

**THE HEALTH PLAN  
FEDERALLY ELIGIBLE INDIVIDUAL  
PRE-ENROLLMENT QUESTIONNAIRE**

In order for The Health Plan to determine if you are an "eligible" individual for one of our *Federally Eligible Plans*, we ask that you take a few moments to answer the following questions.

1. Were you recently covered (within the past 63 days) by employer sponsored group health insurance, governmental or church plan? Yes  No

If yes, which one were you covered by:

Group Health Plan     Governmental Plan     Church Plan

Name of Plan \_\_\_\_\_ Date Coverage Terminated \_\_\_\_\_

2. Are you currently eligible for:
- |                     |                              |                             |
|---------------------|------------------------------|-----------------------------|
| Group Coverage      | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Medicare A and/or B | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Medicaid            | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Other Coverage      | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

If yes, name & type of other coverage: \_\_\_\_\_

3. Were you eligible for COBRA or State continuation coverage when you lost your group coverage? Yes  No

If yes, did you elect the continuation coverage? Yes  No

If yes, has your continuation coverage exhausted? Yes  No

If yes, when did it exhaust? Date \_\_\_\_\_

If no, when does it exhaust? Date \_\_\_\_\_

4. Did loss of your most recent coverage occur due to non-payment of premiums or fraud? Yes  No

Name (Print) \_\_\_\_\_ Address \_\_\_\_\_

Phone # \_\_\_\_\_ Email Address \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please attach a copy of your "Certificate of Coverage" from your previous carrier and this Questionnaire to the Enrollment Form and mail to The Health Plan. We will notify you in writing or by email as to whether or not you have met the Federal Eligibility Guidelines. **Please do not include any money at this time.****

***Insurance Fraud Warning***

Pursuant to Ohio Revised Code Section 3999.21, "Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.



# The Health Plan of the Upper Ohio Valley, Inc.

## Ohio Valley & Mountaineer Regions

52160 National Road East  
St. Clairsville, Ohio 43950-9365  
Phone: 1-800-624-6961

## HomeTown Region

100 Lillian Gish Boulevard  
P.O. Box 4816  
Massillon, OH 44648-4816  
Phone: 1-877-236-2289

### ENROLLMENT FORM (SEE INSTRUCTIONS ON BACK)

HEALTH PLAN USE ONLY	
GROUP NO.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/>
<input type="checkbox"/> COV.	EFFECTIVE DATE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

PLEASE PRINT

Subscriber Name (Last, First, M.I.)

Street Address

Apt.#

City

State

County

ZIP Code

Phone 1#

Phone 2#

Email Address\*

**You must choose a Primary Care Physician for each member of your family. Also, members may select a Secondary Care Physician which are comprised of Obstetrics, Gynecology, and various subspecialties. Please refer to your Health Plan Provider Directory for a complete listing of physicians. Primary Care Physicians must be selected before claims can be processed for payment.**

**If you have any questions regarding eligibility for coverage, please contact The Health Plan.**

#### FAMILY MEMBERS TO BE ENROLLED

#### PRINT EACH PHYSICIAN'S NAME BELOW

FAMILY CODE	LAST NAME	FIRST	MI	DATE OF BIRTH MO/DAY/YR	M OR F	SOCIAL SECURITY NUMBER *	PRIMARY CARE PHYSICIAN (First Initial/ Last Name)	OB-GYN / SECONDARY CARE PHYSICIAN (First Initial/ Last Name)
<b>SUB</b>	Subscriber						<input type="checkbox"/> ESTABLISHED <input type="checkbox"/> NEW	<input type="checkbox"/> ESTABLISHED <input type="checkbox"/> NEW
<b>SP</b>	Spouse						<input type="checkbox"/> ESTABLISHED <input type="checkbox"/> NEW	<input type="checkbox"/> ESTABLISHED <input type="checkbox"/> NEW
<b>03</b>	Dependent						<input type="checkbox"/> ESTABLISHED <input type="checkbox"/> NEW	<input type="checkbox"/> ESTABLISHED <input type="checkbox"/> NEW
<b>04</b>	Dependent						<input type="checkbox"/> ESTABLISHED <input type="checkbox"/> NEW	<input type="checkbox"/> ESTABLISHED <input type="checkbox"/> NEW
<b>05</b>	Dependent						<input type="checkbox"/> ESTABLISHED <input type="checkbox"/> NEW	<input type="checkbox"/> ESTABLISHED <input type="checkbox"/> NEW
<b>06</b>	Dependent						<input type="checkbox"/> ESTABLISHED <input type="checkbox"/> NEW	<input type="checkbox"/> ESTABLISHED <input type="checkbox"/> NEW
<b>07</b>	Dependent						<input type="checkbox"/> ESTABLISHED <input type="checkbox"/> NEW	<input type="checkbox"/> ESTABLISHED <input type="checkbox"/> NEW

*\*This information is used for internal purposes only.*

Have you ever been enrolled with The Health Plan before?  YES  NO

Subscriber or Spouse's Maiden Name: \_\_\_\_\_

If any dependents listed to enroll have last names that differ from the subscriber's, **legal documentation must be attached to prove the relationship.** Examples: Marriage Certificate, Adoption, Guardianship or Foster Child Papers.

Does spouse and all dependents listed above reside with the subscriber?  YES  NO

If no, list spouse or dependent(s) and his/her address below:

NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

Explanation for not residing with subscriber: \_\_\_\_\_

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## LANGUAGE

FAMILY CODE	
SUB	<p>If available, which language do you prefer for written materials? _____</p> <p>Can one or more members of your household read English? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What language do you feel most comfortable speaking? <input type="checkbox"/> English <input type="checkbox"/> Other</p> <p>What is the primary language spoken at home? <input type="checkbox"/> English <input type="checkbox"/> Other</p> <p>If other, what language is preferred? _____</p>
SP	<p>If available, which language do you prefer for written materials? _____</p> <p>Can one or more members of your household read English? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What language do you feel most comfortable speaking? <input type="checkbox"/> English <input type="checkbox"/> Other</p> <p>What is the primary language spoken at home? <input type="checkbox"/> English <input type="checkbox"/> Other</p> <p>If other, what language is preferred? _____</p>
03	<p>If available, which language do you prefer for written materials? _____</p> <p>Can one or more members of your household read English? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What language do you feel most comfortable speaking? <input type="checkbox"/> English <input type="checkbox"/> Other</p> <p>What is the primary language spoken at home? <input type="checkbox"/> English <input type="checkbox"/> Other</p> <p>If other, what language is preferred? _____</p>
04	<p>If available, which language do you prefer for written materials? _____</p> <p>Can one or more members of your household read English? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What language do you feel most comfortable speaking? <input type="checkbox"/> English <input type="checkbox"/> Other</p> <p>What is the primary language spoken at home? <input type="checkbox"/> English <input type="checkbox"/> Other</p> <p>If other, what language is preferred? _____</p>
05	<p>If available, which language do you prefer for written materials? _____</p> <p>Can one or more members of your household read English? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What language do you feel most comfortable speaking? <input type="checkbox"/> English <input type="checkbox"/> Other</p> <p>What is the primary language spoken at home? <input type="checkbox"/> English <input type="checkbox"/> Other</p> <p>If other, what language is preferred? _____</p>
06	<p>If available, which language do you prefer for written materials? _____</p> <p>Can one or more members of your household read English? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What language do you feel most comfortable speaking? <input type="checkbox"/> English <input type="checkbox"/> Other</p> <p>What is the primary language spoken at home? <input type="checkbox"/> English <input type="checkbox"/> Other</p> <p>If other, what language is preferred? _____</p>
07	<p>If available, which language do you prefer for written materials? _____</p> <p>Can one or more members of your household read English? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What language do you feel most comfortable speaking? <input type="checkbox"/> English <input type="checkbox"/> Other</p> <p>What is the primary language spoken at home? <input type="checkbox"/> English <input type="checkbox"/> Other</p> <p>If other, what language is preferred? _____</p>

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**RACE/ETHNICITY - OPTIONAL**

FAMILY CODE	(This information is designed for the purpose of data collection and will not be used for determining eligibility, rating or claim payment.)
SUB	<input type="checkbox"/> White -01 <input type="checkbox"/> African American/Black -02 <input type="checkbox"/> Hispanic/Latino -03 <input type="checkbox"/> Asian -04 <input type="checkbox"/> American Indian/Alaska Native-05 <input type="checkbox"/> Native Hawaiian/Other Pacific Islander-06 <input type="checkbox"/> Other-07
SP	<input type="checkbox"/> White -01 <input type="checkbox"/> African American/Black -02 <input type="checkbox"/> Hispanic/Latino -03 <input type="checkbox"/> Asian -04 <input type="checkbox"/> American Indian/Alaska Native-05 <input type="checkbox"/> Native Hawaiian/Other Pacific Islander-06 <input type="checkbox"/> Other-07
03	<input type="checkbox"/> White -01 <input type="checkbox"/> African American/Black -02 <input type="checkbox"/> Hispanic/Latino -03 <input type="checkbox"/> Asian -04 <input type="checkbox"/> American Indian/Alaska Native-05 <input type="checkbox"/> Native Hawaiian/Other Pacific Islander-06 <input type="checkbox"/> Other-07
04	<input type="checkbox"/> White -01 <input type="checkbox"/> African American/Black -02 <input type="checkbox"/> Hispanic/Latino -03 <input type="checkbox"/> Asian -04 <input type="checkbox"/> American Indian/Alaska Native-05 <input type="checkbox"/> Native Hawaiian/Other Pacific Islander-06 <input type="checkbox"/> Other-07
05	<input type="checkbox"/> White -01 <input type="checkbox"/> African American/Black -02 <input type="checkbox"/> Hispanic/Latino -03 <input type="checkbox"/> Asian -04 <input type="checkbox"/> American Indian/Alaska Native-05 <input type="checkbox"/> Native Hawaiian/Other Pacific Islander-06 <input type="checkbox"/> Other-07
06	<input type="checkbox"/> White -01 <input type="checkbox"/> African American/Black -02 <input type="checkbox"/> Hispanic/Latino -03 <input type="checkbox"/> Asian -04 <input type="checkbox"/> American Indian/Alaska Native-05 <input type="checkbox"/> Native Hawaiian/Other Pacific Islander-06 <input type="checkbox"/> Other-07
07	<input type="checkbox"/> White -01 <input type="checkbox"/> African American/Black -02 <input type="checkbox"/> Hispanic/Latino -03 <input type="checkbox"/> Asian -04 <input type="checkbox"/> American Indian/Alaska Native-05 <input type="checkbox"/> Native Hawaiian/Other Pacific Islander-06 <input type="checkbox"/> Other-07

**MEDICARE INFORMATION**

Upon your effective date with The Health Plan (or within 60-days of the effective date) will you, or any of your covered dependents, have Medicare coverage?  YES  NO

If yes, please provide the information below:

Medicare Enrollee Name	Medicare I.D. #	Part A Effective Date	Part B Effective Date
1. _____	_____	_____	_____
2. _____	_____	_____	_____

Do you have Medicare Part D coverage?  YES  NO If yes, effective date: 1. \_\_\_\_\_  
2. \_\_\_\_\_

**OTHER HEALTHCARE COVERAGE**

Upon your effective date with The Health Plan will you, or any of your covered dependents, have other healthcare coverage?  YES  NO

If yes, please provide information below:

Coverage Type:  Group Policy  Individual Policy  Workers' Compensation  Medicaid  Other

Covered Benefits: (check all that apply)  Hospital/Medical  RX  Vision  Dental  Other, please explain:

Name of other coverage: \_\_\_\_\_ Phone #: \_\_\_\_\_

Policyholder name: \_\_\_\_\_ I.D. #: \_\_\_\_\_

If other family members are covered, please list names: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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## ELECTION OF COVERAGE UNDER THE HEALTH PLAN ("PLAN")

I hereby elect coverage for myself, and my eligible dependents listed on this Enrollment Form, for benefits offered under the applicable (Conversion, Non-Group/Individual, HIPAA or Open Enrollment) Health Plan Non-Group Agreement ("the Agreement"). I understand my eligible dependents and I must meet the eligibility guidelines as stated in the Evidence of Coverage (Member Handbook) in conjunction with any State or Federal laws to include but not limited to the Patient Protection Affordable Care Act ("PPACA") and Ohio House Bill 1 (Ohio residents only). I understand that I may obtain a copy of these eligibility guidelines upon request or that I may contact The Health Plan with any questions regarding eligibility prior to submitting the Enrollment Form.

I agree on my behalf, and on behalf of my eligible dependents, to be bound by the benefits, deductibles, copayments, coinsurance payments, exclusions, limitations and other terms of the Agreement, or as amended, and understand that all services must be obtained from Plan providers unless the Plan specifically provides otherwise. Furthermore, at any time upon request by the Plan, I agree to provide the Plan any legal or other documentation to verify eligibility (i.e., marriage license, birth certificate, driver license, voter registration). I understand that failure to comply with the request may cause interruption of claims processing or possible termination of coverage.

I understand on my behalf, and on behalf of my covered dependents, that all information furnished by me here is true and complete to the best of my knowledge and shall be deemed representations and that coverage can be rescinded if I, or my covered dependents or a person seeking coverage on my behalf or covered dependents behalf, performs an act, practice or omission that constitutes fraud; or makes an intentional misrepresentation of material fact, as prohibited by the terms of the Agreement.

I understand on my behalf, and on behalf of my eligible dependents, that certain information may be disclosed to other entities. (This disclosure is further explained in The Health Plan Privacy Notice included in the enrollment packet, or upon request or on the Plan website at [www.healthplan.org](http://www.healthplan.org).)

Cancellation Notice. Any person obligated for any part of a prepayment may cancel such agreement within 72 hours after he/she has signed an agreement or offered to enroll. Cancellation occurs when written notice of cancellation is given to the Plan either in person or by mail.

Insurance Fraud Warning. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submit an application or files a claim containing false or deceptive statements is guilty of insurance fraud.

Subscriber's signature: \_\_\_\_\_ Date: \_\_\_\_\_

***This form MUST be completed in its entirety, failure to do so will cause a delay in your enrollment.  
Please review for completeness.***

## **INSTRUCTIONS**

1. Please use pen, print clearly and press hard.
2. Please use Provider Directory to identify primary care physician (and secondary care physicians and/or OB-GYN if applicable)

### **When You Join The Health Plan**

1. You will receive a new member enrollment packet that will include your I.D. card(s) and a member handbook.
2. The member handbook outlines The Health Plan services in detail (please read carefully).