Alaska Comprehensive Health Insurance Association (ACHIA)
MAIL TO: Benefit Management, Inc.
2015 – 16th Street P.O. Box 1090 Great Bend, KS 67530
Customer Service (888) 290-0616

TAA ELIGIBILITYAND ENROLLMENT FORM

Requested Effective Date
_____

Preferred Provider (PPO) Comprehensive Major Medical:
_____ $1,000 Deduct./$2,500 Out of Pocket _____ $5,000 Deduct./$10,000 Out of Pocket
_____ $1,500 Deduct./$3,000 Out of Pocket _____$10,000 Deduct./$15,000 Out of Pocket
_____ $2,500 Deduct./$5,000 Out of Pocket _____$15,000 Deduct./$25,000 Out of Pocket

Non PPO Comprehensive Major Medical:
_____$1,000 Deduct./$2,500 Out of Pocket

PLEASE PRINT

1. _____
First, Middle and Last Name (Area Code) (Home Phone) (Work Phone)

Mailing Address _____

City _____ State _____ ZIP _____ Sex _____

Birth Date _____Age _____ Social Security # _____ Email: _____

How did you hear about the Association Plans? _____

Please refer to the Eligibility Requirements in the ACHIA brochure. If you are not eligible to receive Trade Readjustment Allowances, please do not complete this application. If you have eligibility questions, call 888-290-0616, however, neither ACHIA nor Benefit Management can establish your eligibility under the Trade adjustment Assistance Act (TAA). It is a Federal program. If you are covered by Medicaid or TRICARE, you are not eligible for ACHIA.

2. (TAA ELIGIBLE INDIVIDUALS ONLY) A TAA eligible individual means an individual domiciled in the state of Alaska that includes displaced workers who are eligible to receive Trade Readjustment Allowances (TRA) under the Trade Adjustment Assistance Act (TAA), or the Alternative Trade Adjustment Assistance (ATAA) program and for individuals receiving benefits from the Pension Benefit Guaranty Corporation (PBGC); an individual is not eligible for coverage under a health benefit plan, Medicare, Medicaid and who does not have other health care insurance coverage, provided that not more than 90 days has elapsed between the date of termination of coverage and application for ACHIA coverage.

A. Are you currently living and domiciled in Alaska? ☐ Yes ☐ No

B. Eligibility Criteria

(1) Have you been certified to receive any Trade Adjustment Assistance Act (TAA) benefits? ☐ Yes ☐ No
(Attach your certification to the application)

(2) Do you have group health coverage that has ended or will be ending? ☐ Yes ☐ No.
(Attach your most recent Certificate(s) of Coverage, if available, or provide proof of creditable coverage in another acceptable manner.)
If "Yes," please provide the name of the Insurance Company (Companies) and policy identification number(s).

_____ _____ _____ _____
(Name of Company) (Policy Number) (Description of Coverage) Date Coverage Ended

_____ _____ _____ _____
(Name of Company) (Policy Number) (Description of Coverage) Date Coverage Ended

_____ _____
Name of Employer Street Address City State/ZIP

If your spouse or parent/guardian is employed, does the employer offer health insurance for its employees?
☐ Yes ☐ No

If yes, are you currently under your spouse's or parent's/guardian's employer's plan: ☐ Yes ☐ No

(3) Have you ever enrolled in the Alaska Comprehensive Health Insurance Association plan before? ☐ Yes ☐ No
When? _____

(4) Do you have any other health insurance coverage: ☐ Yes ☐ No Describe the Coverage_____

_____

INSURANCE UNDER THE ASSOCIATION POLICY MAY BE EFFECTIVE RETROACTIVELY TO THE DATE YOUR COVERAGE TERMINATED IF YOU: (a) APPLY FOR THIS PLAN WITHIN 60 DAYS AFTER THE PREVIOUS CONTRACT OR POLICY TERMINATED, (b) ARE ACCEPTED BY THE ADMINISTRATOR; AND (c) PAY A SPECIFIC PREMIUM FOR THE PERIOD OF RETROACTIVE COVERAGE. OTHERWISE, THIS PLAN WILL BE EFFECTIVE ON THE FIRST OF THE MONTH FOLLOWING RECEIPT OF YOUR APPLICATION.

THE BENEFITS OF THE POLICY MAY NOT BE PAYABLE FOR ANY PREEXISTING INJURY OR SICKNESS FOR THE FIRST SIX MONTHS FOLLOWING THE POLICY DATE. PREEXISTING INJURY OR SICKNESS MEANS ANY INJURY OR SICKNESS WHICH: (a) MANIFESTED ITSELF WITHIN THREE MONTHS IMMEDIATELY BEFORE THE POLICY DATE IN SUCH A WAY AS WOULD CAUSE AN ORDINARY PRUDENT PERSON TO SEEK DIAGNOSIS, CARE OR TREATMENT FROM A PRACTITIONER; OR (b) MEDICAL ADVICE OR TREATMENT WAS RECOMMENDED OR RECEIVED WITHIN THREE MONTHS IMMEDIATELY BEFORE THE POLICY DATE. SEE THE PREEXISTING CONDITION EXCLUSION SECTION OF THE ACHIA BROCHURE FOR EXCEPTIONS.

I certify that I am a resident of Alaska as defined above, am not currently covered under an Association policy or any other health insurance policy or subscriber contract except as referred to above and that the foregoing statements are true and accurate to the best of my knowledge and belief. I understand that no coverage will be effective until the full initial premium is paid AND this application has been approved by the Association. Any misrepresentation or omissions may result in a termination or loss of coverage.

X_____ _____ _____

(Signature of Applicant) (Date) (Signature of Parent or Legal Guardian if the Applicant is Under Age 18 or Legally Incompetent)

3. All Applicants

Please remit at least one month's premium with this application. Checks should be made out to "ACHIA."

You will be notified of the acceptance of your application and will be billed any additional premium amount due at that time. Coverage will only become effective after receipt of the initial premium.

HAVE YOU

Answered all questions completely? Signed the application? Enclosed your first premium? Attached all required notices?

FAILURE TO PROVIDE COMPLETE AND ACCURATE RESPONSES TO THIS MAY DELAY THE EFFECTIVE DATE OF COVERAGE UNDER THE SELECTED PLAN.

IF APPLICATION HAS BEEN MADE WITH ASSISTANCE FROM AGENT — THE AGENT MUST COMPLETE THE FOLLOWING:

_____ _____ _____ _____

(Print Agent's Name) (Life&Disability License Number/Expiration Date) (Signature) (Date)

_____ _____ _____ _____ _____ _____

(SS# or Firm and PINNumber) Telephone # (Mailing Address) City State (ZIP Code)