Appendix A

COLORADO UNIFORM **INDIVIDUAL** APPLICATION FOR MAJOR MEDICAL HEALTH BENEFIT PLANS

This form is designed for an individual's application for coverage. Please contact your carrier with questions regarding this form.

Federal financial assistance may be available for coverage purchased through Connect for Health Colorado. If purchasing coverage through Connect for Health Colorado, you will need to provide additional information for determination of eligibility for federal financial assistance. Further information may be found at www.connectforhealthco.com.

COVERAGE INFORMATION

Application Type: (check all that apply)	☐ New Coverage ☐ Change/Modification to Existing Coverage ☐ Open Enrollment ☐ Special Enrollment*				
Is the applicant purchasing this plan using a reimbursement arrangement (if applicable):	☐ Yes ☐ No	If so, what type:	☐ HRA	☐ ICHRA	☐ QSEHRA
Special Enrollment Period Qualifying event: ☐ Loss of Coverage ☐ Birth/Adoption/Placement for Adoption ☐ Marriage ☐ Other:_____ Date of Event:_____					
Requested Effective Date:	_____/_____/_____(MM/DD/YYYY)				

* Proof of eligibility for special enrollment will be required – information available on the DOI website at: https://www.colorado.gov/pacific/dora/division-insurance

PRIMARY APPLICANT/INSURED INFORMATION

Instructions: Please type or print using black or blue ink. Please fill out the entire application for each person for whom coverage is being sought. If a person is currently enrolled in Medicare, this application should not be completed for that enrolled individual. If additional pages are needed to fully complete this application please attach, sign, and date each page.

First Name:		Middle Initial:		Last Name:	
SSN/TIN/ALT ID #: (Optional)		Date of Birth:	/ /	Current Age:	Gender: ☐ M ☐ F ☐ X

SSN is only necessary to determine eligibility for federal Advance Premium Tax Credit and Cost Sharing Reductions. Not filling out this field shall not be a reason to deny an application for coverage

Physical Address:				City:	
County:		State:		Zip:	
Mailing Address (If different, can be P.O. Box):				City:	
County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:	

Are you (check one): ☐ Single ☐ Married ☐ Common Law ☐ Civil Union ☐ Legally Separated ☐ Divorced ☐ Under 21

Are you or is anyone in your family American Indian or Alaskan Native? ☐ Yes ☐ No

This question is being asked as American Indians and Alaskan Natives have an enhanced ability to enroll in health benefit plans

ADDITIONAL APPLICANTS

Complete ONLY if your spouse/partner, and/or child(ren) under the age of 26 (older if medically disabled) are applying for coverage. If a dependent child is applying as an individual rather than as part of a family list the child as the primary applicant. If there is not enough space provided, please attach additional family information. Please sign and date the additional sheet. SSN is only necessary to determine eligibility for federal Advance Premium Tax Credit and Cost Sharing Reductions. Not filling out that field shall not be a reason to deny an application for coverage

Name First, MI, Last)	SSN/TIN/ALT ID #:	Gender	Relationship	Disability Y/N	Birth Date (MM/DD/YY)
		☐ M ☐ F ☐ X	SPOUSE/PARTNER	☐ Yes ☐ No	
		☐ M ☐ F ☐ X	☐ Child ☐ Dependent	☐ Yes ☐ No	
		☐ M ☐ F ☐ X	☐ Child ☐ Dependent	☐ Yes ☐ No	
		☐ M ☐ F ☐ X	☐ Child ☐ Dependent	☐ Yes ☐ No	
		☐ M ☐ F ☐ X	☐ Child ☐ Dependent	☐ Yes ☐ No	

Do(es) the child(ren) named within the application live with you at the same physical address shown above? ☐ Yes ☐ No (if no, complete below)

Child(ren)'s Name:		Mailing Address (If different):					
City:		County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:			

Name of the Legal Guardian or Parent responsible for carrying health insurance for the child:							
If the primary applicant is under the age of 21 and different from above, provide the name and mailing address of the legal guardian or custodial parent:							
Legal Guardian or Custodial Parent's Name:				Mailing Address (If different):			
City:		County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:			

Please answer the following questions to the best of your knowledge. 45 CFR 147.102(a)(1)(iv) "For purposes of this section, tobacco use means use of tobacco on average four or more times per week within no longer than the past 6 months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco. Further, tobacco use must be defined in terms of when a tobacco product was last used."
Has anyone named in this application used tobacco or smokeless tobacco during the past 6 months? If yes, provide the information requested below.

Name of Person	Used Tobacco Products	
	☐ Yes	☐ No
	☐ Yes	☐ No
	☐ Yes	☐ No
	☐ Yes	☐ No

MEDICARE/MEDICAID INFORMATION		
Is any applicant enrolled in Medicare?	☐ Yes	☐ No
Name of person covered by Medicare: _____. **For this applicant, please stop here, this insurance may duplicate existing Medicare coverage.**		
Is any applicant enrolled in Medicaid, CHIP+, or other governmental health program?	☐ Yes	☐ No
Name of person covered by Medicaid or other governmental health program: _____. For this applicant, please be aware that obtaining individual health insurance may affect which coverage is primary and/or applicant's eligibility for APTC.		

CURRENT MEDICAL COVERAGE

Do you, your spouse/partner, or your dependent child(ren) listed in this application currently have health insurance? ☐ Yes ☐ No

(Dental Coverage in next Section)

Name	Carrier Name	Effective Date of Coverage (MM/DD/YY)	Termination Date of Coverage (MM/DD/YY)	Coverage Type

If any applicant has current health coverage, will that applicant cancel current coverage if this application is accepted? ☐ Yes ☐ No

Type of Coverage Key: G = Group Comprehensive Major Medical; I = Individual Comprehensive Major Medical; MS = Medicare Supplement; H = Hospital Coverage Only; V = Vision Coverage Only O=Other, please explain:_____

CERTIFICATION OF DENTAL INSURANCE COVERAGE (Certification of dental insurance coverage is not required when purchasing coverage through Connect for Health Colorado)	
Pediatric dental coverage is a required essential health benefit. The plan you select may not include pediatric dental coverage. Do you have pediatric dental coverage under another plan?	☐ Yes ☐ No Note: you may be required to provide proof that you have obtained coverage before this policy will be approved

TERMS AND CONDITIONS

I acknowledge that I have read all sections of this Application, and I certify on behalf of my eligible family dependents and myself that the answers contained in this Application are complete and accurate to the best of my knowledge.

I understand that my answers, together with any supplements or additional pages, are the basis for the certificate or policy that is issued. I agree that no insurance will be effective until the date specified by the carrier on the certificate or policy.

I understand that my signature constitutes an attestation that I have obtained the required pediatric dental coverage under a separate policy, and may be required to provide proof of this pediatric dental policy prior to this policy being issued and approved. (Certification of dental insurance coverage is not required when purchasing coverage through Connect for Health Colorado)

I understand that any intentional misrepresentation relied upon by the carrier may be used to deny a claim. I further understand that this contract can be voided if, within the first 24 months from the date of the policy or certificate, it is determined that I or a family member made an intentional misrepresentation in this application.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance carrier for the purpose of defrauding or attempting to defraud the carrier. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance carrier or agent of an insurance carrier who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

I understand that I may request a copy of this Application. I agree that a photographic copy of this Application shall be as valid as the original. A legible facsimile signature shall have the same force and effectiveness as the original. This document, or the information contained herein, will become a part of the contract when coverage is approved and issued.

I would like to receive all policy notices, premium notices, and other notices relating to this policy through the supplied email address above. ☐ Yes ☐ No

I understand I can change this designation at a later date by contacting my carrier directly, and understand it is my responsibility to notify my carrier of any changes to my email address.

Signature of Primary Applicant/Parent or Legal Guardian for Child-Only Plans	Date Signed:
Complete this section if someone assisted you in the completion of this Application	
The following person assisted me in completing the Application:	Please explain the assistant's relationship to you and your family:

AGENT/PRODUCER INFORMATION	
This section is to be completed by Agent or Producer.	
Agent / Agency of Record: (for commissions and correspondence)	Writing Agent / Producer:
Name (print):	Name (print):
Agent ID # (NPN):	Agent ID #(NPN):
Agent replacement questions: Will this policy replace any existing accident and sickness insurance policy(s)? ☐ Yes ☐ No As the Writing Agent/Producer, I acknowledge that I am responsible to personally interact with the primary applicant submitting this application in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the primary applicant in the benefits summary document or other plan literature.	
Writing Agent Signature	Date

DISCLOSURES

This document is a publication of the Colorado Division of Insurance. If you have questions about the content of this document please contact our offices at 303-894-7499 or visit our website at http://www.dora.colorado.gov/insurance. For questions regarding coverage or enrollment please see your carrier.

This section may be used to provide additional information that was required in the sections above and did not fit in the space provided.

_____

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_____

_____

Signature of Primary Applicant: _____ Date Signed: _____