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

ELIGIBILITY AND ENROLLMENT FORM **Requested Effective Date** _____

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

Non PPO Comprehensive Major Medical: _____$5,000 Deduct./$6,500 Out of Pocket

Medicare Supplement
(High Risk Individuals Only)
_____ Plan F
Plan G
_____ Medicare Carveout Plan
(Age 64 or less)
Must provide copy of Medicare card

PLEASE PRINT

1. _____
First, Middle and Last Name

_____
(Area Code) (Home Phone) (Cell 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. There are three ways that you can be eligible for coverage under the plan. If you meet the "high risk rules," please complete PARTS 2 and 4 of this application. If you meet the "federal rules," please complete PARTS 3 and 4 of this application. (Complete Parts 3 and 4 if you meet "both" rules.) If you have eligibility questions, call 888-290-0616. If you are covered by Medicaid or TRICARE, you are not eligible for ACHIA.

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2. (HIGH RISK INDIVIDUALS ONLY)

I certify that I am eligible for coverage under the "high risk rules" because I meet the following requirements:

(a) Residency

"Residency" means a person who: (1) is physically present in the State of Alaska; (2) has lived in the State of Alaska for at least the 12 months immediately preceding application or since birth if less than 12 months; and (3) intends to remain permanently in the State of Alaska.

"Resident" also means a person who is not physically in the state if: 1) the person lived in the state for at least 9 of the 12 months immediately preceding application for a state plan; and 2) the person's absence from the state is for medical treatment or education.

Current Physical Address _____

I have been a resident of Alaska continuously since _____
(Date)

(b) Eligibility Criteria

(1) Please indicate which of the following actions or notifications you have received due to health reasons within the **last (6) months**:

☐ A notice from one company of rejection for health insurance coverage due to medical reasons. (Attach Copy)
☐ You are under the age of 65 and on Medicare due to a disability

☐ As an alternative to the above, if you have any of the conditions listed in the Association Brochure, you may obtain coverage under the plan without having to submit the rejection notice otherwise required. Please list all conditions that apply. _____

_____

☐ Your current coverage contains or you were offered coverage that contains substantially restrictive riders that reduce coverage. A COPY OF THE RIDER OR NOTICE FROM THE INSURANCE COMPANY MUST BE ATTACHED.

(If you check this box, you must terminate your current coverage in order to be covered under ACHIA.)

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

(3) If you are applying for ACHIA's Medicare supplement or Medicare Carveout coverage, please provide your Medicare Health Insurance number _____. These plans are designed for persons enrolled in Parts A and B of Medicare.

(4) Are you currently eligible for health insurance benefits under Medical Assistance (Medicaid/Title 19) ☐ Yes ☐ No
If yes, please provide your medical assistance number_____

(5) Are you currently covered or have you been covered in the past 18 months by other health insurance (including ACHIA)? ☐ Yes ☐ No Attach any certification(s) of such coverage available. (If yes, complete Section #3.)
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 and Reason

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

Are you (check one): ☐ An employee ☐ Self-employed ☐ Not employed

_____ _____
Name of Employer Street Address City State/ZIP

If employed, does your employer offer health insurance for its employees? ☐ Yes ☐ No
Are you covered under your employer's plan? ☐ Yes ☐ No *If no, give reason:* _____

Have you ever been covered by your current employer's plan? ☐ Yes ☐ No

If yes, give date and reason coverage terminated: _____

Are you (check if applicable): ☐ Married ☐ Under age 18

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

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

If no, give reason: _____

Have you ever been covered by your spouse's or parent's/guardian's current employer's plan? ☐ Yes ☐ No

If yes, give date and reason coverage terminated: _____

(6) Do you intend to lapse or otherwise terminate your present policy, to be replaced by ACHIA coverage?
☐ Yes ☐ No ☐ Doesn't Apply If "Yes," date terminated: _____
Reason for termination: _____

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 PAYMENT OF PREMIUM.

THE BENEFITS OF THE POLICY WILL 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. If I'm applying for ACHIA's Medicare supplement or Medicare Carveout coverage, I understand that if I am not enrolled in Part B of Medicare, the amount that is payable under these plans will not include benefits usually paid by Medicare Part B. 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)

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3. (FEDERALLY ELIGIBLE INDIVIDUALS ONLY) A Federally Defined Eligible Individual means an individual domiciled in the state of Alaska with at least 18 months of creditable coverage whose most recent prior creditable coverage was under a health plan offered in the group market (or certain other church or government plans) who is not eligible for coverage under a health benefit plan, Medicare, Medicaid and who does not have other health care insurance coverage and whose most recent coverage was not terminated based on nonpayment of premiums or fraud and who, if offered continuation coverage, e.g., COBRA, accepted such coverage and has exhausted it, 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. Do you have group health coverage that has ended or will be ending? ☐ Yes ☐ No

Provide a history of your most recent 18 months of coverage. Attach your certification(s) of coverage, or provide proof of creditable coverage in another acceptable manner.

(I) Existing or Most Recent Employer/Group Health Benefit Plan:

Employer Name:		
Address:		Telephone No.:
Insurance Company Name:		
Address:		Telephone No.:
Coverage Start Date:	Coverage End Date:	Reason:

(II) Previous Employer or Group Health Plan Name, if Individual Coverage:

Employer Name:		
Address:		Telephone No.:
Insurance Company Name:		
Address:		Telephone No.:
Coverage Start Date:	Coverage End Date:	Reason:

(III) Previous Employer or Group Health Plan Name, if Individual Coverage:

Employer Name:		
Address:		Telephone No.:
Insurance Company Name:		
Address:		Telephone No.:
Coverage Start Date:	Coverage End Date:	Reason:

C. Are you on COBRA continuation coverage? ☐ Yes ☐ No
If yes, when was or will that coverage be exhausted? _____
You are not eligible for this ACHIA coverage until your COBRA coverage has ended. If you have more than 2 months until your COBRA coverage ends, please re-apply for this Plan at a later date.

D. Do you have any other health insurance coverage: ☐ Yes ☐ No Describe the Coverage _____

Applicant Signature **X**_____ Date_____

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4. (ALL APPLICANTS)

If you have not disclosed your condition(s) above, please state the primary condition(s) which prevent you from obtaining standard coverage. This information will be used for managing the program as well as for reporting to the Alaska Legislature. The answers will also be helpful from a case management perspective._____

Please remit at least one month's premium with this application. Checks should and 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)