NOTICE - YOU MUST PERSONALLY BEAR ALL COSTS IF YOU UTILIZE HEATH CARE NOT AUTHORIZED BY THIS PLAN OR PURCHASE DRUGS WHICH ARE NOT AUTHORIZED BY THIS PLAN

CHRISTUS Health Plan

Application for Individual & Family Plan

Get help with this application by contacting your broker or CHRISTUS Health Plan Individual Plan Sales Team.

SUBMIT BY FAX:	SUBMIT BY MAIL:
469-282-3013	CHRISTUS Health Plan 5101 N. O'Connor Blvd. Irving, TX 75039

APPLICATION INSTRUCTIONS

1. Dependent children aged 26 or older must apply for separate policies. When a covered dependent child turns 26, they can transfer to their own policy without reapplying as long as the request to transfer is submitted within 31 days of the covered dependent's 26th birthday.
Incapacitated dependents are not required to apply separately.

2. Your effective date will be the first (1st) of the month if application is received by the fifteenth (15th) day of the month or the first (1st) of the following month, if the application is received after the fifteenth (15th) day of the month. There are exceptions on effective coverage. Please contact the plan to determine your effective date.

STEP 1 Tell us about yourself

(We will need one adult in the family to be the contact person for your application.)

1. First Name, Middle Name, Last Name & Suffix

2. Home Address (Leave blank if you don't have one)			3. Apartment Number
4. City	5. State	6. ZIP Code	7. County
8. Mailing Address (if different from home address)			9. Apartment Number
10. City	11. State	12. ZIP Code	13. County
14. Phone Number		15. Other Phone Number	

16. Do you want to get plan information by email? ☐Yes ☐No
Email address:

17. Social Security Number
___ – ___ – ____

18. Sex ☐Male ☐Female

19. Date of Birth (mm/dd/yyyy)

20. Do you need health coverage? ☐Yes ☐No, child only coverage. Go to step 2

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STEP 2 Tell us who else needs health coverage

(If you have more people to include, make a copy of this page.)

STEP 2: PERSON 2

1. First Name, Middle Name, Last Name & Suffix		2. Relationship to you
3. Social Security Number – –	4. Date of Birth (mm/dd/yyyy)	5. Sex ☐ Male ☐ Female

STEP 2: PERSON 3

1. First Name, Middle Name, Last Name & Suffix		2. Relationship to you
3. Social Security Number – –	4. Date of Birth (mm/dd/yyyy)	5. Sex ☐ Male ☐ Female

STEP 2: PERSON 4

1. First Name, Middle Name, Last Name & Suffix		2. Relationship to you
3. Social Security Number – –	4. Date of Birth (mm/dd/yyyy)	5. Sex ☐ Male ☐ Female

STEP 2: PERSON 5

1. First Name, Middle Name, Last Name & Suffix		2. Relationship to you
3. Social Security Number – –	4. Date of Birth (mm/dd/yyyy)	5. Sex ☐ Male ☐ Female

STEP 2: PERSON 6

1. First Name, Middle Name, Last Name & Suffix		2. Relationship to you
3. Social Security Number – –	4. Date of Birth (mm/dd/yyyy)	5. Sex ☐ Male ☐ Female

STEP 2: PERSON 7

1. First Name, Middle Name, Last Name & Suffix		2. Relationship to you
3. Social Security Number – –	4. Date of Birth (mm/dd/yyyy)	5. Sex ☐ Male ☐ Female

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STEP 3

Tell us about you or your family's tobacco use

Do you or a member of your family use tobacco products? ☐ No ☐ Yes

If you answered YES above, please list those members below.

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____

STEP 4

Tell us what plan you would like to choose by marking an X in the appropriate box below.

☐	Standard Expanded Bronze
☐	Bronze Essential
☐	Value Bronze
☐	Bronze Essential Plus
☐	Bronze Plus
☐	Value Bronze Plus

☐	Standard Gold
☐	Gold Essential
☐	Gold
☐	Gold Essential Plus
☐	Gold Plus

☐	Standard Silver
☐	Standard Silver 73
☐	Standard Silver 87
☐	Standard Silver 94
☐	Silver Essential
☐	Silver Essential 73
☐	Silver Essential 87
☐	Silver Essential 94

☐	Value Silver
☐	Value Silver 73
☐	Value Silver 87
☐	Value Silver 94
☐	Silver Essential Plus
☐	Silver Essential Plus 73
☐	Silver Essential Plus 87
☐	Silver Essential Plus 94

☐	Value Silver Plus
☐	Value Silver Plus 73
☐	Value Silver Plus 87
☐	Value Silver Plus 94
☐	Silver Plus
☐	Silver Plus 73
☐	Silver Plus 87
☐	Silver Plus 94

The limited plans listed below are only available to American Indian American Natives.

☐	American Indian Zero Cost Sharing
☐	American Indian Zero Cost Sharing Plus
☐	American Indian Zero Cost Sharing Plus Fitness
☐	American Indian Zero Cost Sharing Plus Fitness Dental Vision

☐	Standard Expanded Bronze Limited
☐	Bronze Essential Limited
☐	Value Bronze Limited
☐	Bronze Essential Plus Limited
☐	Bronze Plus Limited
☐	Value Bronze Plus Limited

☐	Standard Silver Limited
☐	Silver Essential Limited
☐	Value Silver Limited
☐	Silver Essential Plus Limited
☐	Silver Plus Limited
☐	Value Silver Plus Limited

☐	Standard Gold Limited
☐	Gold Essential Limited
☐	Gold Limited
☐	Gold Essential Plus Limited
☐	Gold Plus Limited

CHRISTUS Health Plan

STEP 5 Tell us how you will pay your monthly premiums

(If you do not select a payment option, we will send you a bill.)

Please select one option and complete corresponding details below:

☐ Credit / Debit Card ☐ Automatic Bank Draft ☐ Get a Bill

Credit/Debit Card

☐ MasterCard ☐ Visa ☐ Discover

Card Number _____

Name on Card _____ Card Expiration Date _____

Card Billing Address

Street Address _____

City _____ State _____ ZIP Code _____

Automatic Bank Draft

☐ Checking Account ☐ Savings Account

Name of Bank _____

Account Number _____ Routing Number _____

Name of Account Holder _____

STEP 6 Read and sign this application

CHRISTUS Health Plan (CHP) insurance is prepaid health coverage. This means you must pay your premium payment for coverage prior to the month.

I hereby authorize and request CHP to initiate withdrawal entries from the account(s) and the financial institution(s) indicated above for the monthly premium payments required by the Policy and Evidence of Coverage. These withdrawals are for premium payments for the enrolled individuals listed in Step 1 and/or Step 2 of this application. This authorization is to remain in effect until CHP and/or the financial institution(s) named above are notified in writing.

I understand that applicants enrolled for coverage shall be provided a ten-day period from the effective date of coverage to examine and return the contract and have the premium refunded. If medical services were received during the ten-day period, and the member returns the contract to receive a refund of the premium paid, he or she must pay for those services.

CHRISTUS Health Plan

I understand covered benefits and services are subject to the provisions of the Policy and Evidence of Coverage. For a complete list of benefits, please refer to the Summary of Benefits or Policy and Evidence of Coverage. These documents are found at www.christushealthplan.org or you can contact CHP Member Services by phone toll-free at 844-282-3025, Monday through Friday from 8:00 a.m. to 5:00 p.m. CST. TTY users may call 711.

I hereby authorize to the extent permitted by applicable law, the use or release of my protected health information (PHI) by any person or entity, without limitation including practitioners, providers, and insurance companies to CHP or its designees for any permitted purpose. Purposes including, but not limited to, evaluating my application for insurance, quality assurance, utilization review, processing of claims, financial audits or other purposes related to the treatment, payment, or healthcare operations activities of CHP. This consent shall not permit use or disclosure of PHI when authorization is required by law. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. This authorization shall be valid for two years from this date and may be revoked at any time by sending written notice to CHP.

I confirm that no one applying for health coverage on this application is incarcerated, other than incarcerated pending disposition of charges.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FORM FOR PAYMENT OF A LOSS OF BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

I understand that upon enrollment, I will receive my CHP Policy and Evidence of Coverage, which contains the benefits, limitations, and exclusions applicable to my healthcare plan. I understand that I am entitled to a copy of this signed Application upon request.

I acknowledge (or Legal Guardian of Minor Dependent), that I have read and understand this Application in its entirety.

x _____ _____

signature date

**Application will expire within 60 days from the date of your signature*

For certified application counselors, navigators, agents, and brokers only.
Complete this section if you're a certified application counselor, navigator, agent, or broker filing out this application for somebody else.

1. First Name, Middle Name, Last Name & Suffix	2. Phone Number
3. Organization Name	4. ID Number (if applicable)

CHRISTUS Health Plan

Notices

1. NOTICE - YOU MUST PERSONALLY BEAR ALL COSTS IF YOU UTILIZE HEALTH CARE NOT AUTHORIZED BY THIS PLAN OR PURCHASE DRUGS WHICH ARE NOT AUTHORIZED BY THIS PLAN.

2. YOUR RIGHTS REGARDING THE RELEASE AND USE OF GENETIC INFORMATION:
Under Louisiana law LSA-R.S. 22:1023(B)(2), no health and accident insurer or health maintenance organization may require an applicant for coverage under a policy or plan, to be the subject of a genetic test, release genetic test information, or be subjected to questions relating to the medical conditions of persons not being insured under such policy or plan. The results of any genetic tests, including genetic test information, shall not be used as the basis to terminate, restrict, limit, or otherwise apply conditions to the coverage of an individual or family member under the policy or plan, or restrict the sale of the policy or plan to an individual or family members; or cancel or refuse to renew the coverage of an individual or family member under the policy or plan; or deny coverage or exclude an individual or family member from coverage under the policy or plan; or impose a rider that excludes coverage for certain benefits or services under the policy or plan; or otherwise discriminate against an individual or family member in the provision of insurance.

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https://www.christushealthplan.org/

1-844-282-3025