Chorus Community Health Plans
PO Box 1997| Milwaukee, WI 53201-1997
Toll-free: 1-844-708-3837
chorushealthplans.org

Enrollment Application for Individual or Family Dental Coverage

- All applicants must be U.S. citizens, U.S. nationals, or have eligible immigration status.
- For help with your application, please call our Sales Department directly at 1-844-708-3837 from 8:00 a.m. to 4:30 p.m., Monday through Friday.
  - For interpreter services, call 1-800-264-1552.
  - Hearing-impaired applicants, call 7-1-1.

Once your application is complete, please return it by one of the following options:

- Email: CCHP-MemberSales@chorushealthplans.org
- Fax: 1-414-266-1611
- Mail: Chorus Community Health Plans
  P.O. Box 1997
  Milwaukee, WI 53201-1997

Step 1 - Type of Enrollment

☐ **Initial Enrollment** **Date:** _____ **List qualifying events:** _____

☐ **Special Enrollment** **Date:** _____ _____

(Please attach your special enrollment/qualifying life event documentation to this application)

Step 2 - Plan Selection

☐ **Check this box if anyone listed on the application is participating in an Individual Coverage Health Reimbursement Arrangement (ICHRA) or a Qualified Small Employer HRA (QSEHRA).**

Dental Plan Name: _____

Quoted Dental Premium: _____

Step 3 - Applicant Information

Full name: _____ **SSN:** _____ **DOB:** _____ MM/DD/YYYY

Physical address: _____ **Gender:** _____

City: _____ **State:** _____ **County:** _____ **Zip:** _____

Mailing address (if different than above): _____

City: _____ **State:** _____ **County:** _____ **Zip:** _____

Preferred phone number: _____ **Other phone number:** _____

Email address: _____

By providing your email, you are agreeing to receive digital communications from Chorus Community Health Plans.

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Step 4 - Dependent Information

Please list all dependents who will need dental coverage. When applying for more than three dependents please attach a separate sheet. If you are applying for a dependent over the age of 26, who is legally disabled and eligible to be on your plan Please submit proof of disability along with this application for approval.

Full name: ____________________ **Relationship:** __________ **DOB:** __________ MM/DD/YYYY

SSN: ____________________ **Gender:** __________ **Marital Status:** __________

Physical Address (if different than above)**:** ______________________________

City: ____________________ **State:** __________ **Zip:** __________

Full name: ____________________ **Relationship:** __________ **DOB:** __________ MM/DD/YYYY

SSN: ____________________ **Gender:** __________ **Marital Status:** __________

Physical Address (if different than above)**:** ______________________________

City: ____________________ **State:** __________ **Zip:** __________

Full name: ____________________ **Relationship:** __________ **DOB:** __________ MM/DD/YYYY

SSN: ____________________ **Gender:** __________ **Marital Status:** __________

Physical Address (if different than above)**:** ______________________________

City: ____________________ **State:** __________ **Zip:** __________

Full name: ____________________ **Relationship:** __________ **DOB:** __________ MM/DD/YYYY

SSN: ____________________ **Gender:** __________ **Marital Status:** __________

Physical Address (if different than above)**:** ______________________________

City: ____________________ **State:** __________ **Zip:** __________

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Step 5 - Eligibility

Please provide additional information.

1. **Are all applicants U.S. citizens or U.S. nationals?** ☐ **Yes** ☐ **No**

   If no, do you have eligible immigration status? ☐ **Yes** ☐ **No**

   If yes – List immigration document type and ID number in the section below.

   If no – You are not eligible for this plan

2. **Are any applicants American Indian or Alaskan Native?** ☐ **Yes** ☐ **No**

   If yes – Is the tribe federally recognized? ☐ **Yes** ☐ **No**

   If no – List name and state of tribe: _____

3. **Are any applicants incarcerated?** ☐ **Yes** ☐ **No**

   If yes – Is applicant facing charges?

If you're not a U.S. citizen and have eligible immigration status, please complete the section below:

Applicant's Full Name: _____

Document Type: _____ **Immigration Document ID Number:** _____

Spouse's Full Name: _____

Document Type: _____ **Immigration Document ID Number:** _____

Dependent's Full Name: _____

Document Type: _____ **Immigration Document ID Number:** _____

Dependent's Full Name: _____

Document Type: _____ **Immigration Document ID Number:** _____

Dependent's Full Name: _____

Document Type: _____ **Immigration Document ID Number:** _____

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Step 6 - Other Dental Insurance

Will you or any other proposed dependent have any other dental insurance coverage, including Medicaid, when this contract becomes effective? ☐ **Yes** ☐ **No**

If YES, please complete the section below.

Covered person's name: _____

Insurance Company Name: _____ **Type of Coverage:** _____

Effective Date: _____ **Termination Date:** _____

Is proposed coverage replacing this coverage? ☐ **Yes** ☐ **No**

Covered person's name: _____

Insurance Company Name: _____ **Type of Coverage:** _____

Effective Date: _____ **Termination Date:** _____

Is proposed coverage replacing this coverage? ☐ **Yes** ☐ **No**

Covered person's name: _____

Insurance Company Name: _____ **Type of Coverage:** _____

Effective Date: _____ **Termination Date:** _____

Is proposed coverage replacing this coverage? ☐ **Yes** ☐ **No**

Step 7 - Effective Date Selection

Your effective date will be the first (1st) of the next month if application is received by the fifteenth (15th) day of the prior month. Alternatively, if you apply for coverage after the 15th of the month, your effective date will be the 1st of the following month.

☐ Next available

☐ Requested: _____ (month) within 60 days of your signature date for this application.

There are exceptions on effective dates for members enrolling due to a qualifying event such as loss of coverage or the birth of a child. Please contact Chorus Community Health Plans to determine your effective date.

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Step 8 - Agent / Agency Information

Agent name: _____ **Agent ID (NPN):** _____

Agency name: _____ **Agency phone:** _____

Agent email: _____

Step 9 - Insurance Notice

ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

To issue a contract, Chorus Community Health Plans needs to obtain information about the applicant (you) and any dependents from other sources. That information and any subsequent information collected by Chorus Community Health Plans may in certain circumstances be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding.

If you wish to have a more detailed explanation of our information practices, please contact:
Chorus Community Health Plans
P.O. Box 1997
Milwaukee, WI 53201-1997

FRAUD NOTICE

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to an applicant or covered person for the purpose of defrauding or attempting to defraud the applicant or covered person with regard to a settlement or award payable from insurance proceeds, shall be reported to the appropriate regulatory agency in your state.

PRIVACY

We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted by law. We collect nonpublic information about you from the following sources: (1) information Chorus Community Health Plans receives from you on enrollment forms or other information related thereto or as part of policy administration, and (2) information about your transactions with our affiliates, others or Chorus Community Health Plans. We restrict access to nonpublic personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your nonpublic personal information. We may disclose nonpublic personal information about you to nonaffiliated third parties as permitted by law. Chorus Community Heath Plans does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

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Step 10 - Read and Sign

Your premium payment – I understand my plan is pre-paid coverage. This means that I pay my premium payment in the month for that month of coverage. I understand if I do not choose an automatic payment option, I will get an invoice in the mail each month.

10-day contract review period – I understand applicants enrolled for coverage shall be provided a 10-day period from receipt of the contract to examine and return the contract and have the premium refunded. If dental services were received during the 10-day period, and I return the contract to receive a refund of the premium paid, I must pay for such services.

Your contract documents – I understand covered benefits, services, utilization management procedures, exclusions, and are subject to the provisions of the contract and/or Evidence of Coverage. These documents may be found on our website at chorushealthplans.org/togdental, or you may call the Chorus Community Health Plans Sales Department at 844-708-3837, Monday through Friday from 8:00 a.m. to 4:30 p.m. If you or someone you're helping has questions about Chorus Community Health Plans, you have the right to get help and information in your language at no extra cost. For interpreter services, call 1-800-264-1552. Hearing-impaired applicants may call Wisconsin Relay 711.

Your protected health information – 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 Chorus Community Health Plans 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 Chorus Community Health Plans. 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. Notices of Privacy Practices can be found online at chorushealthplans.org. This authorization shall be valid for two years from this date and you have the right to revoke this authorization at any time by sending written notice to Chorus Community Health Plans.

Commission Disclosure

Chorus Community Health Plans is committed to providing members with enrollment support. Members are able to receive support from navigators, certified application counselors, and agents and brokers at no cost. Chorus Community Health Plans is responsible for providing compensation to agents and brokers contracted with Chorus Community Health Plans. We do this through one of our contracted General Agencies, whom we compensate $5 commission. The General Agencies compensate each agent or broker a minimum of $4 at no additional cost to the member. Members looking for enrollment support may call Chorus Community Health Plans at 844-708-3837.

» I understand that I am entitled to a copy of this signed application and applicable attestations upon request.

» I acknowledge that I have read and understand this application in its entirety and attest to its accuracy.

Printed Name of Applicant or Legal Guardian

Today's date:

Signature of Applicant or Legal Guardian
Note: Application expires 60 days from the date of your signature.

Health Equity Questionnaire

This questionnaire is optional and your answers will not affect your medical care, costs, or your benefits and it will be kept confidential. This information helps us provide better services for all of our members. **If submitting a questionnaire for more than one individual on this application, please include a separate questionnaire for each person.**

Member Name (required):

Race and Ethnicity

Which category best describes your ethnicity?

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I choose to not answer

Which category best describes your race?

☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ Asian

☐ American Indian or Alaska Native ☐ Other race ☐ White ☐ I choose to not answer

Language

What language do you feel most comfortable speaking?

☐ English ☐ Spanish ☐ Hmong ☐ Other (please specify):

How would you rate your ability to speak and understand English?

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Not at all

☐ Unknown ☐ I choose to not answer

In what language would you feel most comfortable reading medical or health care instructions?

Please specify:

Gender Identity and Sexual Orientation

What sex were you assigned at birth?

☐ Male ☐ Female ☐ Unknown ☐ I choose not to answer.

What gender do you identify as?

☐ Male ☐ Female

☐ Transgender man/trans man/female-to -male (FTM)

☐ Transgender woman/trans woman/ male-to -female (MTF)

☐ Genderqueer/gender nonconforming neither exclusively male nor female

☐ Unknown ☐ Other (please specify): ☐ I choose to not answer

How do you identify?

☐ Straight or heterosexual ☐ Lesbian, gay or homosexual

☐ Bisexual ☐ Queer, pansexual and/or questioning

☐ Other (please specify):

☐ I choose not to answer

Pronouns

What are your preferred pronouns?

☐ He/his ☐ She/her ☐ They/them ☐ I choose not to answer ☐ Other (please specify):

Information you provide to Chorus Community Health Plans and its affiliates is voluntary, and may be used to better communicate with you. Chorus Community Health Plans has controls around physical and electronic access to Protected and Personal Health Information to protect your privacy. They include policies, rules, and technical measures. Chorus Community Health Plans will never use your personal information for underwriting. It would also not be used to deny you treatment, services, coverage or benefits. From time to time, Chorus Community Health Plans may share your personal information to help provide the best care for you. It might also be shared for routine activities, such as:

- Arranging for health care for you and your covered family members.
- Making payments to doctors, hospitals, and other health care providers for your care.

Performing certain health care operations. We use these to monitor the quality of the health care coverage and services you have received.