

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

1. You, or any dependent applicants, **ARE** a Non-Federally Eligible Individual if you meet the following conditions:
- √ You, are not a member of or eligible for an employer-sponsored plan, member of an association or member of any other group plan.
 - √ You do not have any other health coverage and are not eligible to be covered under any private or public health benefit plans including the following:
 - a. Medicare or Medicare supplement policy
 - b. Medicaid
 - c. Any COBRA or State continuation coverage plan
 - d. Other health benefits arrangement
2. Are you, or any dependent applicants, currently confined to a hospital, nursing home or other health care facility? Yes No
3. As a Non-Federally Eligible Individual, coverage will be limited for pre-existing conditions for the first 12 months; however, we will credit time you, or any dependent applicants, were covered under a recent previous health plan.
- Were you, or any dependent applicants, recently covered (within the past 63 days) by another health plan? Yes No

If yes, please attach a copy of the “Certificate of Coverage” from the previous plan for each individual applying.

I have read and understand all of the terms of membership as stated and discussed above. I understand that the information is true to the best of my knowledge.

Signature of Applicant _____
Date

Phone# _____ Email Address _____

Signature of Health Plan Representative _____
Date

Please attach proof of residency (copy of driver license or utility bill), Certificate of Coverage from previous carrier (if applicable) 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 Non-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 false or deceptive statement is guilty of insurance fraud.

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LANGUAGE

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

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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.)

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).