IQChoice® Individual Health Plans from QualChoice

2017 Application for Individual Coverage — HMO

Before you begin, please read this information carefully:

- Please answer each question carefully. Type or print neatly. We cannot accept your application if information is missing.
- All applicants must be age 64 or younger, permanent, legal residents of Arkansas, and legal residents of the United States or U.S. citizens.
- HMO plans include our *Select* network. To review the network, go to ***QualChoice.com*** and select *Provider Search*.
- To find your premium amount please call an IQChoice sales representative at 866.645.1790, or your broker/agent.
- You must let QualChoice know if you use tobacco, including what type, how much and how often.
- There is an annual Open Enrollment Period for all individual plans (dates may vary). For a Special Enrollment Period (SEP), you must have a *qualifying event* (such as, birth, marriage, divorce or other). You must request coverage and provide proof of most *qualifying events* within 60 days of the event or within 90 days of a birth.
- Pediatric dental coverage is required under the Affordable Care Act and is available with our benefit plans. Please contact your broker, the Health Insurance Marketplace, or your dental insurance carrier if you wish to purchase a stand-alone dental product.
- Each applicant age 18 and over must sign and date this application. A digital signature may be used on a writable PDF.

This form is available online at *myIQChoice.com* as a writable PDF. You can fill it out, save it to your computer and print it. *For the latest version of Adobe Reader (the free software needed to read the PDF), visit adobe.com.*

For printed applications only:

- ✓ Use black or dark blue ink.
- ✓ If you make a mistake, mark through it and initial it. Then write in the correct information. Do not use correction fluid or correction tape.
- ✓ Your first month's premium payment must be included with your application.
- ✓ Sign and date any attachments containing additional information.

Policy Effective Date: Your effective date will be assigned in accordance with applicable law. Applications will not be regarded as received until they are complete. A complete application includes all required documents and the first month's premium.

■ Applying during an annual Open Enrollment Period

If application is received during an Open Enrollment Period	Policy Effective on:
on or before the 15th of the month	the first of the following month
after the 15th of the month	the first of the second following month
after December 15, 2016	February 1, 2017

■ Applying during a Special Enrollment Period with a qualifying event (see **Step 2**)

If application is received during a Special Enrollment Period	Policy Effective on:
on or before the 15th of the month	the first of the following month
after the 15th of the month	the first of the second following month

NOTE: Coverage for a newborn is effective on the date of the birth if we are notified within 90 days.

Premium Payment: We must receive your first month's premium payment with your application in order to process it. Please see **Step 10** for payment instructions**.**

Mail or fax your application, any required documents, and your first month's premium to:

QualChoice
ATTN: IQChoice
P.O. Box 26208
Little Rock, AR 72221
Fax: 866.645.1788

Step 1: Contact Person

One adult in your family between the ages of 18 and 64 must be the contact person for your application. All information is required.

First Name	MI	Last Name		
Email Address *(will receive important benefit messages)*		Main Phone No.		Other Phone No.
Home Address (No P.O. Box please)	City	State	Zip	County
Mailing Address (if different from home address)	City	State	Zip	County

Step 2: Eligibility

☐ I am applying during an Open Enrollment Period

☐ I am applying during a Special Enrollment Period.

If your application is not received during an Open Enrollment Period, you must send appropriate documentation confirming qualifying event/Special Enrollment Period (such as, copy of birth or death certificate, copy of marriage license, guardianship documentation etc.). This must be sent to us no more than 45 days before the event and no later than 60 days after the event (90 days for birth). Please check (✓) all boxes below that apply and provide date of *qualifying event.*

Qualifying Event — **Date of Qualifying Event**

☐ Birth ..... Date _____

☐ Adoption ..... Date _____

☐ Death ..... Date _____

☐ Divorce/Legal Separation ..... Date _____

☐ Marriage ..... Date _____

☐ New guardianship/legal custody/court order to add child ..... Date _____

☐ Loss of Minimum Essential Coverage ..... Date _____

☐ Non-Calendar Year Policy expires outside OEP ..... Date _____
This is a one-time SEP used for those losing coverage due to expiration of a non-grandfathered policy

☐ New coverage becoming available as a result of a permanent move ..... Date _____

☐ Errors, misinterpretation, inaction by the Health Insurance Marketplace, HHS, or their agents ..... Date _____

☐ Qualified Health Plan contract violation in relation to an individual ..... Date _____

☐ Loss of eligibility for Advanced Premium Tax Credit (APTC) ..... Date _____

Step 3: Policy Effective Date

Requested Policy Effective Date: (MM/DD/YYYY) _____

■ Applying during an annual Open Enrollment Period

If application is received during an Open Enrollment Period	Policy Effective on:
on or before the 15th of the month	the first of the following month
after the 15th of the month	the first of the second following month
after December 15, 2016	February 1, 2017

■ Applying during a Special Enrollment Period with a qualifying event (see **Step 2**)

If application is received during a Special Enrollment Period	Policy Effective on:
on or before the 15th of the month	the first of the following month
after the 15th of the month	the first of the second following month

NOTE: Coverage for a newborn is effective on the date of the birth if we are notified within 90 days.

Step 4: Applicant(s) Information

Who is applying for health insurance? Check (✓) one box only.

☐ Individual ☐ Individual & Spouse ☐ Individual & Children ☐ Family

Is the contact person listed in **Step 1** applying for coverage? ☐ Yes ☐ No

Please list below all who are applying for coverage. Tell us the relationship of each applicant, such as: self, spouse, son, daughter, stepson, or stepdaughter. **IMPORTANT:** All applicants (excluding minor children) **must live in Arkansas**. If you have permanent legal custody of a child, please attach appropriate court documents. Domestic partners are not eligible dependents**. If anyone applying is not a U.S. citizen, they must complete Step 5. If anyone applying uses tobacco products, they must complete Step 6**.

First Name	MI	Last Name	Relationship	Male (M) or Female (F)	Birth Date (MM/DD/YYYY)	Social Security Number	Tobacco Use
1							☐ Yes ☐ No
2							☐ Yes ☐ No
3							☐ Yes ☐ No
4							☐ Yes ☐ No
5							☐ Yes ☐ No

Step 5: U.S. Citizenship Status

Are all applicants listed in **Step 4** U.S. citizens? ☐ Yes ☐ No If **NO**, complete the information below.

First Name	MI	Last Name	Immigration Document Type	Immigration Document ID No.
1				
2				
3				
4				
5				

Step 6: Tobacco Use

Has any applicant(s) listed in **Step 4** used a tobacco product (other than for religious or ceremonial use) on an average of 4 or more times per week in the last 6 months? ☐ Yes ☐ No If **YES**, complete the information below.

First Name	MI	Last Name	Date Last Used	Type Used	Amount Used Per Week *Example: 6 packs of cigarettes per week*
1					
2					
3					
4					
5					
6					

Step 7: Email Address

Enter the email address of each applicant age 18 and over to receive messages about their benefits.

First Name	MI	Last Name	Email Address
1			
2			
3			
4			
5			
6			

Step 8: Select Your Benefit Plan

For information about the available benefit plans, please call an IQChoice sales representative at 866.645.1790, Monday — Friday, 8:00 a.m. to 5:00 p.m. **NOTE:** HMO plans use our Select network. Pediatric dental coverage is required by the Affordable Care Act. If you already have a qualified pediatric dental plan, you may choose a plan without it.

Pediatric Dental *Please check (✓) one.*	**Benefit Plan** *Please check (✓) one.*
I am requesting a benefit plan: ☐ With pediatric dental ☐ Without pediatric dental	☐ Bronze Basic Saver 5000 — HSA-qualified high deductible health plan ☐ Silver Basic 4000 ☐ Silver Basic Saver 3500 — HSA-qualified high deductible health plan ☐ Gold Basic 2000

Step 9: Primary Care Physician (PCP)

Your plan requires you to use a Primary Care Physician (PCP) who is in the *Select* network. To find a PCP and Provider ID, use *Provider Search* at *QualChoice.com*. Search within the *Select* network. You may also call 501.228.7111 or toll free 800.235.7111. You must use your PCP to direct your care, including referrals to specialists. *If you do not have a PCP, you will be assigned one.*

First Name	MI	Last Name	Relationship to Subscriber	PCP Name/Provider ID
1			☐ Self ☐ Spouse ☐ Dependent	Name: ID #:
2			☐ Self ☐ Spouse ☐ Dependent	Name: ID #:
3			☐ Self ☐ Spouse ☐ Dependent	Name: ID #:
4			☐ Self ☐ Spouse ☐ Dependent	Name: ID #:
5			☐ Self ☐ Spouse ☐ Dependent	Name: ID #:
6			☐ Self ☐ Spouse ☐ Dependent	Name: ID #:

Step 10: Premium Payment

Payment for first month's premium must be included with this application. To find the amount of your premium payment, call us at 866.645.1790 or your broker/agent.

- **First Month's Premium**

Amount of first month's premium: $_____

Choose your first month's payment method below.

Charge my first month's premium to my: ☐ Visa ☐ MasterCard ☐ Discover

Card No. _____ Expiration Date _____/_____ Sec. Code (3 digit no. on back of card) _____

☐ Check enclosed ☐ Cashier's check enclosed ☐ Bank draft (must complete *Bank Draft Payment Authorization* below)
☐ Cash (*visit the QualChoice office at 12615 Chenal Parkway, Little Rock, AR, Monday through Friday between 8:00 a.m. and 5:00 p.m.*)

- **Future Premium Payments** Please check (✓) your future payment method below. All future monthly payments are due on the first day of each month's coverage period. If the 'bank draft' method of payment is checked, you must complete the *Bank Draft Payment Authorization* below.

Choose your future payment method: *(Your application cannot be processed without this information.)*

Monthly Billing *Due first day of each month*	**Quarterly Billing** *Due first day of coverage period*	**Annual Billing** *Due first day of coverage period*
☐ Bank Draft	☐ Bank Draft ☐ Check ☐ Cash	☐ Bank Draft ☐ Check ☐ Cash

ONLINE BILL PAYMENT: You can also pay your premiums quickly, accurately and securely from your bank account. Go to *QualChoice.com,* select Online Bill Payment.

Bank Draft Payment Authorization

1. I authorize QualChoice and the Bank/Financial institution indicated below to debit my health insurance premium from the account listed below.
2. This authorization is to remain in full force and effect until my Bank has received written notification from me of the Bank Draft termination. This notice must be received in such time and such manner as to afford the Bank a reasonable opportunity to act on it, or until the Bank has sent me ten (10) days' written notice of the Bank's termination of this agreement.
3. I understand that by revoking the Bank Draft after I have agreed to it, I will also be terminating my insurance coverage, unless QualChoice has received written notice from me of my desire to continue coverage at least **twenty (20) days** prior to the Bank Draft withdrawal date.
4. I understand that if my bank rejects a bank draft due to insufficient funds in my account, QualChoice may charge me a fee of up to $20.00.

☐ I understand and agree that my **first month's premium** will be drafted upon initial acceptance of coverage.
☐ I understand and agree that **future monthly premiums** will be drafted on the 1st day of each month for Monthly Bank Draft, or on 1st day of coverage period for Quarterly or Annual billing.

Name of Bank or Financial Institution	**Account Type (check one)** ☐ Checking ☐ Savings		
9 Digit Bank Routing Number	**Bank Account Number**		
Account Holder Name			
Address	**City**	**State**	**Zip**

By signing this *Bank Draft Payment Authorization*, I agree to all terms and conditions expressed in the payment method I have chosen above. I understand that if I do not follow what has been authorized on this form, QualChoice may cancel my policy.

Signature of Account Holder **X**	**Date Signed** (MM/DD/YYYY)

Disclosures: All applicants must read.

I agree to and understand the following:

1. The insurance I am applying for will not become effective until my application has been approved and I have paid the first month's premium.
2. If an agent/broker has worked with me on this application, he/she may receive compensation (payment) from QualChoice. Any such compensation is included in my insurance premium. (To learn more about any compensation involved, please contact your agent/broker.)
3. If I am not truthful in my answers on this application, QualChoice may, in some cases, cancel my coverage as of the original starting date and I may not reapply for this coverage.
4. If I give false information about tobacco use, QualChoice can change my premium to what it should have been when the policy began.
5. My signature lets QualChoice coordinate my benefits with other insurance I may have.
6. My signature authorizes QualChoice to release to my broker/agent necessary information about myself and any family members listed on this application. This includes information related to substance use or abuse, but not psychotherapy notes, as defined in Department of Health and Human Services HIPAA regulation 45 CFR §164.501. I understand that I may cancel this authorization by sending a written notice to QualChoice, Attn: IQChoice, P.O. Box 26208, Little Rock, AR 72221.
7. QualChoice may call or email me for more information, if needed.

Authorized Signatures: In signing below, I agree that:

1. My statements and answers in this application and any signed and dated attachments are true, complete and correct.
2. I must let QualChoice know in writing of any changes to the information on my application before the policy effective date.
3. I signed this application in the State of Arkansas and all applicants (excluding minor children) listed are permanent, legal residents of Arkansas.

Each applicant, who is 18 years of age or older, must sign and date below. Please sign correct line only.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.			
Signature of:	**Full Name**	**Signature**	**Date Signed** (MM/DD/YYYY)
Person listed in Step 1 **or** parent/legal guardian *(if applying)*		**X**	
Spouse *(if applying)*		**X**	
Adult *(only if 18 and over and applying)*		**X**	
Adult *(only if 18 and over and applying)*		**X**	
Adult *(only if 18 and over and applying)*		**X**	
Adult *(only if 18 and over and applying)*		**X**	

This section to be completed by Broker/Agent

Broker/Agent Name (Please print)			Phone No.
Agency Federal Tax ID No. *(if applicable)*	Broker Agency Name	Broker/Agent E-mail	
Broker/Agent Signature **X**		Date Signed (MM/DD/YYYY)	National Producer No. (NPN)

IMPORTANT

Privacy Disclosure

We use and disclose *protected health information* (PHI) in a number of different ways in connection with health care operations, the payment for health care, and treatment. The following are only a few examples of the types of uses and disclosures of PHI that we are permitted to make **without individual authorization**.

A. Payment: We will use and disclose PHI to administer health benefits policy or contract, which may involve the determination of eligibility; claims payment; utilization review and care management; medical necessity review; coordination of care, benefits and other services; and responding to complaints, appeals and external review requests. Likewise, we may also share PHI with another entity to assist with subrogation of health claims or to another health plan to coordinate benefit payments. In some instances, we may also use and disclose PHI for purposes of premium billing, underwriting, and the determination of premium rates and co-payments, deductibles, coinsurance and other cost sharing amounts.

B. Treatment**:** We may disclose PHI to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers) who request it in connection with treatment. We may also disclose PHI to health care providers in connection with preventive health, early detection and care management programs, in plans that offer these programs.

C. Health Care Operations: We will use and disclose your Protected Health Information to support other business activities, including the following:

1. Quality assessment and improvement activities: peer review and credentialing of Network Providers and accreditation by independent organizations such as the National Committee for Quality Assurance and URAC;
2. Performance measurement and outcomes assessment, health claims analysis and health services research;
3. Operation of preventive health, early detection, care management, and coordination of care programs in plans that offer these programs, including information about treatment alternatives, therapies, health care providers, settings of care or other health-related benefits and services;
4. Medical care review;
5. Underwriting, premium determination and administration of reinsurance;
6. Risk management, auditing, legal services and detection and investigation of fraud and other unlawful conduct;
7. Transfer of eligibility and plan information to business associates (for example: pharmacists, mental health management companies) for the management of mental health benefits, and other programs as necessary to administer your benefit plan.
8. Other general administrative activities, including data and information systems management and customer service.

Individual Right of Access and Additional Information

QualChoice maintains strict adherence to the protection and confidentiality of PHI. Additional information within QualChoice may be directed to the Privacy Official, Security Official, or the Office of the General Counsel. In addition, any individual may request and receive a copy, including an electronic copy of his or her PHI on file with QualChoice. Please submit inquiries or requests to:

QualChoice
ATTN: Privacy Official
P.O. Box 25610
Little Rock AR 72221

P: 501.228.7111 or 800.235.7111

Individual questions or concerns may also be addressed by the:

- Department of Health & Human Services
  www.hhs.gov/ocr/privacy/hipaa/complaints/
- Office for Civil Rights (OCR) — Will need to file a Health Information Privacy Complaint