PRINTING INSTRUCTIONS

WHEN PRINTING THIS APPLICATION
PLEASE PRINT EACH
SHEET SEPARATELY
(DO NOT BACK-TO-BACK
ANY OF IT)

INDIANA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION
P.O. Box 33009
Indianapolis, IN 46203-0009
1-800-552-7921
317-614-2133
www.ichia.org

Dear Applicant:

Thank you for your interest in health care coverage offered by Indiana Comprehensive Health Insurance Association (ICHIA). Please complete the checklist below prior to mailing your application to ensure we receive all of the necessary information needed to process your application.

- ❍ Is your application completely filled out and signed in **black** ink?
- ❍ Did you choose a health care plan (Plan 1, 1 Rx, 2, 2 Rx, 3, 3 Rx, 4, 5)? **Application Section I.**
- ❍ Did you specify an effective date? If not, the effective date will be the date a complete and accurate application is approved. **Application Section I.**
- ❍ If you have a post office box, is a street address also included? We must have a street address to prove residency. **Application Section II.**
- ❍ If you listed dependents, do they meet the eligibility requirements listed? Have you included proof of dependency? **Application Section III.**
- ❍ Did you check an eligibility category? Did you include a copy of the documentation asked for under the category you checked? **Application Section IV.**
- ❍ Have you included proof of Indiana residency (for at least 12 months)? If a driver's license is used as proof of residency, it must be issued at least 12 months prior to the date of your application. **Application Section IV.**
- ❍ ***If you qualify based on rejection of other coverage or a higher premium than ICHIA***, did you identify any other health care coverage for which you or your spouse is eligible? **Application Section V.**
- ❍ ***If you qualify based on rejection of other coverage or a higher premium than ICHIA***, did you complete and include the proof of Medicaid Application? *You must apply for Medicaid within 60 days PRIOR to applying with ICHIA.* **It is not required if you are federally eligible**. **Application Section V.**
- ❍ ***If you qualify based on rejection of other coverage or a higher premium than ICHIA***, have you individually listed ALL medical advice, care or treatment you received in the three months preceding your application? **It is not required if you are federally eligible**. **Application Section VII.**
- ❍ ***If you qualify as federally eligible***, did you include a Certificate of Coverage from your previous insurance carrier / employer? **Application Section V.**
- ❍ ***If you qualify based on rejection of other coverage or a higher premium than ICHIA***, did you provide gross income and number of family members? **Application Section VIII.**
- ❍ Did you sign the Disclosure Authorization and Declaration? **Application Section IX.**
- ❍ Did you identify a premium payment cycle (Monthly, Quarterly, Monthly Bank Draft, Quarterly Bank Draft or Monthly Credit Card)? **Application Section XI.**
- ❍ Have you included the premium payment due according to the payment cycle chosen (monthly payment cycle requires an initial two months of premium)? **Application Section XI.**
- ❍ If you chose the Monthly or Quarterly Bank Draft premium payment cycle, did you complete and sign the Authorization Agreement for Automatic Withdrawal? Did you attach a voided check? **Application Section XI.**
- ❍ If you chose the Credit Card premium payment cycle, did you complete and sign the Authorization Agreement for Automatic Credit Card Withdrawal? **Application Section XI.**

Your application should be processed within 10 business days from the date of receipt if all necessary information is included.

APPLICATION FOR COVERAGE

INDIANA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION (ICHIA)

P.O. Box 33009
Indianapolis, IN 46203-0009
1-800-552-7921 OR 317-614-2133
www.ichia.org

POLICY ADMINISTERED BY:
ACS Healthcare Solutions (ACS)

Please don't cancel your current insurance until you have been notified you are approved by ICHIA.

Please type or print in black ink. All questions must be filled out with complete detail (attach a separate piece of paper if necessary). If you have questions while completing the application, log onto our **web site** at **www.ichia.org** or call **customer service** at **1-800-552-7921.**

FOR OFFICE USE ONLY

EFFECTIVE DATE OF COVERAGE: ____ ____ ____

SECTION I: PLAN INFORMATION

Please choose one: I understand once eligibility is verified, the effective date of coverage will be the later of: 1) the date application is approved, 2) the day after your previous major medical coverage ends or 3) the following date as requested _____. (Requested date must be a future date not exceeding 60 days.)

A

- ☐ **PLAN 1** ($500 DEDUCTIBLE and $1,000 COINSURANCE = $1,500 OUT-OF-POCKET MAXIMUM)
- ☐ **PLAN 2** ($1,000 DEDUCTIBLE and $2,000 COINSURANCE = $3,000 OUT-OF-POCKET MAXIMUM)
- ☐ **PLAN 3** ($1,500 DEDUCTIBLE and $2,500 COINSURANCE = $4,000 OUT-OF-POCKET MAXIMUM)
- ☐ **PLAN 4** ($2,500 DEDUCTIBLE [CO-MINGLED PHARMACY AND MEDICAL] and $2,500 COINSURANCE = $5,000 OUT-OF-POCKET MAX)
- ☐ **PLAN 5** ($5,000 DEDUCTIBLE [CO-MINGLED PHARMACY AND MEDICAL] and $900 COINSURANCE = $5,900 OUT-OF-POCKET MAX)

NOTE: YOU MUST HAVE PROOF OF MEDICARE D IN ORDER TO APPLY FOR THE PLANS BELOW WITHOUT RX

- ☐ **PLAN 1 Rx** (SAME AS PLAN 1 ABOVE WITH MEDICARE PART D INSTEAD OF ICHIA'S PHARMACY COVERAGE)
- ☐ **PLAN 2 Rx** (SAME AS PLAN 2 ABOVE WITH MEDICARE PART D INSTEAD OF ICHIA'S PHARMACY COVERAGE)
- ☐ **PLAN 3 Rx** (SAME AS PLAN 3 ABOVE WITH MEDICARE PART D INSTEAD OF ICHIA'S PHARMACY COVERAGE)

Please Note: In the future, you may only elect to change a Plan to one with a HIGHER deductible. This change will take effect on the following January 1st only and must be received by us not later than December 1st.

SECTION II: APPLICANT INFORMATION

E-MAIL ADDRESS (optional)

B

LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER
			– –

STREET ADDRESS (Mandatory)	SEX (check one)	BIRTHDATE: MONTH DAY YEAR	AGE
	☐ Male ☐ Female	/ /	

CITY	STATE	ZIP CODE	COUNTY OF RESIDENCE

HOME TELEPHONE	WORK TELEPHONE	CUSTODIAL PARENT / GUARDIAN IF APPLICANT IS A MINOR	SOCIAL SECURITY NUMBER
( )	( )		– –

SECTION III: DEPENDENT / SPOUSE INFORMATION

List dependents (including spouse) to be covered under this plan. Dependents must be (1) unmarried and under the age of 19, (2) unmarried, under the age of 24, or unmarried, under the age 25 AND a full-time student at an accredited high school, technical or vocational school, or college or university and is chiefly dependent upon you for support, OR (3) unmarried, incapable of self-sustaining employment by reason of mental retardation or mental or physical disability, and chiefly dependent upon you for support. Proof may be required.

C

LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER
			– –

RELATIONSHIP TO APPLICANT	FULL-TIME STUDENT	INCAPABLEOF SELF-SUSTAINING EMPLOYMENT DUE TO MENTAL OR PHYSICAL DISABILITY	SEX (check one)	BIRTHDATE: MONTH DAY YEAR	AGE
☐ Spouse ☐ Child	☐ Yes ☐ No	☐ Yes ☐ No	☐ Male ☐ Female	/ /	

D

LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER
			– –

RELATIONSHIP TO APPLICANT	FULL-TIME STUDENT	INCAPABLEOF SELF-SUSTAINING EMPLOYMENT DUE TO MENTAL OR PHYSICAL DISABILITY	SEX (check one)	BIRTHDATE: MONTH DAY YEAR	AGE
☐ Spouse ☐ Child	☐ Yes ☐ No	☐ Yes ☐ No	☐ Male ☐ Female	/ /	

E

LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER
			– –

RELATIONSHIP TO APPLICANT	FULL-TIME STUDENT	INCAPABLEOF SELF-SUSTAINING EMPLOYMENT DUE TO MENTAL OR PHYSICAL DISABILITY	SEX (check one)	BIRTHDATE: MONTH DAY YEAR	AGE
☐ Spouse ☐ Child	☐ Yes ☐ No	☐ Yes ☐ No	☐ Male ☐ Female	/ /	

SECTION IV: ELIGIBILITY INFORMATION

PLEASE CHECK AND INITIAL EACH ELIGIBILITY CATEGORY FOR WHICH YOU ARE APPLYING

F Each Eligibility Category **REQUIRES ONE** of the following Documentary Proofs of Residency:

1) **PROOF OF CURRENT RESIDENCY** in the state of Indiana, which may include one of the following documents; a receipt within 3 months prior to the date of the application for rent, mortgage payment, utility bill; a resident Indiana income tax return for the most recent 12 month tax period; a copy of your active Indiana driver's license **OR** a copy of your active Indiana personal identification card issued by the Indiana Bureau of Motor Vehicles; or
2) **PROOF OF 12 MONTH RESIDENCY** in the state of Indiana, which may include one of the following documents; a receipt 12 months prior to date of application **AND** another receipt within the last 3 months prior to the date of application for rent, mortgage payment, utility bill; a resident Indiana income tax return for the most recent 12 month tax period, a copy of your Indiana driver's license issued at least 12 months ago **OR** a copy of your Indiana personal identification card issued by the Indiana Bureau of Motor Vehicles dated 12 months or more prior to the date of application for ICHIA. Federally eligible individuals only need to submit current proof of residency.

I CERTIFY that I am eligible for coverage because:

✓ **(Please check the eligibility category you are applying under)**

F-1 ☐ **FEDERALLY ELIGIBLE**

I am federally eligible according to the Health Insurance Portability and Accountability Act (HIPAA) of 1996 because I have had health care coverage for at least 18 months prior to the effective date of coverage with no lapse in coverage exceeding 63 days. My most recent coverage was under a group plan and I have exhausted my benefits under the Consolidated Omnibus Budget Reconciliation Act (COBRA), IF OFFERED. I am not eligible under another group health plan offered by my employer or as a dependent for coverage through my spouse, parent or guardian; my most recent coverage was not cancelled because I failed to pay my premiums, failed to pay my premiums in a timely manner or committed fraud; I am not eligible for Medicare or Medicaid; and I did not accept a conversion policy or a short-term limited duration policy after my group, COBRA or state continuation coverage ended.

Name of the organization that provided your last month of coverage:_____

(month/date/year)

The date you terminated from the organization that provided your last month of coverage:_____/_____/_____

Reason for termination of coverage: ☐ Failure to pay premiums ☐ For Fraudulent Reasons ☐ Other (Explain) _____

_____

Did your former employer sponsor a health insurance plan for any of its employees? ☐ YES ☐ NO

Which of the following types of organizations was your former employer? ☐ Company ☐ Governmental Entity ☐ Church ☐ Other (Explain)_____

At the time you terminated employment with your former employer, did your former employer offer you an opportunity to continue your group insurance coverage (with you paying the premium) under COBRA or state continuation coverage? ☐ YES ☐ NO

REQUIRED DOCUMENTATION (Must Accompany This Application):

1) A copy of the **Certificate of Health Plan Coverage** provided by your previous insurance carrier / employer, a letter from the insurance carrier dated AFTER your coverage ended indicating your length of coverage, explanations of benefits (EOBs), other correspondence from a plan or issuer or paystubs that clearly establish 18 months of coverage with no lapse in coverage exceeding 63 days.
2) **Documentary PROOF OF CURRENT RESIDENCY** in the state of Indiana (See Section F for required documentation).

_____**Initial Here**

F-2 ☐ **REJECTION FOR OTHER HEALTH COVERAGE**

I received notification of rejection from one health insurer for individual health insurance coverage substantially similar to the coverage offered by ICHIA.

Date your last health coverage ended: _____

If your health coverage ended within 90 days of the date of application, have you been offered a Conversion Policy? ☐ YES ☐ NO

REQUIRED DOCUMENTATION (Must Accompany This Application):

1) A copy of the letter of rejection from health insurer on company letterhead that is dated within 90 days of the date on the application and must be signed by an underwriter or appropriate staff person. It must include ICHIA applicant's name and show that they are uninsurable.
2) **Documentary PROOF OF 12 MONTH RESIDENCY** in the state of Indiana (See Section F for required documentation).

_____**Initial Here**

F-3 ☐ **PREMIUM RATE HIGHER THAN ICHIA**

I am currently on an individual policy and am not eligible for any coverage that equals or exceeds the minimum requirements for Accident and Sickness policies in Indiana. I received a recent premium notice for health insurance coverage exceeding the premium rate for coverage by ICHIA.

REQUIRED DOCUMENTATION (Must Accompany This Application):

1) **A copy of the premium notice and deductible for the policy** must accompany your application.
2) **Documentary PROOF OF 12 MONTH RESIDENCY** in the state of Indiana (See Section F for required documentation).

_____**Initial Here**

SECTION V: OTHER HEALTH CARE COVERAGE

G

☐ YES ☐ NO Do you or any person named on this application have any other **medical or hospital insurance in effect or for which you are eligible?**

If **YES**: Name of person(s): _____ _____

Insurance Company Name: _____ _____

Insurance Company Phone: _____ _____

Are you eligible for **MEDICARE Part A** ☐ **Yes** ☐ **No** If yes, Effective Date of Part A_____

Are you eligible for **MEDICARE Part B** ☐ **Yes** ☐ **No** If yes, Effective Date of Part B_____

Are you eligible for **MEDICARE Part D** ☐ **Yes** ☐ **No** If yes, Effective Date of Part D_____

YOU MUST SEND IN A COPY OF YOUR MEDICARE CARD WITH THIS APPLICATION.

TYPE OF COVERAGE::

Is your current coverage GROUP? ☐ YES ☐ NO

(month/date/year)

The date you terminated or will be terminated from the organization that is providing your group coverage ___/___/___

Are you currently covered by COBRA or state continuation coverage? ☐ YES ☐ NO

If **YES**, and if you are approved for coverage with ICHIA, how many months will you have been on COBRA or state continuation coverage by the time you start coverage with ICHIA?_____

Is your current coverage INDIVIDUAL? ☐ YES ☐ NO

If **YES**, check the box that best describes your coverage:

☐ Comprehensive Major Medical (CMM) ☐ Limited benefit (e.g., "hospital-only" coverage or "cancer-only" coverage, etc.)

☐ Union plan ☐ Professional or trade association plan ☐ Student health plan

☐ Another state health benefits risk pool (a plan like ICHIA)

☐ Medicare (disabled) under age 65 ☐ Medicare over age 65

☐ Other (Explain):_____

Is it your intent to replace your current coverage with ICHIA coverage? ☐ YES ☐ NO

If **YES**, please explain the reason for replacement:_____

If **NO**: Does your current employer offer health coverage to any of its employees? ☐ YES ☐ NO

If **YES**, has your employer offered you an opportunity to participate in the employer-sponsored health plan? ☐ YES ☐ NO

If **YES**, why aren't you participating in the employer-sponsored plan?

☐ I have waived my employer-sponsored coverage

☐ I have been directed or encouraged to apply for _____ (Please explain under "Other" above.)

Based on Indiana Law, effective July 1, 2003 **all ICHIA applicants must apply for Medicaid within 60 days prior to applying to ICHIA. You must provide proof of Medicaid Application**. (This does not apply to federally eligible individuals.) If it is determined you are eligible for Medicaid after you are approved for ICHIA, your ICHIA coverage will be terminated the date you were **eligible** for coverage under Medicaid. Any premium paid for periods subsequent to the Effective Date of coverage under Medicaid will be returned to you, less any unrecoverable claim payments, including drugs, made for services incurred during enrollment in ICHIA. No claims will be paid for any period which premium has not been received. Have you enclosed the proof of Medicaid Application? _____(check here)

SECTION VI: PREMIUM PROVISION

H

Will any **PART** or ALL of the premium used to purchase this coverage be provided by:

A church / church affiliated group	☐ **YES** ☐ **NO**
A division of government, either county, city, state, federal or other?	☐ YES ☐ NO
A government agency, such as Medicaid, Medicare, public health department or other programs such as indigent programs?	☐ **YES** ☐ **NO**
A public or private foundation?	☐ **YES** ☐ **NO**
A health care provider?	☐ **YES** ☐ **NO**
An employer of the individual?	☐ **YES** ☐ **NO**
A person other than the individual's parent, adult child or guardian?	☐ **YES** ☐ **NO**
Other _____ (please explain)	☐ **YES** ☐ **NO**

If you answered "YES" to any question above, please list the following:

Name of organization: _____

Address of organization: _____

Phone number of organization: _____

SECTION VII: PRE-EXISTING CONDITIONS PROVISION - DOES NOT APPLY TO FEDERALLY ELIGIBLE

I

Benefits under any ICHIA policy (including spouse / dependent) will not be payable for a pre-existing condition (injury or sickness) for the first three months following the effective date of coverage if medical advice or treatment for the pre-existing injury or sickness was recommended or received within a period of three months before the effective date of coverage.

☐ YES ☐ NO Have you been diagnosed, treated or sought any medical advice or examination within the past 3 months? If so, explain: _____
_____

☐ YES ☐ NO Have you had any major medical coverage in the last three months?

WAIVER BENEFIT: You and any person named on this application may be eligible for a waiver of the pre-existing condition wait period if you lost your health insurance coverage within the last six months. **A copy of the Certificate of Health Plan Coverage provided by your previous health insurance carrier / employer or other evidence of medical coverage must be sent along with this application**. If you qualify for an ICHIA policy under the federally eligible category, you cannot be denied coverage for a condition, based upon the fact that the condition was present before the first day of coverage, regardless of whether any medical advice, diagnosis, care or treatment was recommended or received before that day.

PLEASE ANSWER THE FOLLOWING QUESTION:

☐ YES ☐ NO Have you or any person named on this application received medical advice, care or treatment, including any prescription medications in the three months preceding the effective date of coverage?

If **YES**, please provide **Medical Information** for each person named above (attach an additional sheet of paper if necessary).

APPLICANT NAME	PHYSICIAN NAME	DIAGNOSIS	TREATMENT and/or MEDICATION	DATES OF TREATMENT	DATES OF HOSPITALIZATION

SECTION VIII: INCOME INFORMATION - DOES NOT APPLY TO FEDERALLY ELIGIBLE

ICHIA is required to gather information on your family income as of the date of this application. Please fill in the information below.

Number in family _____

Annual Gross Income _____

ICHIA reserves the right to request supporting documentation including copies of your most recent income taxes filed.

SECTION IX: DISCLOSURE AUTHORIZATION AND DECLARATION

The foregoing statements and answers are full, complete, and true to the best of my knowledge and belief; and any coverage issued will be in full reliance upon this representation. I understand and agree that no coverage shall be effective until all requirements have been completed.

I understand and agree that referring agents or individuals are not authorized to interpret, amend or alter the terms of the ICHIA policy, nor are referring agents authorized to bind ICHIA in any way.

I hereby authorize and permit any physician, pharmacist, hospital or other health care provider, insurer, prepayment organization, or other health plan provider to provide ICHIA, the Administrator, or its designated representative that has executed a Business Associates Agreement any medical information about me or my enrolled dependents, including information about physical and mental health, medical history and drug or alcohol use. This information will be used solely to assist in my medical care and management. This authorization is continuous and in effect during my period of coverage. I further authorize the Administrator, if necessary, to contact my employer or my spouse's employer about prior insurance coverage. A reproduction of this authorization shall be as valid as the original.

The information provided on this form and any attachments is private data under Indiana law. By providing this data, I authorize ICHIA and its Administrator to use and disclose the data only so allowable by law. The law does not require me to provide any data, but failure to do so will result in loss of eligibility for ICHIA. Any data provided may be made available to the agents, directors or officers of ICHIA, the Administrator or legal counsel. The data may be made available to provider and peer review panels or consultants, the actuarial or research organizations, or other persons authorized by law to receive such data.

I have read the above statement, and I agree to the above authority, and to supply the data.

J SIGNATURE OF APPLICANT	DATE OF APPLICATION (MONTH / DAY / YEAR) / /

K SIGNATURE OF CUSTODIAL PARENT OR GUARDIAN (if applicant is under age 18)	DATE: (MONTH / DAY / YEAR) / /

SECTION X: RESEARCH AUTHORIZATION

Under limited circumstances, ICHIA may use or share some medical information of its participants for the purpose of research and research-related studies. The information used or shared will not individually identify any participant and will meet all privacy law requirements in effect at the time.

L SIGNATURE OF APPLICANT

DATE OF APPLICATION (MONTH / DAY / YEAR) / /

M SIGNATURE OF CUSTODIAL PARENT OR GUARDIAN (if applicant is under age 18)

DATE: (MONTH / DAY / YEAR) / /

SECTION XI: PREMIUM PAYMENT

N **PLEASE CHOOSE ONE OF THE PREMIUM PAYMENT OPTIONS BELOW:**

☐ **MONTHLY** - 2 MONTHS PREMIUM **MUST BE SENT** WITH APPLICATION.

☐ **QUARTERLY** - 3 MONTHS PREMIUM **MUST BE SENT** WITH APPLICATION.

PAYMENT METHOD SELECTION

☐ **I have enclosed a CHECK in the amount of $_____.**

☐ **I will continue to pay by CHECK the premium payment option I have chosen above.**

- OR -

☐ **I would like my premium payment withdrawn automatically every month or every quarter from my checking account. I have completed the Authorization Agreement for Automatic EFT Withdrawal.**

- OR -

☐ **I would like future payments withdrawn from my credit card. I UNDERSTAND THAT MY CREDIT CARD WILL BE CHARGED MONTHLY EVERY MONTH THEREAFTER UNTIL SUCH TIME AS MY POLICY IS TERMINATED OR I ELECT TO CHANGE MY PAYMENT METHOD.**

☐ **Please bill my CREDIT CARD based on the option I have chosen above. I have completed the Authorization Agreement for Automatic Credit Card Withdrawal.**

☐ **I will continue to pay by CREDIT CARD. I UNDERSTAND THAT AFTER THE INITIAL PREMIUM PAYMENT IS DRAWN ON MY CREDIT CARD, IF I CHOOSE TO CONTINUE BY CREDIT CARD, MY CREDIT CARD WILL BE CHARGED MONTHLY EVERY MONTH THEREAFTER UNTIL SUCH TIME AS MY POLICY IS TERMINATED OR I ELECT TO CHANGE MY PAYMENT METHOD.**

- OR -

☐ **I would like my premium payment withdrawn automatically every month or every quarter from my checking account. I have completed the Authorization Agreement for Automatic EFT Withdrawal.**

- OR -

☐ **I will make premium payments by check based on the premium payment option I have chosen above.**

IF YOU ELECT TO PAY YOUR PREMIUM BY CHECK AND NO PREMIUM IS RECEIVED WITH THE APPLICATION, YOUR APPLICATION WILL BE REJECTED.

O **USE THE PREMIUM RATE TABLE TO DETERMINE YOUR PREMIUM PAYMENT:**

RATE AREA YOUR RESIDENCE IS IN:

PREMIUM AMOUNT ENCLOSED → $

FOR OFFICE USE ONLY

$, . | PREMIUM PAYMENT | CHECK NUMBER

AUTHORIZATION AGREEMENT FOR AUTOMATIC EFT WITHDRAWAL OF INSURANCE PREMIUM

The Indiana Comprehensive Health Insurance Association (ICHIA) offers a convenient payment option for enrollees who are on a **monthly or quarterly premium payment cycle.** Your premiums can be automatically withdrawn from your checking account on a monthly / quarterly basis.

The withdrawal is done on the 1st Friday of each month in the bank's nightly cycle. (If the 1st Friday of the month falls on the 1st, 2nd or 3rd day of the month, the withdrawal takes place on the 2nd Friday of the month).

To have your premium payment automatically withdrawn from your checking account monthly or quarterly:

1. Complete the **Authorization Agreement** below.
2. Verify your **Account Number** and **Routing Number** with your financial institution (frequently, the account number listed on your check includes digits that are not actually part of the account number).
3. Send a copy of a **Voided Check** with your application.

(detach here)

AUTHORIZATION AGREEMENT FOR AUTOMATIC EFT WITHDRAWAL (CHOOSE MONTHLY OR QUARTERLY EFT ONLY)

If you are already an ICHIA member, please state your Member Identification No._____

I hereby request and authorize the Financial Institution named below to pay and charge to my account checks / drafts drawn on my account by and payable to the order of Indiana Comprehensive Health Insurance Association (ICHIA) provided there are sufficient collected funds in my account to pay such checks / drafts upon presentation. I agree that your rights in respect to each such check / draft shall be the same as if it were a check / draft drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such check / draft.

I further agree that if any such check / draft is not honored, whether with or without cause and whether intentionally or inadvertently, you shall have no liability whatsoever even though such action results in forfeiture of medical insurance coverage. This authorization is to remain in effect until you receive 15 days written notice from me of its revocation.

BANKING INFORMATION

NAME OF INSURED (APPLICANT)		NAME OF JOINT ACCOUNT HOLDER	
NAME OF FINANCIAL INSTITUTION			TYPE OF ACCOUNT ☐ Checking ☐ Savings
FINANCIAL INSTITUTION ADDRESS			☐ Monthly EFT ☐ Quarterly EFT
			ACCOUNT NUMBER
CITY	STATE	ZIP CODE	9 DIGIT ROUTING NUMBER

SIGNATURE OF ACCOUNT HOLDER(S)

NAME OF ACCOUNT HOLDER (please print)	NAME OF JOINT ACCOUNT HOLDER (please print)
SIGNATURE	SIGNATURE
DATE (mm / dd / yy) / /	DATE (mm / dd / yy) / /

TO FINANCIAL INSTITUTION: In consideration of your honoring pre-authorized checks / drafts drawn against depositors of your financial institution for the payment of amounts to the Indiana Comprehensive Health Insurance Association (ICHIA), we agree that no liability or responsibility shall attach to your financial institution as a result of honoring or not honoring such checks / drafts, and we further agree to hold you harmless from and reimburse you for any loss resulting as a consequence of your actions taken pursuant to your agreement to honor such checks / drafts. We shall defend any action brought against you by any of your depositors or any other person because of your compliance with the pre-authorized check / draft plan.

USE FOR EFT WITHDRAWAL ONLY

AUTHORIZATION AGREEMENT FOR CREDIT CARD WITHDRAWAL OF INSURANCE PREMIUM

The Indiana Comprehensive Health Insurance Association (ICHIA) offers a convenient payment option for members who are on a **monthly premium payment cycle.** Your premiums can be automatically withdrawn from your credit card account on a monthly basis.

The withdrawal from your credit card is done on the 15th of the month for the next month's coverage period with the exception of your initial withdrawal which **will be for 2 months**. If the 15th falls on a weekend or holiday, the withdrawal will be done on the next business day.

To have your premium payment automatically withdrawn from your credit card account monthly or quarterly:

1. Complete the **Credit Card Withdrawal Authorization Agreement** below.
2. Verify your **Account Number**
3. **NOTE:** This form must be 100% filled out in order to do the withdrawal. If any part is not completed, the **entire form will have to be done over.**

(detach here)

CREDIT CARD WITHDRAWAL AUTHORIZATION AGREEMENT

If you are already an ICHIA member, please state your Member Identification No._____

I hereby request and authorize Indiana Comprehensive Health Insurance Association (ICHIA) to automatically withdraw from my credit card account the amount of the monthly premium bill and applicable service and transaction fees due by me. I agree that your rights in respect to each such credit card withdrawal shall be the same as if it were a charge signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such credit card withdrawal. **NOTE: I must give 60 days written notice to stop or change this authorization. ICHIA will not refund any transaction fees or interest fees. ICHIA will not be held liable for any interest charges incurred by my credit card company unless an error is a direct result of ICHIA.**

I further agree that if any such credit card withdrawal is not honored, whether with or without cause and whether intentionally or inadvertently, you shall have no liability whatsoever even though such action results in forfeiture of medical insurance coverage. This authorization is to remain in effect until you receive **60 days written notice** from me of its revocation.

NOTE TO DEBIT CARD HOLDERS: You may wish to use the EFT option to avoid the Visa / MasterCard transaction fees.

CREDIT CARD INFORMATION

ALL BLOCKS MUST BE 100% FILLED IN OR YOU WILL HAVE TO FILL OUT ANOTHER FORM IN ITS ENTIRETY

NAME OF CARD HOLDER	NAME OF INSURED (IF DIFFERENT THAN CARD HOLDER)S	TYPE OF CREDIT CARD ☐ Visa ☐ MasterCard
CARD HOLDER ADDRESS	CREDIT CARD NUMBER (**You must include the CVV2 number**.This is a 3-digit number at the end of your credit card number located in the printed version of the number on the back of the card.)	CVV2 Number (see below)
	EXPIRATION DATE _____ / _____	☐ One Time Only Deduction ☐ Continuous Deduction
CITY / STATE / ZIP CODE		

TOTAL CREDIT CARD CHARGE TO BE WITHDRAWN:

This withdrawal will be taken on the 15th of each month for the next coverage period.

How to Calculate Your Credit Card Charge:
PLEASE SEE THE BACK OF THIS FORM FOR INSTRUCTIONS

1) $_____ **Monthly** Premium Amount
2) $_____ 2.17% Visa / MasterCard Fee
3) $_____ $3.00 Transaction Fee (DO NOT double this fee with your initial premium)

TOTAL $_____

* This premium is subject to change based on the member's birthday due to the rate differentials by age and periodic ICHIA rate changes.

SIGNATURE OF ACCOUNT HOLDER(S)

NAME OF ACCOUNT HOLDER (please print)	NAME OF JOINT ACCOUNT HOLDER (please print)
SIGNATURE	SIGNATURE
DATE (mm / dd / yy) / /	DATE (mm / dd / yy) / /

TO FINANCIAL INSTITUTION: In consideration of your honoring pre-authorized credit card withdrawals against card owners of your financial institution for the payment of amounts to the Indiana Comprehensive Health Insurance Association (ICHIA), we agree that no liability or responsibility shall attach to your financial institution as a result of honoring or not honoring such credit card withdrawals, and we further agree to hold you harmless from and reimburse you for any loss resulting as a consequence of your actions taken pursuant to your agreement to honor such credit card withdrawals. We shall defend any action brought against you by any of your credit card owners or any other person because of your compliance with the pre-authorized credit card withdrawal plan.

INSTRUCTIONS ON HOW TO CALCULATE YOUR CREDIT CARD CHARGE

If you are filling out this form at the same time you are filling out your application, please use the following steps.

Multiply your monthly fee x 2 and enter it on line 1.
Multiply line 1 times 2.17% which is the Visa / MasterCard Fee and enter this dollar amount on line 2.
Line 3 will **always** be $3.00 (it will not increase because you are sending 2 month's premium).
Add lines 1, 2 and 3 together and this will be the TOTAL Premium you need to send in with your application or if you prefer, you can request us to withdraw this amount from your credit card.

If you are filling out this form at a later date because you are changing the way you are paying your monthly premium:

Enter your monthly fee on line 1.
Multiply line 1 times 2.17% which is the Visa / MasterCard Fee and enter this dollar amount on line 2.
Line 3 shows the Transaction Fee of $3.00.
Add lines 1, 2 and 3 together and this will be the TOTAL Premium that will be withdrawn from your credit card each month.

YOU MUST SUBMIT A NEW CREDIT CARD AUTHORIZATION FORM WHEN YOUR CURRENT CREDIT CARD EXPIRES

IF YOU DO NOT SEND IN A NEW ONE, YOU WILL BE AUTOMATICALLY SWITCHED TO MONTHLY PAPER BILL