# Individual Enrollment Form

**Plan Year 2019**

NOTICE - YOU MUST PERSONALLY BEAR ALL COSTS IF YOU UTILIZE HEALTH CARE NOT AUTHORIZED BY THIS PLAN OR PURCHASE DRUGS WHICH ARE NOT AUTHORIZED BY THIS PLAN.

**Please Print Clearly**

## SECTION 1 COMPLETE THE FOLLOWING INFORMATION ABOUT YOU

APPLICANT INFORMATION

| APPLICANT'S LAST NAME | FIRST NAME | MI | SEX (M/F) | DOB (MM/DD/YYYY) |
|---|---|---|---|---|
| | | | | |

| MAILING ADDRESS | CITY | STATE | ZIP | SSN |
|---|---|---|---|---|
| | | | | |

| HOME PHONE | CELL PHONE | PREFERRED COMMUNICATION METHOD |
|---|---|---|
| | | ◯ E-mail ◯ Text ◯ Phone Call |

| E-MAIL ADDRESS | PREFERRED PLAN MATERIALS |
|---|---|
| | ◯ View documents online rather than paper booklets ◯ Receive paper materials |

| MEDICAL HOME PRIMARY CARE PROVIDER (MH-PCP)* | MARITAL STATUS |
|---|---|
| | ◯ Single ◯ Married ◯ Divorced ◯ Widowed |

If Policy Holder is under age 18, please provide the name and phone number of the Policy Holder's legal guardian:

NAME: PHONE:

## SECTION 2 COMPLETE THE FOLLOWING INFORMATION FOR YOU AND YOUR DEPENDENTS

DEPENDENT(S) INFORMATION

| FULL NAME (FIRST, MIDDLE, LAST) | SSN | RELATION (e.g. CHILD) | BIRTH DATE (MM/DD/YYYY) | SEX (M/F) | TOBACCO USE (Y/N) | MH-PCP PROVIDER* |
|---|---|---|---|---|---|---|
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## SECTION 3 CHOOSE YOUR POLICY SELECTION BELOW

POLICY SELECTION

**All policy selections include Medical, Prescription Drug and Preventive Dental coverage.**
**Please make your plan selection by marking only one policy in the categories below.**

The following plans include Comprehensive Dental for Children and Adults.

**Freedom:** ◯ Platinum ◯ Gold 1000 ◯ Silver 2500 ◯ Silver 3000 ◯ Silver 4000

**Essential:** ◯ Gold 1500 ◯ Silver 3500 ◯ Bronze 6500

**Savings:** ◯ Silver 3800

Dental child + adult

The following plans include Comprehensive Dental for Children. Comprehensive Dental for Adults is not covered.

**Freedom:** ◯ Silver 2500 ◯ Silver 4000

**Savings:** ◯ Gold 3000 ◯ Silver 3800 ◯ Silver 5000 ◯ Bronze 5500 ◯ Bronze 6750

Dental child only

**Desired Plan Effective Date:** _____ ****All plans will term on the last day of the year.**

* A Medical Home Primary Care Provider("MH-PCP") must be selected by the Applicant for this application to be processed.

***Continued on next page.***

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**Please Print Clearly**

## SECTION 4 LIST ANY OTHER INSURANCE YOU HAVE FOR COORDINATION OF BENEFITS

OTHER COVERAGE

**Please mark the boxes for any health insurance you or anyone listed in Section 2 currently have in effect and provide the policy information in the chart below. Indicate which coverage you will keep while enrolled with Vantage by checking the "Keep this Coverage" box.**

☐ Dental ☐ Medicaid ☐ Individual Health Insurance ☐ Employer Group Health Insurance
☐ Medicare Part A (Hospital) ☐ Medicare Part B (Medical) ☐ Medicare Part C (Medicare Advantage) ☐ Medicare Part D (Prescription Drugs)

| NAME OF POLICY HOLDER | IDENTIFICATION NUMBER | NAME OF CARRIER/ INSURANCECOMPANY | SINGLE | FAMILY | KEEPING THIS COVERAGE |
|---|---|---|---|---|---|
| | | | ☐ | ☐ | ☐ |
| | | | ☐ | ☐ | ☐ |
| | | | ☐ | ☐ | ☐ |

## SECTION 5 ACKNOWLEDGEMENTS & AUTHORIZATIONS

ACKNOWLEDGEMENTS & AUTHORIZATIONS

**I. AUTHORIZATION TO RELEASE MEDICAL RECORDS FOR TREATMENT, PAYMENT & OPERATIONS**

My dependents, spouse, and I authorize any physician, medical healthcare practitioner, hospital, clinic, veterans administration facility, other medical or medically related facility, Pharmacy Benefit Manager, insurance, HMO, reinsuring company, or consumer reporting agency having information regarding myself, my dependents (including spouse), including information concerning, advice, diagnosis, treatment and care of physical, psychiatric, mental or emotional conditions, drug, substance or alcohol abuse or illness, and any non-medical information (e.g. demographics), to give any and all such information to Vantage Health Plan, Inc. (hereafter "Vantage"), Vantage's affiliates, or their legal representatives.

My dependents, spouse, and I understand and agree that the information obtained by use of this authorization will be treated as confidential. Any information obtained will not be released by Vantage to any person or organization except to reinsuring companies or other persons or organizations performing health care operations or business or legal services in connection with any application, claim or as may be otherwise lawfully required, or as we may further authorize. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

I understand that Vantage will provide a copy of this authorization upon request. A photographic copy of this authorization shall be as valid as the original. This authorization may be revoked in writing at any time. Revocation will not affect the rights of any party prior to receiving notice of revocation. You have a right to receive a copy of the Vantage privacy policy upon request at any time. We provide this notice to all members upon enrollment. You can also view the notice on our web site at www.VantageHealthPlan.com. Should any of our privacy practices change, we reserve the right to change the terms of the notice and to make the new notice effective for all protected health information that we maintain. Once revised, the new notice will be posted on the internet. If you have a question or complaint concerning privacy, please contact Vantage at 888-823-1910 or *privacy.officer@vhpla.com*.

**II. YOUR RIGHTS REGARDING THE RELEASE AND USE OF GENETIC INFORMATION**

Under Louisiana law LSA-R.S. 22:1023(B)(2), no health and accident insurer or health maintenance organization may require a policy holder for coverage under a policy or plan, or an individual or family member who is presently covered under a policy or plan, to be the subject of a genetic test, release genetic test information, or to be subjected to questions relating to the medical conditions of persons not being insured under such policy or plan. The results of any genetic tests, including genetic test information, shall not be used as the basis to terminate, restrict, limit, or otherwise apply conditions to the coverage of an individual or family member under the policy or plan, or restrict the sale of the policy or plan to an individual or family member; or cancel or refuse to renew the coverage of an individual or family member under the policy or plan; or deny coverage or exclude an individual or family member from coverage under the policy or plan; or impose a rider that excludes coverage for certain benefits or services under the policy or plan; or establish differentials in premium rates or cost sharing for coverage under the policy or plan; or otherwise discriminate against an individual or family member in the provision of insurance.

**III. BALANCE BILLING**

Under Louisiana law LSA-R.S. 22:1880 B, all health insurers must inform their members of the possibility of balance billing at in-network facilities. Health care services may be provided to you at an in-network facility by facility-based physicians who are not in Vantage's provider network. You may be responsible for payment of all or part of the fees for those out-of-network services, in addition to applicable amounts due for co-payments, co-insurance, deductibles and non-covered services.

This law will not affect the way Vantage currently handles claims arising from out-of-network physicians at in-network facilities. Specific information about in-network and out-of-network facility-based physicians can be found at *www.VantageHealthPlan.com* or by calling Member Services at (888) 823-1910.

**IV. UNPAID BALANCES**

Subscribers are required to pay any unpaid balances on previous Vantage coverage before re-enrolling with Vantage during a Special Election Period or during an annual enrollment period. Subscribers must pay the Balance Due (which includes any outstanding premium balance on a past enrollment) as noted on their first premium bill before new coverage can begin. Call Vantage's Member Services department at (844) 833-7505 for help understanding their premium bill.

**I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance, or a claim for payment of a loss, containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime punishable by fine and imprisonment under federal and state laws. I understand that any intentional misrepresentation of material fact, non-compliance with Plan procedures, or the non-payment of premium charges may result in cancellation of membership. Pre-Authorization must be obtained from Vantage for all designated services. I further understand that this Application is a part of the Agreement, and that I must promptly advise Vantage of any changes affecting the eligibility of myself or any of my covered dependents (including spouse). I represent that this Application is true and correct and agree to its terms and conditions. I have read and understand my rights as stated herein.**

**I acknowledge and agree that the use of this policy of health insurance is subject to the terms and conditions set forth in the policy's Certificate of Coverage including, but not limited to, Vantage's right to subrogation.**

| POLICY HOLDER SIGNATURE | PRINT NAME | DATE |
|---|---|---|
| AGENT SIGNATURE | PRINT NAME | DATE |

* A Medical Home Primary Care Provider("MH-PCP") must be selected by the Applicant for this application to be processed.