Application for Health Coverage

State of Tennessee ● Department of Finance and Administration

Return this application to:

AccessTN c/o BCBST

1 Cameron Hill Circle

Chattanooga, TN 37402

Secure Fax: 1-866-636-0161

AccessTN is administered by BlueCross BlueShield of Tennessee, Inc. - an Independent Licensee of the BlueCross BlueShield Association.

Section A - Applicant Info

Last Name	First Name	MI	Sex ☐ Female ☐ Male	Date of Birth (mm/dd/yy)	Social Security Number

Home Address *(Attach one proof of residency)*	City	State	Zip Code

IMPORTANT! You must send one proof of your residency with this form. It can be a copy of a driver's license, utility bill, etc. If you do not send proof of residency, your form will be denied.

TN resident for at least 6 months? ☐ Yes ☐ No	How long have you lived at this address?________________ If less than 6 months, list prior address:

Mailing Address *(if not the same as Home Address)*	City	State	Zip Code

Home Phone, with area code ( )	Work Phone, with area code ( )	Cell ( ) Email

State and # of the most recent Driver's License:	US Citizen ☐ Yes ☐ No Qualified Legal Alien ☐ Yes ☐ No *(If yes, put papers with this form that prove your immigration status.)*	Primary language (optional) ☐ English ☐ Spanish ☐ Other __________________

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed	Racial/Ethnic Heritage (for Title VI purposes) ☐ Asian ☐ Black/African American ☐ Hispanic/Latino ☐ Native American/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ White/Caucasian ☐ Mixed Ethnicity/Other_________________________

Section B – Choose Your Benefit Plan

See the Plan Overview* for plan benefits and premiums.

Note: Premium assistance is not available.

☐ **$1,000 deductible – Plan One**
Plan that offers the lowest deductible.

☐ **$3,000 deductible – Plan Two**
Qualified HDHP (High-Deductible Health Plan).

☐ **$5,000 deductible – Plan Three**
High deductible plan NOT for use with a Health Savings Account

Section C – Info for Premium

Height	Weight

Have you used tobacco products during the past 6 months? ☐ Yes ☐ No

No payment is required with application.
We will bill your monthly premium if you are approved for coverage

Call 1-866-636-0080 toll-free with questions or for help with these papers.

*Enclosed in application packet and available at BCBST.com or AccessTN.gov

Section D – How Do You Qualify? (Choose one of these three ways – D1, D2 or D3)

Pre-existing Conditions - For eligibility categories D1 and D2, you **MUST SEND us proof that you are uninsurable. This means you cannot get insurance because you have a pre-existing health condition.** You can prove a pre-existing condition with one of these:

- **One denial of coverage letter from an insurance company**, based on ANY health condition.
- **An Attending Physician's Statement* or letter from your doctor** showing that you have one of the qualified pre-existing health conditions. See the Attending Physician's Statement* for the list of conditions.
  If your doctor writes a letter, this letter must also tell us the diagnosis and billing code.

This is in addition to **proof of state residency** as we describe on page one.

D1. ☐ **State Uninsurable (Regular coverage)**-You must:

- Be a Tennessee resident for 6 months and a U.S. citizen or qualified legal alien
- Have a pre-existing health condition which makes you uninsurable
- Not be eligible for employer coverage where you work, Medicare or Medicaid and not have other health insurance
- Have been uninsured for the past 3 months before applying for coverage (or meet any approved exception to this requirement)
- Send us proof that you are uninsurable or have one of the listed pre-existing conditions

IMPORTANT! Besides **proof of state residency** (as noted on page 1), **you MUST SEND us proof that you are uninsurable**). Acceptable proof is any one of these:

- **One denial of coverage letter from an insurance company**, based on ANY health condition.
- **An Attending Physician's Statement*** showing that you have one of the qualified pre-existing health conditions. See the Attending Physician's Statement* or Plan Overview* for the list of conditions.
- **A letter from your doctor** showing that you have one of the qualified pre-existing health conditions. See the Attending Physician's Statement* or Plan Overview* for conditions. This letter must also tell us the diagnosis and billing code.

Effective date: Forms approved by the 15th of any month will have coverage starting the 1st of the next month.

Note: Regular Coverage plans have a reduced benefit for pre-existing conditions during the first 6 months of coverage. During this time, outpatient mental health counseling and pharmacy have the full benefit. Other health services for pre-existing conditions are paid as a 50% benefit during the first six months.

If you have chosen State Uninsurable (Regular coverage), mark box D1 above and go to Section E.

Section D continues on the next page.

Section D – How Do You Qualify? (Choose one of these three ways – D1, D2 or D3 - continued)

D2. ☐ **State Portability-If you are applying within 63 days of prior coverage with TennCare (Medicaid), CoverKids or other specified coverage,** you must also:

- Be a Tennessee resident for 6 months and a U.S. citizen or qualified legal alien
- Have a pre-existing health condition which makes you uninsurable
- Not be eligible for employer coverage, Medicare or Medicaid and not have other health insurance
- Send us Proof that you are uninsurable (see below for acceptable proof)

IMPORTANT! Besides proof of state residency (as noted on page 1), you **MUST SEND proof that you are uninsurable, in order to qualify under State Portability.** Acceptable proof is any <u>one</u> of these:

- **One denial of coverage letter from an insurance company**, based on ANY health condition
- **An Attending Physician's Statement*** showing that you have one of the qualified pre-existing health conditions. See the Attending Physician's Statement * or Plan Overview* for conditions.
- **A letter from your doctor** showing that you have one of the qualified pre-existing health conditions. See the Attending Physician's Statement* or Plan Overview* for conditions. The letter must also tell us the diagnosis and billing code.

Note. See AccessTN.gov for the latest list of "other specified coverage" such as a company's ending its group coverage with no COBRA option.

Effective date: State Portability coverage starts the day after the end of your prior coverage. You can apply before your prior coverage ends.

If you have chosen State Portability, mark box D2 above and go to <u>Section E</u>.

Important: If you qualify for HIPAA Portability in D3, you do NOT have to show you are uninsurable or that you have a pre-existing condition.

D3. ☐ **HIPAA Portability-If you are applying within 63 days of prior group coverage**, you must also:

- Be a Tennessee resident and U.S. citizen or qualified legal alien
- Have 18 or more months of combined health coverage without a break in coverage of more than 63 days
- Coverage through an employer-sponsored GROUP health plan as your most recent coverage
- Not eligible for employer coverage, Medicare or Medicaid and not have other health coverage
- Have not been terminated for nonpayment of premiums or fraud under your most recent coverage
- Have taken and completed your full COBRA eligibility if COBRA or group continuation available
- Send proof of prior insurance **(see below for acceptable proof)**

IMPORTANT! Besides **proof of state residency (**as noted on page 1), you **MUST SEND proof of prior coverage.** Acceptable proof is:

- **A certificate of creditable coverage**
- **Any other proof of prior insurance**

Effective date: Portability coverage starts the day after the end of prior coverage. You can apply before your prior coverage ends.

Note: This category is for new HIPAA Portability only. It is not for people already on guaranteed issue HIPAA plans. Go to D1 State Uninsurable (Regular Coverage) to see if you qualify for that category.

This category is NOT for those just finishing TennCare or CoverKids or those with less than 18 months prior coverage. Go to D2 State Portability to see if you qualify for that category.

If you have chosen HIPAA Portability, mark box D3 above and go to <u>Section E</u>.

IMPORTANT! We will figure your premium. To estimate your payment, use the Premium Tables and Weight Status Table in the Plan Overview.*

Section E - Other Insurance Coverage

Tell us what you know about other health insurance you have or recently had in the past.

Are you eligible for Medicare now? ☐ Yes ☐ No Have you applied for Disability benefits? ☐ Yes ☐ No

If you have applied for disability, please tell us where you are in the application process. (Just tell us what you can. Things like: Was it granted? Have you appealed? Who is helping you with your claim?)

Have you ever been covered by AccessTN? ☐ Yes ☐ No | Have you ever been covered by TennCare? ☐ Yes ☐ No

Are you employed? ☐ Yes ☐ No If no, when were you last employed? ___________________________

If yes, how are you employed? ☐ Full-time ☐ Contract worker ☐ Temporary ☐ Part-time

Name of Most Recent Employer (if self-employed, say that)	Street Address	City	State	Zip Code

Does this employer offer group health coverage other than CoverTN or pay the cost of insurance? ☐ Yes ☐ No

If this employer has a group health plan and you are not covered, please tell why:

Note: You can still qualify for AccessTN if you have certain other kinds of coverage. This includes:

- long-term care policies
- cancer or disease-specific coverage.
- liability insurance. This includes medical payments in an auto policy.
- "fixed indemnity". This is the type of insurance that pays you a set dollar amount if certain events take place. For instance, a plan that pays you $250 for each day you spend in the hospital.
- nursing home coverage.
- accident or disability only coverage.
- some short-term policies.

Are you covered now or have you been covered by any other insurance in the last 3 months? *(This includes Medicare or TennCare)*

☐ No **If No**, go on to section F.

☐ Yes **If Yes, you can sign up for AccessTN before your other plan ends to reduce any break in coverage.**

Tell us what you can in the boxes below about any coverage you have had in the last 3 months. You may attach a copy of the face pages of the policy. But doing this is **not required** unless we ask. If you do not know the Policy # or other requested information, just write "I don't know" in that box.

Type of Policy: ☐ Individual ☐ Group ☐ Medicare ☐ TennCare ☐ COBRA ☐ Group Continuation

☐ If another type or you don't know, tell us what you can about the coverage:

Primary Policy Holder	Social Security Number or ID Number of Policyholder	
Name of Insurance Company	Policy #	Group #
Start Date of Coverage	End Date of Coverage	Reason Coverage Ended

If a Group, COBRA or group continuation policy, give name of the employer.

If you marked "Group" above, did you meet the rules for: **COBRA** ☐ Yes ☐ No **Group Continuation** ☐ Yes ☐ No

If yes, tell us the Start Date of Coverage________________ End Date_________________

If no, why?

If individual coverage and policy excludes a major body system, like circulatory (heart), please tell us about the limit:

Note: The limit must be based on your personal health history. It must also be a permanent exclusion of a major body system. See the first column of the Attending Physician's Statement* for other examples. Attach a copy of the exclusion.

Call 1-866-636-0080 toll-free with questions or for help with these papers.

*Enclosed in application packet and available at BCBST.com or AccessTN.gov

Section F - Health History

Please answer the health questions below to the best of your knowledge. This will help AccessTN plan for your health care. (A five-year time period is used to help find out more of your needs for care management.) Your health history can be updated after the form is sent. Mail any changes to **AccessTN, c/o BCBST, 1 Cameron Hill Circle, Chattanooga TN 37402**.

Applicant Name	Date of Birth	Height	Weight

Have you used tobacco products in the past 6 months? ☐ Yes ☐ No ☐ Cigarettes ☐ Chewing tobacco ☐ Pipe ☐ Cigars	How Long?	How Often?
Have you gained or lost more than 10 pounds in the last year? Yes ☐ No ☐ If yes, ☐ Gained weight ☐ Lost weight	If yes, how much?	
If yes, tell the cause of the weight gain/loss if you know:		

In the past five years, have you been counseled about, consulted a health provider, or received health care for any of the below? If you answer "yes" to any of the questions, please list any facts that you recall, such as your doctor's name or date of service, in the space provided.	
1. Heart disease or disorder?	☐ Yes ☐ No
2. Ulcers, stomach or digestive system disorder?	☐ Yes ☐ No
3. Urinary, kidney disorder or gynecological problem?	☐ Yes ☐ No
4. Diabetes, connective tissue, pituitary, thyroid or endocrine system disorder?	☐ Yes ☐ No
5. Allergies, asthma or other respiratory system issue?	☐ Yes ☐ No
6. Arthritis, fibromyalgia, back/neck, joint/bone disorder or other musculoskeletal issue?	☐ Yes ☐ No
7. Brain disorder, aneurysm, paralysis, cerebral palsy, epilepsy or other seizures, headaches, multiple sclerosis or other nervous system issue?	☐ Yes ☐ No
8. Cancer, tumor or abnormal growth?	☐ Yes ☐ No
9. Eye or ear disorder?	☐ Yes ☐ No
10. Psychological disorder or mental illness?	☐ Yes ☐ No
11. Organ or other type of transplant or implant (including breast implants)?	☐ Yes ☐ No
12. Any other injury, surgery, illness or health service for any condition not already listed; or given recommendation to have a test or surgery which was not done, for any reason?	☐ Yes ☐ No
13. In the past month, have you often been bothered by feeling down, depressed or hopeless?	☐ Yes ☐ No
14. In the past month, have you often been bothered by little interest or pleasure in doing things?	☐ Yes ☐ No
15. In the past five years, have you been treated for alcoholism or chemical dependency; or joined any group for alcoholism or chemical dependency; used illegal drugs; or been told by a health professional to cut the use of alcohol or illegal drugs? If yes, please explain: ____________________ ____________________	☐ Yes ☐ No
Section F continues on the next page.	

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Section F - Health History (continued)

16. In the past five years, have you sustained an injury due to an auto or work-related accident? If yes, please explain: ____________	☐ Yes ☐ No
17. In the past five years, have you been treated by a health professional for HIV/AIDS? We are NOT seeking HIV test results.	☐ Yes ☐ No
18. Are you pregnant? If Yes, tell us your due date:	☐ Yes ☐ No

This is extra space if you need to write more on any question (tell us which number question).

Prescription History - If you are taking drugs or were ordered any in the past three years, please list them below. Tell us what you can in the space below:

- When you took it (for example, "three years ago" or "taking now")
- What dosage if you know
- What Health problem is being treated by each drug if you know

Add more pages as needed. Print your name, sign, and date each page.

Name of drug	Health condition for which drug was ordered	Dosage & frequency (i.e., 20 mg 2X daily)	Year drug taken (i.e., 2007-2009)	Name and city of doctor ordering drug

Call 1-866-636-0080 toll-free with questions or for help with these papers.

*Enclosed in application packet and available at BCBST.com or AccessTN.gov

Section G - Applicant Signature

Your signature applies to the entire form and to any attachments. It applies to Section I "Protected Health Information" and to Section J "Statement of Understanding and Affirmation."
Be sure to read those sections carefully.

Applicant's Signature in ink (or by parent, legal guardian, or conservator, if applicant not legally competent or a minor)	Date
If signed by applicant, nothing has to be filled out in this block. If signed by parent, legal guardian or conservator for the applicant, please print name, address, phone number and relationship.	

Section H - Fill Out This section If Someone Helped You or Can Help Us With This Form

To the Applicant: YOU are responsible for information in your form. You are signing above that it is correct.
You only need to fill out this part if a friend, family member or other person helped you fill out this application.

Helper Name	Group, Company, or Relationship		Phone
Helper Address	City	State	Zip Code

Fill out and sign below if you give us your OK to talk to the helper you listed above, or to your family or friend about your health facts. Tell us their names and phone numbers.

(Optional) If it is OK for us to talk about your health facts and form to the people checked here, **sign in the box below**: ☐ the helper or group named above ☐ the other persons listed (tell us their names, who they are - family, friends, etc.- and how to reach them) ____________________

See Sections G & I that let us get in touch with your health providers. You only need to list non-medical people.

Applicant's Signature goes here if OK for AccessTN to contact those checked above	Date here if signing on a day different than in Section G

Call 1-866-636-0080 toll-free with questions or for help with these papers.
*Enclosed in application packet and available at BCBST.com or AccessTN.gov

Section I - Protected Health Information and Authorization

This part tells how AccessTN may use your personal information. Please read it closely.

Protected Health Information (PHI) means facts and records about your health. It may include:

- Claims records
- Correspondence
- Medical records
- Billing statements
- Diagnostic imaging reports
- Laboratory reports
- Dental records
- Hospital records, like nursing records or progress notes
- Facts, like your address and date of birth

Federal and state laws protect the privacy of your health facts. Privacy rules do not let AccessTN or your health providers give others your PHI unless you approve. State and federal law allow exceptions. These include:

- Releasing information for your health care or AccessTN operations

When we say "AccessTN" in this part, we mean:

- AccessTN
- Its contractors
- Its agents, and
- Its representatives

AccessTN contractors include:

- BlueCross Blue Shield of Tennessee (BCBST)
- Health Assist Tennessee
- Shared Health, Inc.

These contractors may change. All AccessTN contracts require contractors to keep your health facts private. This is an Authorization by you. By signing at Section G, you:

- Authorize your providers, employers, or any others you name on this form to give information to AccessTN about you as part of your enrollment or coverage. This includes TennCare if you were ever on TennCare.
- Authorize disclosure to and use by AccessTN of:
  - Information on your health insurance coverage
  - Health insurance forms
  - Health claims
  - TennCare or other Medicaid eligibility, and
  - Health record information about you for any purpose allowed by law. This includes use to:
    - ⇒ Decide eligibility for coverage
    - ⇒ Preauthorize or process claims for benefits
    - ⇒ Do case management. This includes utilization or quality assurance reviews, or
    - ⇒ Do an audit or look into possible fraud
- Authorize any of these to disclose your health information to AccessTN:
  - Doctor
  - Health care provider
  - Hospital
  - Health plan
  - Insurance company
  - Reinsurance company

Section I continues on the next page.

- Insurance information bureau. This authorization includes the disclosure to an use by AccessTN of the below information, if any:
  - ⇒ Records of alcohol or chemical dependency and my care for those conditions
  - ⇒ Records of any mental health care, excluding psychotherapy notes
  - ⇒ Records of my care for HIV/AIDS
  - ⇒ Records of genetic testing about any health problem listed on this form, if you are using that problem as a basis for qualifying or for care management of that problem

Your Authorization starts on the date you sign the form. It is in force for twelve (12) months after that. If you are on AccessTN, it lasts through your coverage, plus twelve (12) months, or through any health claim, whichever is longer. A copy of this Authorization is as valid as the original.

You may ask for a copy of your Authorization pages. You may cancel this Authorization at any time. Send a request in writing to AccessTN to cancel. If you cancel this Authorization, it will not affect any action AccessTN took before it got your request. It will not affect AccessTN's use of your PHI health facts for its health care operations. If you do not get rid of this Authorization, it will come to an end on its own:

- twelve (12) months after the end of your coverage, or
- later if you have a health claim pending

Under Federal law, AccessTN must tell you: if the person or group you approve to get your PHI health facts is not a health plan or provider. State and federal privacy rules may no longer protect it. Alcohol and drug abuse records are protected against re-disclosure by special federal confidentiality rules (42 CFR, Part 2). Those rules ban: re-disclosure of alcohol and drug abuse record information without specific authorization in writing.

Section J - Statement of Understanding and Affirmation

Read this section closely. It has important terms of your coverage. When you sign at Section G, you affirm that you understand these statements:

- Access Tennessee (AccessTN) is a non-profit entity of the State of Tennessee.
- I am applying to AccessTN for coverage of: medical; surgical; prescription; and hospital services. This health plan will be partly supported by the State of Tennessee. It may have federal funding.
- I do not have to sign this form. But if I do not fill out this form and sign it, or if I take back my permission in Sections I and J, AccessTN may deny my eligibility. Forms not filled out or signed may be sent back.
- The AccessTN Board of Directors (Board) may change: the benefits; premium assistance; administration rules; and care management rules for all AccessTN plans. These may be changed at any time.
- THE INFORMATION GIVEN ON THIS FORM IS CORRECT. There are civil and criminal penalties: for not giving correct information; for letting someone else use my benefits; and for other acts of fraud. I will help with requests for more information.
- I have a duty to let AccessTN know about: changes in my work; my income; or access to other health insurance. I must do this in a timely manner.
- MY EMPLOYER(S) OR MY HEALTH PROVIDER(S) WILL NOT PAY FOR OR GIVE ME BACK MY PAYMENTS. I will make known any help with my AccessTN payments I get from any other person or group. This includes my health providers.
- I can check **AccessTN.gov** or call Member Services at 1-866-636-0080 to get the latest rules and member materials. This includes pre-existing conditions.
- My answers on this form are complete and correct to the best of my knowledge.
- If this form contains material misstatements or omissions, AccessTN may:
  - cancel the coverage as though it was never effective, and refund my payments, less any claims paid; and/or.
  - deny benefits under the pre-existing conditions period and recover claims paid; and/or.
  - take any other action available to it by law.

Section J continues on next page.

AccessTN may do this within two years from the date that coverage was issued.
This time limit does not have to do with fraudulent statements.

This also has to do with my duty to let AccessTN know about changes in my eligibility for benefits. I will help with any investigation done on behalf of AccessTN.

- This is the definition of a pre-existing condition:

  A pre-existing condition includes any condition which, during a period six months immediately preceding the effective date of my coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment or for which medical advice, care, or treatment was recommended or received as to such condition.

- AccessTN may set rules to vary: deductibles: coinsurance: or treatment levels of its health plans.
- I will help with and adhere to AccessTN health promotion and disease prevention. This includes AccessTN care management guidelines. If I fail to follow through with these, my AccessTN coverage may be affected. This includes:
  - Reduction or elimination of my incentive discount, and
  - Reduction or termination of my health coverage
- Written notice mailed to my latest address of record with AccessTN is notice to me.
- When my form is approved by AccessTN, my coverage will start once:
  - the Plan Administrator informs AccessTN that I have been approved, and
  - my full correct first payment is processed
- My effective date for Regular coverage will be on the first day of the month. My effective date for Portability coverage will be on the day after the termination of my prior qualifying coverage, if I was an eligible Tennessee resident at that time. If I am not approved for coverage or if I do not make my payment, AccessTN will not cover me.
- After the first month of coverage, my payment must be received by the Plan Administrator on or before the due date. If I plan for automatic payment by bank draft or by credit or debit charge, such transaction will be made in accord with the schedule given by the Plan Administrator. It may be before the due date. I have a grace period of thirty-one (31) days from the due date, inclusive.
- MY COVERAGE MAY BE STOPPED ON THE FIRST DAY OF ANY MONTH IF THE PLAN ADMINISTRATOR HAS NOT GOTTEN AND CREDITED COLLECTED FUNDS TO MY ACCESSTN ACCOUNT BY THE DUE DATE. IT SHALL REMAIN SUSPENDED DURING MY GRACE PERIOD UNTIL THE FUNDS ARE RECEIVED AND PROCESSED. MY COVERAGE WILL BE ENDED AT THE END OF THE THIRTY-ONE (31) DAY GRACE PERIOD IF MY PAYMENT IS NOT RECEIVED AND PROCESSED.
- If my bank does not cover my check or other payment, my coverage will be ended at the end of the thirty-one (31) day grace period. This period does not begin on the date I got notice, but starts on the due date.
- IF MY COVERAGE IS ENDED FOR NONPAYMENT, I MUST WAIT ONE YEAR BEFORE I CAN ENROLL AGAIN.
- I have the right to appeal an enrollment decision. To appeal through the AccessTN grievance process, call 1-866-636-0080. Then ask for an appeal form.
- Important note regarding insurance agents: AccessTN does not employ insurance agents and does not pay commissions on AccessTN premiums. In certain cases an insurance agent may qualify for a referral fee from AccessTN. As applicant, my signature at Section G of this Application for Health Coverage confirms:

  "I understand that I may be referred to AccessTN or helped in applying to AccessTN by an insurance agent licensed in Tennessee or by another individual. I am responsible for the information in my Application for Health Coverage. No insurance agent or other person referring me to AccessTN or assisting me is authorized as my representative or AccessTN's representative under Tennessee insurance law. No insurance agent may charge me any separate fee for help with AccessTN."