

Ohio

- Application for HIPAA Eligible Individuals
- Application for Open Enrollment
(Cannot be currently confined in a health care facility)



(For HIPAA Eligible Individuals, Certificate(s) of creditable coverage must be provided at the time of application)

Please complete application in blue or black ink.

A. PERSONS APPLYING FOR COVERAGE

List all Family Members who meet the definition of a HIPAA Eligible Individual.

Full Name First-Middle-Last (Include Maiden Name if used within past 5 yrs.)	Relationship to Applicant	Sex M/F	Date of Birth	Social Security Number	✓ if FT Student
	Key Applicant				
	Spouse				
	Child				
	Child				
	Child				

2. Home Address

Street		
City	State	Zip
County		
Phone No.		

3. Billing Address if other than Home Address

Name		
Street		
City	State	Zip

B. PREMIUM PAYMENT INFORMATION

INITIAL PREMIUM PAYMENT OPTIONS: (make checks payable to American Community Mutual Insurance Company)

Credit Card Check \$ _____ EFT (Only if EFT is chosen as the billing option)

INITIAL PREMIUM SHORTAGE OPTIONS:

Credit Card Check \$ _____ EFT (Only if EFT is chosen as the billing option)

Please complete Credit Card and/or EFT information if you have selected them as a Premium Payment Option.

CREDIT CARD (for initial payment only)

MasterCard Card Holder Name: _____

Visa Card Number: _____ Expiration Date: _____

Signature: X _____ **Date signed:** _____

BILLING FREQUENCY:

Monthly* Quarterly Semi-Annually Annually

BILLING OPTIONS:

Bill Me EFT (Electronic Fund Transfer)

*Administrative Charge: Once approved, an additional Monthly Billing Fee of \$4.75 will be applied (fee is waived for EFT, Quarterly, Semi-Annually, or Annually).

<p>ELECTRONIC FUNDS TRANSFER (EFT)</p> <p><input type="checkbox"/> Checking</p> <p><input type="checkbox"/> Savings</p> <p>(If allowed by bank)</p>	<p>Name of Financial Institution: _____</p> <p>Address: _____ City: _____ State: _____ Zip Code: _____</p> <p>Account Holder's Name: _____</p> <p>Transit Routing Number: _____ Account Number: _____</p> <p>Authorization Agreement For Electronic Funds Transfer for Premium Payment</p> <p>I authorize American Community Mutual Insurance Company (Company) to initiate monthly electronic withdrawals, in the amount of the then-current monthly premium rate, from the account and financial institution (Bank) named above. This authority remains in effect until Company and Bank receives written notification from me of its termination in such time and manner as to give Company and Bank a reasonable opportunity to act on it. Company reserves the right to void this agreement at any time without prior notice.</p> <p>Signature: X _____ Date Signed: _____</p>
--	--

Returned Check Fee: If any premium payment made directly by check or by Electronic Funds Transfer (EFT) is returned for non-sufficient funds, a nonrefundable service fee will be charged.

C. PLAN SELECTION

Plans for HIPAA Eligible Individuals:

- Basic Plan \$1,000 deductible, 50% coinsurance
- Standard Plan (\$750 deductible, 70% coinsurance)

Open Enrollment Plans:

- Basic Plan \$250 deductible, 60% coinsurance
- Standard Plan (\$500 deductible, 60% coinsurance)

Requested Effective Date of Coverage: _____ (For HIPAA Eligible Individuals, Effective Date cannot be earlier than the postmark date (if mailed) or the received date (if no postmark). The Effective Date cannot be the 29th, 30th, or 31st of any month. If not indicated, the Effective Date will be the date received or the earliest date available after the received date. For those applying under the Open Enrollment provision, the Effective Date will be no earlier than 90 days after the application is received.

D. CONSENT, TERMS AND CONDITIONS

1. I am applying for only the benefits indicated.
2. I understand that this is a policy only available to Individuals who meet the definition of HIPAA Eligible Individual or Individuals who qualify for an open enrollment period. I have been provided a copy of these definition and certify that I meet the definition for HIPAA Eligible Individual or Open Enrollment).
3. I acknowledge that I have been provided with a "Notice of Your Privacy Rights".

I certify the above statements are true and correct.

X _____ Signature Key Applicant (or if minor Child, Parent or Guardian)	_____ Date	X _____ Spouse's Signature	_____ Date
--	---------------	--------------------------------------	---------------

WARNING: Any person who, with intent to defraud or knowing that he or she is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

PROXY

The undersigned hereby appoints the President of American Community Mutual Insurance Company, with full power of substitution as the undersigned's proxy with full power, to vote and act on their behalf on all issues at all meetings of the members of the Company and any adjournments thereof. If the proxy named herein, or his named substitute, is for any reason unable to act, the Board of Directors of the Company may fill the place of such proxy by appointing another. The proxy named herein shall only vote for those persons to serve as directors who have been nominated by the Board of Directors of the Company. If such persons are unable or unwilling to serve, then the proxies named herein may select other nominees and vote for such other nominees to serve as directors. In addition, all other matters properly brought before the meeting of the members the proxy will vote in accord with the recommendation of the Board of Directors, if any, and, if none, according to his judgment. This proxy will continue in force for the period of time the undersigned is the named insured of a policy issued and in effect by the Company. The proxy may be revoked by the undersigned at any time by filing with the Secretary of the Company a written revocation, a duly executed proxy bearing a later date or by attending and voting in person at any meeting of the members.

X _____
Signature

Date

AGENT INFORMATION: Name: _____ Number: _____
 Phone # _____ Fax # _____ **Signature: X** _____

E. IMPORTANT INFORMATION FOR THE APPLICANT

I. To be eligible for a HIPAA guaranteed issue policy you must meet the following definition HIPAA Eligible Individual:

1. Have 18 months of creditable coverage without a significant break in coverage. Creditable coverage includes health insurance coverage and other health coverage, such as coverage under group health plans, Medicare, Medicaid, and Public Health Plans. A significant break in coverage is 63 days without any creditable coverage.
2. The most recent prior creditable coverage was under a group health plan, church plan, or governmental plan. The term 'governmental plan' means a plan established or maintained for its employees by the government of the United States, by the government of any state or political subdivision thereof, or by any agency or instrumentality of any of the foregoing. It also includes any plan to which the Railroad Retirement Act of 1935, or 1937 applies, and which is financed by contributions required by the Act and any plan of an international organization which is exempt from taxation under the provisions of the International Organizations Immunities Act.
3. Not eligible for health insurance coverage under any of the following:
 - a. A group health plan
 - b. Part A or Part B of Title XVIII (Medicare) of the Social Security Act
 - c. A state plan under Title XIX (Medicaid) of the Social Security Act (or any successor program).
4. Do not have any other health insurance coverage
5. The most recent coverage did not terminate because of non-payment of premiums or fraud.
6. Have elected and exhausted the COBRA continuation provision or any similar state program available.
7. American Community has not exceeded its HIPAA guaranteed issue policy limit for the calendar year.

II. To be eligible for the Ohio Individual Open Enrollment you must meet the following conditions:

1. Are not applying for coverage as an employee of an employer, as a member of an association, or as a member of any other group.
2. Are not confined to a health care facility because of chronic illness, permanent injury, or other infirmity.
3. Are not covered, and are not eligible for coverage, under any other private or public health benefits arrangement, including the Medicare program established under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, or any other act of congress or law of this or any other state of the United States that provides benefits, comparable to the benefits provided under this section, any Medicare supplement policy, or any continuation of coverage policy under state or federal law.
4. Understand a pre-existing condition limitation will apply that excludes or limits coverage for charges or expenses incurred during the twelve month period following the effective date of coverage as to a condition which, during the six month period immediately preceding the effective date of coverage had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received , or a pregnancy existing on the effective date of coverage.
5. American Community has not exceeded its open enrollment limit for the calendar year.

NOTICE OF YOUR PRIVACY RIGHTS

We know that your trust in us is very important. We are committed to protecting your privacy rights. [Please read this document carefully.](#) It discloses your privacy rights.

Obtaining Information About You - We may obtain information from your application, a telephone interview with you, claims history with us, policies you have or had with us, account balances and premium payment history, and other sources, such as health care providers (medical information), and consumer reporting agencies (credit reports). Your address, birthday, telephone number, social security number are examples of such information. An investigative consumer report may be prepared where information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted to obtain information as to your character, general reputation and personal characteristics. You may have to share such information with us, our affiliates, agencies or others working with us.

Our Use of Personal Information - We will share such information only with companies associated with us. We, or your agent or broker may use your information to offer you products or help you choose a product.

We may, as permitted by the law and without your prior approval, give information about you to persons who do business for us, your agent or broker, other insurance companies, or other persons handling your business, insurance company support organizations, regulatory or law enforcement authorities; and our affiliated companies. Information obtained from a report prepared by an insurance-support organization may be retained by the insurance-support organization and disclosed to other persons.

Your Rights

- ➔ The right to access, inspect and copy the personal information pertaining to you that we maintain in our files about you.
- ➔ The right to request that we correct or amend any personal information that we have about you.
- ➔ To request an interview in connection with the preparation of an investigative consumer report.

To exercise these rights, please send a written request to the attention of the Privacy Coordinator.

How We Protect Your Personal Information - We protect the information we share with companies working for us through an agreement. The agreement obligates those companies to keep your information confidential.

Only our employees who work to service your business see your personal information. We have trained our employees to closely follow our privacy rules for your protection. Your privacy rights will continue if you cease to be our customer.

THE REMAINDER OF THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required to maintain the privacy of your personal medical information and provide you with this notice as to our legal duties and privacy practices. We are required to abide by the terms of this notice. We reserve the right to change the terms of this notice and to make any new provisions effective to all of the medical information that we maintain about you. If we revise this notice, we will provide you with a revised notice by mailing the revised notice to the address you have supplied us.

STATEMENT OF YOUR RIGHTS

You have the right to know how we use or disclose your personal medical information. There are certain uses and disclosures of your personal medical information that we are permitted or required to make by law without your permission. In addition, you have:

- ➔ The right to request that we place additional restrictions on our uses and disclosures of your personal medical information, but we are not obligated to agree to any such restrictions.
- ➔ The right to access, inspect and copy the protected information pertaining to you that we maintain in our files, and the right to request that we correct or amend any personal medical information that we have about you.
- ➔ The right to receive an accounting of the disclosures of your personal medical information that we make for purposes other than activities related to your treatment, or our payment functions or other health care operations.
- ➔ The right to request that you receive communications of personal medical information in a confidential manner.
- ➔ The right to obtain a paper copy of this notice from us on request.

To exercise these rights please send a written request to the attention of the Privacy Coordinator.

PERMISSIBLE USES AND DISCLOSURES OF PROTECTED MEDICAL INFORMATION

Payment Functions. We may use or disclose your protected medical information without your permission to carry out activities relating to reimbursing you for the provision of health care, obtaining premiums, determining coverage, and providing benefits under the policy of insurance that you are purchasing. For example, payment functions may include (but are not limited to) reviewing health care services with respect to medical necessity, coverage under the policy, appropriateness of care, or justification of charges.

Health Care Operations. We may also use or disclose your protected medical information without your permission to carry out certain insurance-related activities. For example, these activities include using your protected information for underwriting, premium rating, or other activities relating to the creation, renewal or replacement of another contract of health insurance, placing a contract for reinsurance of risk relating to claims for health care, and performing audit functions to ensure compliance and proper claims payment.

Group Health Plan. We may disclose your protected medical information to your employer as necessary for the purpose of reporting claims experience or conducting an audit if you are covered under an employer-based group health insurance plan.

Business Associates. We may disclose your protected medical information to our business associates. There are some services provided in our company through contracts with our business associates.

Uses Permitted By Law. We may also use or disclose your protected medical information without your written permission for purposes permitted or required by law.

Authorized Uses. All other disclosures of your protected medical information will be made only with your written permission, and any permission that you give us may be revoked by you at any time.

COMPLAINTS ABOUT MISUSE OF INFORMATION - If you believe your privacy rights have been violated you may complain either directly to us or to the Secretary of Health and Human Services (H.H.S.). Please submit all complaints in writing and to us or H.H.S. as follows:

American Community Mutual Insurance Company
Attn: Privacy Officer
39201 Seven Mile Road
Livonia, MI 48152

U.S. Department of Health and Human Services (H.H.S.)
Attn: Secretary
200 Independence Ave S.W.
Washington, DC 20201

You will not be retaliated against in any way for filing a complaint.

OBTAINING FURTHER INFORMATION - Please call American Community at 1-800-991-2642 if you have any questions or comments.

Effective: April 14, 2003