Together with CCHP
PO Box 1997, MS 6280| Milwaukee, WI 53201-1997
Toll-free: 1-844-708-3837 | togetherCCHP.org

Enrollment Application for Individual or Family Health 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 1-844-201-4672.
  - Hearing-impaired applicants, call 7-1-1.

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

- Email: CCHP-MemberSales@chw.org
- Fax: 1-414-266-1611
- Mail: Together with CCHP
  P.O. Box 1997, MS6280
  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

Plan Name you have selected: _____

Quoted premium payment amount: _____

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 Together with CCHP.

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Step 4 - Dependent Information

Please list all dependents who will need health 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 health information.

1. **Have you or your spouse (if applying), within the last six months used tobacco FOUR or more times per week on average?** *(Excludes e-cigarettes and religious or ceremonial uses of tobacco.)* ☐ **Yes** ☐ **No**

2. **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

3. **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: _____

4. **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 Health Insurance

Will you or any other proposed dependent have any other health 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 Together with CCHP to determine your effective date.

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Step 8 - Agent / Agency Information

Agent name: _____ **Agent ID:** _____

Agency name: _____ **Agency number:** _____

Agent email: _____ **Agent phone:** _____

Step 9 - Medical Notice

ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

To issue a contract, Children's Community Health Plan needs to obtain information about the applicant (you) and any dependents from other sources. That information and any subsequent information collected by Children's Community Health Plan 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:
Children's Community Health Plan
P.O. Box 1997, MS6280
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 Children's Community Health Plan 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 Children's Community Health Plan. 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. Together with CCHP 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 Together with CCHP is prepaid health 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 medical 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 togetherCCHP.org, or you may call the Together with CCHP 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 Together with CCHP, you have the right to get help and information in your language at no extra cost. For interpreter services, call 844-201-4672. Hearing-impaired applicants may call Wisconsin Relay 711.

Dental services are not part of this plan – I understand this plan does not include dental services for adults, as well as pediatric dental services as required under the federal Patient Protection and Affordable Care Act. This coverage is available in the federal Health Insurance Marketplace and can be purchased as a separate product. Please contact your agent or the federal Health Insurance Marketplace at healthcare.gov if you wish to purchase pediatric dental coverage or a separate dental insurance product.

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 Children's Community Health Plan 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 Children's Community Health Plan. 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 togetherCCHP.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 Children's Community Health Plan.

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

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

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.

Discrimination is against the law.

Children's Community Health Plan (CCHP) complies with all applicable civil rights laws and does not discriminate on the basis of race, color, national origin, sex, age, disability, or other legally protected status, in its administration of the plan, including enrollment and benefit determinations.

Children's Community Health Plan provides appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and who have language services needs and information in alternate formats, free of charge and in a timely manner, when such aids and services are necessary to ensure an equal opportunity to participate to individuals with disabilities.

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance in person, by mail, fax or email. The grievance must be filed with 60 days of the person filing the grievance becomes aware of the alleged discriminatory action. It is against the law for Children's Community Health Plan to retaliate against anyone who files a grievance, or who participates in the investigation of a grievance. Members can request Children's Community Health Plan's grievance procedure by contacting the Section 1557 Coordinator:

Director, Corporate Compliance
Mail Station C760
P.O. Box 1997
Milwaukee, WI 53201-1997

Telephone: (414) 266-2215
TDD-TTY (for the hearing impaired): (414) 266-2465
Fax: (414) 266-6409
Email: TTwinem@chw.org

Members must submit their complaints in writing with their name, address, the problem or action alleged to be discriminatory and the remedy or relief sought. Members can also file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail at:

U.S. Department of Health and Human Services
200 Independence Avenue
SW Room 509F
HHH Building
Washington, D.C. 20201

Complaint forms are available at:
http://www.hhs.gov/ocr/office/file/index.html

together with **CCHP**™

Language Services

ALBAINIAN

Nëse ju, ose dikush që po ndihmoni, ka pyetje për Children’s Community Health Plan, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin 1-844-201-4672 (TTY: 7-1-1)

ARABIC

هدعاست صخش ىدل وأ كيدل ناك نإ
صوصخب ةلئسأ Children’s Community
Health Planةيرورضلا كيدلف قحلا يف لوصحلا
تامولعملاو ةدعاسملا ىلع
ةفلكت ةيا نود نم كتغلب (ب لصتا عم ثدحتلل.
مجرتم 1-844-201-4672 (TTY: 7-1-1)

BURMESE

Children’s Community Health Plan နှင့်ပတ်သက်၍ သင် သို့မဟုတ် သင်အကူအညီပေးနေသူတစ်ဦးတွင် မေးမြန်းစရာများ ရှိမည်Âဆိုပါက၊ အကူအညီနှင့် သတင်းအချက်အလက်များကို အခမဲ့သင်ရယူပိုင်ခွင့် ရှိပါသည်။ စကားပြန်ဆိုသူ တစ်ဦးထံသို့စကားပြောဆိုရန်၊ 1-844-201-4672 တွင် ဖုန်းခေါ်ဆိုပါ။ (TTY: 7-1-1)

CHINESE

如果您，或是您正在協助的對象，有關於[插入項目的名稱面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯，請撥電話［在此插入數字 1-844-201-4672 (TTY: 7-1-1)

ENGLISH

If you or someone you’re helping has questions about Children’s Community Health Plan, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-844-201-4672 (TTY: 7-1-1)

FRENCH

Si vous, ou quelqu’un que vous êtes en train d’aider, a des questions à propos de Children’s Community Health Plan vous avez le droit d’obtenir de l’aide et l’information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-201-4672 (TTY: 7-1-1)

GERMAN

Falls Sie oder jemand, dem Sie helfen, Fragen zum Children’s Community Health Plan haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-201-4672 an (TTY: 7-1-1)

HINDI

यदि आपके ,या आप द्वारा सहायता ककए जा रहे ककसी व्यक्तत के Children’s Community Health Plan के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। ककसी ुभािषषए से बात करने के लिए 1-844-201-4672 पर कॉॉ करें। (TTY: 7-1-1)

HMONG

Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Children’s Community Health Plan, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 1-844-201-4672 (TTY: 7-1-1)

KOREAN

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Children’s Community Health Plan 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-844-201-4672 로 전화하십시오 (TTY: 7-1-1)

LAOTIAN

ຈ້ທ່ານ, ຫ ຼືມີທ ່ທ່ານກໍາລງັຊ່ວຍເຫ ຼື,
ມ ຄໍາຖາມກ່ຽວກບັ Children’s Community Health Plan ທ່ານມ ສດິທ ່ຈະໄດຮ້ບັການຊ່ວຍເຫ ຼືແລະຂມໍ້ນູຂ່າວສານທ ່ເປນັພາສາຂອງທ່ານບໍ່ ຄ່າໃຊຈ້່າຍ. ການໂອລ້ມົກບັນາຍພາສາ,
ໃຫໂ້ທຫາ 1-844-201-4672 (TTY: 7-1-1)

PENNSYLVANIA DUTCH

Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Children’s Community Health Plan, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 1-844-201-4672 uffrufe (TTY: 7-1-1)

POLISH

Jeśli Ty lub osoba, której pomagasz macie pytania odnośnie Children’s Community Health Plan, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-201-4672 (TTY: 7-1-1)

RUSSIAN

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Children’s Community Health Plan то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-844-201-4672 (TTY: 7-1-1)

SOMALI

Haddii adiga iyo qof aad caawinaysaa su’aalo qabaan ku saabsan Children’s Community Health Plan, waxaad leedahay xaqa aad caawimo ku hesho iyo macluumaadka luqaddaada iyaddoon kharash kugu fadhiyin. Lahadal turjubaan wac 1-844-201-4672 (TTY: 7-1-1)

SPANISH

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Children’s Community Health Plan tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-201-4672 (TTY: 7-1-1)

TAGALOG

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Children’s Community Health Plan, may karapatan ka na makakuha nga tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-201-4672 (TTY: 7-1-1)

VIETNAMESE

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Children’s Community Health Plan quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-201-4672 (TTY: 7-1-1)