covered as dependents by their parents up until age 26. When a dependent turns 26, coverage may continue until the end of the calendar year. If a dependent listed above is a disabled Dependent age 26 or older, please submit supporting documentation.

Is the application for this policy intended to replace an existing policy? Y N

3. PRIMARY CARE PROVIDER (PCP) ASSIGNMENT

Selecting a Primary Care Provider {PCP} is required under all Community Health Options plans. You have the right to designate any PCP who participates in our network and who is available to accept you and/or your family members. PCPs are typically Family Practice, General Practice or Internal Medicine Doctors, Nurse Practitioners, or Certified Nurses/Midwives. For children, you may designate a pediatrician as your PCP. Our Provider Directory <http://www.healthoptions.org/search-provider> includes a list of Providers and information about providers who are part of our network.

Please complete information for assignment of Network Primary Care Providers for covered family members. If you do not assign a PCP, Community Health Options will assign one to you. You have the right to change your PCP at any time. PCP changes can be submitted through your Member portal or by contacting Member Services at (855) 624-6463.

Member Name (Last, First, MI)	Primary Care Provider Name (First, Last)	Practice Location

4. MEDICAL COVERAGE (Select one plan)

<p>O Health Options CC Catastrophic HMO NE \$8,700 Individual/\$17,400 Family Deductible To qualify for a catastrophic plan, you must be under 30 years old. Certain hardship events may also qualify.</p>	<p>O Health Options CC Silver \$4500 HSA Off Marketplace HMO NE Dental \$4,500 Individual/\$9,000 Family Deductible Includes Pediatric Dental</p>
<p>O Health Options CC Bronze \$8700 HMO NE \$8,700 Individual/\$17,400 Family Deductible Includes Chronic Illness Support</p>	<p>O Health Options CC Silver \$3500 HSA Off Marketplace HMO NE Dental \$3,500 Individual/\$7,000 Family Deductible Includes Pediatric Dental</p>
<p>O Health Options CC Bronze \$8700 PPO NE \$8,700 Individual/\$17,400 Family Deductible Includes Chronic Illness Support</p>	<p>O Health Options CC Silver \$3500 HMO Tiered NE \$3,500 Individual/\$7,000 Family Deductible</p>
<p>O Health Options CC Bronze \$7500 HMO Tiered NE \$7,500 Individual/\$15,000 Family Deductible</p>	<p>O Health Options CC Silver \$3500 HMO NE \$3,500 Individual/\$7,000 Family Deductible</p>
<p>O Health Options CC Bronze \$7500 HMO NE \$7,500 Individual/\$15,000 Family Deductible</p>	<p>O Health Options CC Silver \$3500 PPO National \$3,500 Individual/\$7,000 Family Deductible</p>
<p>O Health Options CC Bronze \$7500 PPO NE \$7,500 Individual/\$15,000 Family Deductible</p>	<p>O Health Options Acadia Silver HMO NE \$2,500 Individual/\$5,000 Family Deductible</p>
<p>O Health Options CC Bronze \$7000 HSA PPO NE \$7,000 Individual/\$14,000 Family Deductible</p>	<p>O Health Options Acadia Silver HMO NE Dental \$2,500 Individual/\$5,000 Family Deductible Includes Pediatric Dental</p>
<p>O Health Options Evergreen Bronze HMO Tiered NE \$5,700 Individual/\$11,400 Family Deductible Includes Chronic Illness Support Program</p>	<p>O Health Options Acadia Silver PPO NE \$2,500 Individual/\$5,000 Family Deductible</p>
<p>O Health Options Evergreen Bronze HMO NE \$5,700 Individual/\$11,400 Family Deductible Includes Chronic Illness Support Program</p>	<p>O Health Options Acadia Silver PPO NE Dental \$2,500 Individual/\$5,000 Family Deductible Includes Pediatric Dental</p>
<p>O Health Options Evergreen Bronze PPO NE \$5,700 Individual/\$11,400 Family Deductible Includes Chronic Illness Support Program</p>	<p>O Health Options Acadia Silver PPO National \$2,500 Individual/\$5,000 Family Deductible</p>
<p>O Health Options Evergreen Bronze PPO NE Dental \$5,700 Individual/\$11,400 Family Deductible Includes Pediatric Dental, Chronic Illness Support Program</p>	<p>O Health Options Katahdin Silver HMO Tiered NE \$3,000 Individual/\$6,000 Family Deductible Includes Chronic Illness Support</p>
<p>O Health Options CC Bronze \$5900 HSA PPO NE \$5,900 Individual/\$11,800 Family Deductible</p>	<p>O Health Options Katahdin Silver HMO NE \$3,000 Individual/\$6,000 Family Deductible Includes Chronic Illness Support</p>
<p>O Health Options CC Silver \$5500 Off Marketplace HMO NE Dental \$5,500 Individual/\$11,000 Family Deductible Includes Pediatric Dental</p>	<p>O Health Options CC Gold \$2500 PPO NE \$2,500 Individual/\$5,000 Family Deductible Includes Chronic Illness Support</p>
<p>O Health Options CC Silver \$5500 Off Marketplace HMO Tiered NE Dental \$5,500 Individual/\$11,000 Family Deductible Includes Pediatric Dental</p>	<p>O Health Options CC Gold \$2500 PPO NE Dental \$2,500 Individual/\$5,000 Family Deductible Includes Pediatric Dental, Chronic Illness Support Program</p>



O Health Options CC Gold \$2500 PPO National Dental \$2,500 Individual/\$5,000 Family Deductible Includes Pediatric Dental, Chronic Illness Support Program	O Health Options CC Gold \$1500 PPO National \$1,500 Individual/\$3,000 Family Deductible
O Health Options CC Gold \$1500 PPO NE \$1,500 Individual/\$3,000 Family Deductible	O Health Options CC Platinum PPO NE \$500 Individual/\$1,000 Family Deductible

Unless otherwise indicated, the policy does not include pediatric dental services. Pediatric dental coverage is included in some health plans, but can also be purchased as a stand-alone product. Please contact your insurance carrier or producer, or seek assistance through Healthcare.gov, if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

5. EFFECTIVE DATE

Open Enrollment

If your application for New or Renewed coverage is received by December 15th during the Annual Open Enrollment Period, your coverage will begin on January 1, 2022.

Special Enrollment Period

If you are applying for coverage based on a Special Enrollment Period, the effective date of coverage will be either the first of the month following the event or the first of the month following receipt of this application by Community Health Options, depending upon the type of qualifying event. In the case of birth or adoption, the effective date of coverage will be the same as the event date.

Requested Effective Date: _____/_____/_____

Coverage will not begin until the first premium payment is received

6. LEGAL ACKNOWLEDGEMENTS AND SIGNATURE

I understand that:

O I am not currently eligible for a premium tax credit or have chosen not to apply for one. I understand checking this box DOES NOT disqualify me from obtaining a tax credit in the future should I become eligible.

- I will receive notice by mail of my Membership status with Community Health Options once Community Health Options has received and processed my application. Upon notification of Membership, I will receive a Member ID Card, online access to the applicable Member Benefit Agreement and other necessary documents relating to my Community Health Options Membership coverage.
- I will receive by mail a statement for my first Premium payment. I understand that no claims will be processed under this coverage unless and until Community Health Options has received the total Premium due. If the Subscriber has a balance with Community Health Options from coverage within the prior 12 months, this prior balance will be due as part of the Binding Premium Payment. If the full amount due (including the prior balance) is not paid prior to the effective date of coverage, your coverage will not go into effect.
- If I decide not to accept coverage, I will send a written request to cancel coverage to Community Health Options, Mail Stop 100, PO Box 1121, Lewiston, ME 04243. I agree to return all materials to Community Health Options within 10 days after their delivery date. Community Health Options will refund any charges I have paid for the contract, and coverage will be null and void.
- If I or any covered family member is insured by more than one health contract, Coordination of Benefits will apply. Coordination of Benefits ensures that the total benefits received from all contracts do not exceed the actual cost of covered services.
- I am requesting coverage for myself and all dependents listed on this application. All applicants listed herein are Maine residents, or are otherwise eligible to purchase insurance from Community Health Options. To the best of my knowledge and belief, all statements and answers I have given are true and complete. I understand any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found in this application may result in denial of benefits, rescission, or cancellation of my coverage(s). I understand all benefits are subject to the conditions stated in the Member Benefits Agreement.



It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

Applicant's Signature _____

Print Name _____

Date ____ / ____ / ____

If you are the parent or legal guardian of a minor in a child-only policy and have signed the enrollment form, please provide the following information about yourself:

Name _____

Address _____

Phone Number (____) _____ Relationship to Enrollee _____

7. PRODUCER OF RECORD INFORMATION

Producer to complete (if applicable)

The producer below has presented Community Health Options individual plans to the applicant. I have assisted the Applicant in the purchase of this policy.

Producer's Name	Agency Name	Producer NPN
Address		
Producer's Signature _____		
Date ____ / ____ / ____		

Please send us the completed application by either Mail, Fax, or Email.

Mail to: Community Health Options, Mail Stop 100, PO Box 1121, Lewiston, ME 04243

Fax to: Community Health Options, 207-402-3745 | Email to: Enrollment@HealthOptions.org

Please call Member Services for Questions on how to fill out this form, 1-855-624-6463