Individual Application

Submit completed application to:
Common Ground Healthcare Cooperative
PO Box 1630
Brookfield, WI 53008-1630

EFFECTIVE DATE*: ______________________________

*If enrolling during Open Enrollment, coverage is effective on the first day of the month following receipt of the application if it is received between the 1st and 15th day of any month. If an application is received between the 16th day and the last day of the month, coverage is effective the first day of the second following month.
*If enrolling outside of Open Enrollment, please include documentation of a qualifying life event or loss of coverage.

I. Applicant Information

FIRST NAME	M.I.	LAST NAME	EMAIL ADDRESS	
HOME ADDRESS – STREET	CITY	STATE	ZIP CODE	COUNTY

PRIMARY PHONE (include area code)	SECONDARY PHONE (include area code)	MARITAL STATUS
		❍ SINGLE ❍ DIVORCED ❍ MARRIED ❍ WIDOWED

II. Plan Selection / Information

PLEASE INDICATE PLAN NAME:

Plan name: ______________________________

I am applying for coverage for: (check all that apply)

☐ Myself ☐ My spouse ☐ My dependent child(ren)

III. Other Insurance Information

Will you or any family members covered by this policy have other health insurance coverage when this policy becomes effective? ❍ Yes ❍ No

IV. Applicant Information *- List all family members to be covered.*

APPLICANT:

APPLICANT	SOCIAL SECURITY NUMBER	DISABILITY (Y/N)	DATE OF BIRTH (MM/DD/YYYY)	RELATIONSHIP	SEX (M/F)	TOBACCO USE(Y/N)
				SELF		

RACE	ETHNICITY	LANGUAGE SPOKEN	LANGUAGE WRITTEN	CULTURE/RELIGIOUS BELIEFS
American Indian/Alaska Native Native Hawaiian/Other Pacific Islander Asian Black Or African American White Some Other Race Unknown Declined	Hispanic Or Latino Not Hispanic Or Latino Unknown Declined	English Spanish Chinese Declined Other:	English Spanish Chinese Declined Other:	Atheism/Agnostic Christian Hinduism Muslim Scientology Declined Buddhism Jehovah's Witness Judaism Paganism Voodoo Other:

DEPENDENTS (Indicate last name ONLY if different than applicant):

NAME (FIRST, MI, LAST)	SOCIAL SECURITY NUMBER	DISABILITY (Y/N)	DATE OF BIRTH (MM/DD/YYYY)	RELATIONSHIP	SEX (M/F)	TOBACCO USE(Y/N)

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V. Applicant's Authorization and Representation *Read this section carefully, sign and date the application.*

I hereby apply for coverage on the basis of the statements and answers to the questions herein. I hereby represent all answers to be true to the best of my knowledge and to accurately represent the health of those persons applying for coverage and waiving coverage. I understand that these statements, answers and subsequent information I provide are the basis for my coverage. **I understand that if my application for new or additional coverage is accepted, that applicable coverage will not be effective until after I am notified of the Effective Date.**

I hereby authorize Common Ground Healthcare Cooperative (CGHC) to obtain from providers of services and hospitals, including those providers with whom CGHC contracts for service, the medical records, including those which relate to mental health and chemical dependency treatment, relating to me and my family members to the extent that those records are necessary for the administration of the CGHC contract, including for purposes of claims payment, case management, fraud investigation and quality of care review. A photocopy of this authorization shall be as valid as the original and remains in effect as long as continually insured by CGHC or until revoked.

I UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMISSION OF RELEVANT INFORMATION TO COMMON GROUND HEALTHCARE COOPERATIVE IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIMS OR CANCELLATION OR RESCISSION OF COVERAGE.

SIGNATURE OF APPLICANT **DATE SIGNED**

VI. Agent's Certification (If applicable.)

I, as writing agent, certify that I have actively participated in the solicitation and placement of this insurance. I understand that I have no authority to alter this application to bind Common Ground Healthcare Cooperative by making any promise and/or representation, or to waive or change terms, conditions and/or provisions of the group insurance policy or any requirement imposed by Common Ground Healthcare Cooperative.

WRITING AGENT'S SIGNATURE **DATE SIGNED**

WRITING AGENT'S PRINTED NAME **WRITING AGENT'S NPN**

AGENCY NAME **TAX IDENTIFICATION NUMBER**

IMPORTANT - PLEASE READ CAREFULLY

Information provided on this application is solely for the purpose of administering the CGHC plan(s).

To enroll in Common Ground Healthcare Cooperative Plan:
- Complete the application by hand in ink.
- Answer every question, providing complete information about yourself and family members you want to cover. If information is missing or incomplete, your enrollment may be delayed and/or your coverage may be limited.

To submit your application:
- Please review all information for completeness and accuracy.
- Be sure to sign and date the application.
- Include a check for the first month's premium made payable to: Common Ground Healthcare Cooperative.
- Submit the application to Common Ground Healthcare Cooperative at address on front.