Wayne County's
HEALTHCHOICE
640 Temple #370
Detroit, MI 48201
1-800-935-5669
HEALTHCHOICE OF MICHIGAN
PRINT ONLY

CHECK ONE:
Original Subscriber Application ☐
Change Form ☐
Term ☐

SUBSCRIBER APPLICATION /CHANGE FORM

SOCIAL SECURITY #	BIRTH DATE	SEX MALE ☐ FEMALE ☐		AREA CODE	HOME PHONE#
LAST NAME	FIRST NAME		MIDDLE INITIAL	AREA CODE	BUSINESS PHONE#
ADDRESS	APT#	CITY	COUNTY	STATE	ZIP CODE
DO YOU HAVE OTHER MEDICAL COVERAGE? YES☐ NO☐	COVERAGE /INSURANCE NAME		POLICY CONTRACT #		
DOES YOUR DEPENDENT(S) HAVE MEDICAL COVERAGE? YES☐ NO☐	COVERAGE /INSURANCE NAME		POLICY CONTRACT #		

MARITAL STATUS: SINGLE☐ MARRIED☐ WIDOWED☐ DIVORCED☐

DATE OF HIRE

PLEASE LIST THE NAMES OF ELIGIBLE DEPENDENTS TO BE COVERED (SEE REVERSE SIDE FOR DEPENDENT CRITERIA)

1.	LAST NAME	FIRST NAME		MIDDLE INITIAL	BIRTH DATE		
	SOCIAL SECURITY #	SEX	RELATION	AGE	MARITAL STATUS	FULL-TIME STUDENT	
2.	LAST NAME	FIRST NAME		MIDDLE INITIAL	BIRTH DATE		
	SOCIAL SECURITY #	SEX	RELATION	AGE	MARITAL STATUS	FULL-TIME STUDENT	
3.	LAST NAME	FIRST NAME		MIDDLE INITIAL	BIRTH DATE		
	SOCIAL SECURITY #	SEX	RELATION	AGE	MARITAL STATUS	FULL-TIME STUDENT	
4.	LAST NAME	FIRST NAME		MIDDLE INITIAL	BIRTH DATE		
	SOCIAL SECURITY #	SEX	RELATION	AGE	MARITAL STATUS	FULL-TIME STUDENT	

ADDITIONAL ELIGIBLE DEPENDENTS LISTED ON SEPARATE SHEET YES☐ NO☐

FOR CHANGE FORM PURPOSES ONLY

DEPENDENT
ADDITION (Date of Event)_____ MARRIAGE☐ NEWBORN☐ PRINCIPLE SUPPORT☐ ADOPTION / LEGAL GUARDIANSHIP☐

DELETION (Date of Event)_____ DIVORCE☐ DEATH☐ OTHER☐

DO YOU OR ANY OF YOUR DEPENDENTS HAVE A PRE-EXISTING CONDITION(S) LISTED ON THE BACK? YES☐ NO☐

WHO?_____

LIST PRE-EXISTING CONDITIONS_____

PLEASE ATTACH CERTIFICATE OF CREDITABLE COVERAGE FROM PRIOR PLAN OR DEMONSTRATE CREDITABLE COVERAGE (SEE SUBSCRIBER CERTIFICATE FOR EXPLANATION)

BY SIGNING BELOW, I ACKNOWLEDGE THAT: (1) I HAVE BEEN PROVIDED WITH A COPY OF THIS TWO PAGE FORM; (2) I HAVE READ, UNDERSTAND, AND AGREE TO THE CONDITIONS ON THE REVERSE SIDE OF THIS FORM; AND (3) I HAVE ATTACHED MY MOST RECENT PAY STUB.

APPLICANT'S SIGNATURE_____ **DATE**_____

EMPLOYER APPLICATION

COMPANY NAME			FEDERAL ID#		
ADDRESS	CITY	STATE	ZIP CODE	AREA CODE	BUSINESS PHONE #
EMPLOYMENT STATUS ACTIVE☐ COBRA☐	IF COBRA, WAS ELIGIBILITY VERIFIED AND NOTICE PROVIDED TO EMPLOYEE? YES☐ NO☐				EMPLOYEE HOURS OF WORK PER WEEK
PROVIDER SELECTED	COMMUNITY CARE ASSOCIATES☐ MIDWEST☐ PROCARE☐				
GOLDEN DENTAL☐				HERITAGE VISION☐	

THE UNDERSIGNED REPRESENTS AND WARRANTS THAT: (1) HE /SHE HAS BEEN AUTHORIZED TO EXECUTE THIS SUBSCRIBER APPLICATION AND MAKE THE FOREGOING CERTIFICATIONS ON BEHALF OF THE EMPLOYER; (2) HE /SHE HAS BEEN PROVIDED WITH A COPY OF THIS TWO PAGE FORM; AND (3) HE /SHE HAS READ, UNDERSTANDS, AND AGREES TO THE CONDITIONS ON THE REVERSE SIDE OF THIS FORM.

EMPLOYER S SIGNATURE_____ **DATE**_____

FOR OFFICIAL USE ONLY **ID#**_____ **GROUP #**_____ **EFFECTIVE DATE**_____

SUBSCRIBER CERTIFICATION OF ELIGIBILITY

By submission of this Subscriber Application, I am applying for Basic Services specified in my Subscriber Certificate of Eligibility with HealthChoice of Michigan and any amendments thereto (hereinafter

collectively referred to as "Subscriber Certificate") and for the selected Supplemental Services (also known as "riders"), as defined in my Subscriber Certificate of Eligibility with HealthChoice of Michigan.

I understand that all Supplemental Services elected have been elected for myself and all eligible dependents as defined in the Subscriber Certificate, and that I am responsible for paying the premium for the Supplemental Services in addition to the premium for Basic Services.

By submission of the Subscriber Application, I hereby certify that, to the best of my knowledge, I qualify as a Subscriber under the terms of the Subscriber Certificate by meeting all of the following criteria:
A) I am an employee of a qualified employer and have an anticipated work future of more than five (5) months.
B) I am currently without health care benefits and am not eligible, without regard to the availability of coverage, for Medicare, Medicaid or other employer sponsored health care coverage.
C) I am currently working at least 20 hours per week. I agree to notify HealthChoice if my hours are reduced to less than 20 hours per week for any reason at any time after enrollment.
D) My employer has not offered or contributed to health care benefits of employees in the same or similar job classification in which I am employed in the 65 day period immediately preceding the effective date of the Group Operating Agreement between my employer and HealthChoice of Michigan.
E) I am a resident of the State of Michigan as defined in the Subscriber Certificate, and I have accurately listed the County of my residence on the reverse side.
F) I have completed and signed this Subscriber Application for enrollment.

By submission of this Subscriber Application for an eligible dependent as defined in the Subscriber Certificate, I hereby certify that, to the best of my knowledge, each eligible dependent listed on this application qualifies as an eligible dependent under the terms of the Subscriber Certificate by meeting all of the following criteria:
(a)Be the spouse of the Subscriber who:
1. Qualifies for coverage, subject to verification of family income;
2. Is not serving in the Armed Forces of the United States;
3. Is without health care benefits at time of enrollment; and
4. Is not eligible, without regard to the scope of coverage, for Medicare, Medicaid or other employer-sponsored health benefit plan or program.
Or
(b) As defined as in Internal Revenue Code § 152 (f)(1), be a child of the Subscriber, which is defined as a son, daughter, stepson, stepdaughter, eligible foster child, or adopted child of the Subscriber until the child reaches the age of 26. An eligible foster child is an individual who is placed with the Subscriber by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. An adopted child includes both a legally adopted child of the Subscriber and a child who is lawfully placed with the Subscriber for legal adoption by the Subscriber. An adult child age 19 and over is not eligible for coverage if the adult child has another offer of employer-sponsored coverage.

By submission of this Subscriber Application to my employer, I hereby authorize my employer to deduct from my wages, as a payroll deduction, an amount not to exceed that portion of the monthly advance premium and any Supplemental Services selected for myself and eligible dependents that my employer may charge to me under the terms of the Subscriber Certificate of Eligibility.

I further certify that I have received and read the Subscriber Certificate, and I acknowledge that I have been advised that the Subscriber Certificate of Eligibility is available online at www.waynecountyhealthchoice.org. I understand that the Subscriber Certificate, any riders thereto and this Subscriber Application Form contain the specific provisions and limitations of my coverage and are my contract with HealthChoice of Michigan.

I appoint my employer as my agent to handle all matters of HealthChoice of Michigan coverage. I am responsible for giving notices of changes in my status and that of my family members, which affect coverage, to my employer. I authorize HealthChoice of Michigan to obtain hospital and medical records relating to me and my family from providers of service.

I have reviewed the Explanation of Pre-Existing Condition Limitations and have disclosed all pre-existing conditions for myself and my eligible dependents on the reverse side of this form. I understand that if I or my eligible dependents have been treated for an injury or illness within six (6) months prior to becoming eligible for benefits under the Subscriber Certificate, then all health care services incurred as a result of such injury or illness will not be considered as Covered Services until expiration of the maximum period authorized by state or federal law for a pre-existing condition limitation (as reduced by any period of creditable service or by other reductions required by law).

HealthChoice or its Managed Care Providers may require any person to verify their ineligibility for Medicaid or Medicare by completion and submission of an application for Medicaid or Medicare benefits as a part of the Subscriber Application for the person or at any time during the period a person is a Member. Refusal by a Member of request by the Program or its Managed Care Providers to complete and submit an application for Medicaid or Medicare benefits may result in termination of this Subscriber Certificate for the Member.

I represent and warrant that the information provided by me on this Subscriber Application is true, correct, and complete. I understand that if I falsify or withhold information requested by HealthChoice on the Subscriber Application, or as required under the Subscriber Certificate, including a refusal of a request by HealthChoice or its Managed Care Providers, I will be terminated from the Program immediately and coverage for myself and my eligible dependents will end as of the effective date of termination.

EMPLOYER CERTIFICATION
By execution of and submission of this Subscriber Application, the undersigned certifies, on behalf of the employer, that to the best of the employer's knowledge, the applicant qualifies as a Subscriber under the terms of the Subscriber Certificate, that all eligible dependents for whom coverage is sought by the Subscriber qualify as eligible dependents under the terms of the Subscriber Certificate and that the employer qualifies as a Group whose employees may enroll as Subscribers under the terms of the Subscriber Certificate by meeting the following criteria unless waived in writing by HealthChoice:
A) Have their principle place of business for global operations located in Wayne County.
B) At the time the Group enters into the Group Operating Agreement, the Group has two (2) or more employees who are otherwise eligible to enroll as Subscribers.
C) Including this Subscriber Application, the employer has submitted two (2) or more complete Subscriber Applications for employees who otherwise qualify as Subscribers and will have two (2) or more employees enrolled in the program.
D) At the time the Group enters into the Group Operating Agreement, not less than 50% of all employees have an hourly wage of fourteen dollars and fifty cents ($14.50) or less.
E) The employer has entered into a Group Operating Agreement with HealthChoice of Michigan.
If this form is being submitted for purposes of a Subscriber Change Form relating to COBRA coverage, employer certifies that it is responsible for determining employee's eligibility for COBRA coverage and sending out all required COBRA notifications. Employer agrees to indemnify and hold harmless HealthChoice of Michigan for all claims related to COBRA eligibility, notification and coverage.

COMMUNITY CARE ASSOCIATES, INC.

*P .O. Box 44230 * Detroit, MI 48244*
Phone 313-961-3100 Fax 313-961-3116

HEALTH INFORMATION REQUEST FORM

In order to better serve you and meet your current healthcare needs, please complete the information listed below.

Have you / your dependents had previous healthcare coverage within the last six months?_____

Due to continuity of care please indicate whether you /or any of your dependents have been treated or received medical advice from any physician within the last 12 months.

List dependent(s):_____
_____
_____

If treated please list Physicians_____
Address: _____
Hospital / Surgery Date : _____

Current Medication(s)_____

I HEREBY DECLARE that the answers and statements are made by me, and are true and complete to the best of my knowledge. I understand that the coverage applied for will not become effective prior to the approval date specified by the plan , **if approved.**

Employee Signature: _____ Date: _____