L.A. Care Covered™ Direct

Application For Healthcare Coverage
L.A. Care Covered *Direct*™

Who can use this application?

You may use this enrollment application to apply for coverage directly with **L.A. Care Health Plan for the L.A. Care Covered Direct™ Plan.**

- If you want coverage for your family on the same L.A. Care Covered Direct™ plan, please complete one (1) application for the entire family.
- If a dependent wants a different benefit plan, he or she must complete a separate application.
- Dependents must be under age 26. If a dependent is over 26, he or she should complete their own application.
- You are eligible to apply for an L.A. Care Covered Direct™ Individual and Family Plan if you reside in Los Angeles County.

To enroll in or modify coverage obtained through Covered California™ and/or to apply for premium assistance through the State Exchange, please contact Covered California™ directly at www.coveredca.com.

Who is the primary applicant?

- In an individual plan, the primary applicant is the person who will be covered by the benefit plan.
- In a family plan, the primary applicant is the family member who is authorized to make changes to the account.
- If this application is only for a child under 18, the child is the primary applicant.
- The primary applicant is the Subscriber of the benefit plan account.

How to make a benefit plan choice?

- Summary of Benefits and Coverage (SBC) forms are available for all medical plans. These forms summarize coverage and benefits for plans in a uniform manner. Visit **www.lacarecovered.org** to download SBC forms for any plan(s) you have applied for.
- You must select a Primary Care Physician (PCP) and Medical Group. To find the most up to date list of L.A. Care contracted physicians and Medical Groups, visit **www.lacarecovered.org** and click on "Find a Doctor". You'll find a complete listing of our Individual & Family Plan network physicians, and you can search by specialty, city, county, or doctor's name. You can also call **1.855.222.4239** (TTY/TDD: **711**) to request provider information, or contact your L.A Care authorized agent/broker.

Billing and payment information

- To obtain a monthly premium quote, please contact an L.A. Care Covered Direct™ representative at **1.855.222.4239** (TTY/TDD: **711**). Note that your final monthly premium may vary due to enrollment status changes upon processing your application.
- L.A. Care sends bills to only one address per subscriber. Therefore, to be billed under the subscriber, all dependent(s) must be billed to the same address.
- After we process your complete application, we will send you a letter with information to make your first monthly premium.
- Please wait for your monthly invoice to make your first payment.
- The first initial payment is due within 30 days of the date on the invoice.
- The proceeding payments are due on the 26th day of the month for coverage in the next month.
- **Do not send cash or deliver payment to L.A. Care with this application.**

Apply faster online

- You can complete an application online at **www.lacarecovered.org**
- Upon receipt of your complete and signed application, we will send you a letter with important information to complete your enrollment.

Things to remember

- This application must be typed or completed in blue or black ink.
- You must apply for coverage by the 15th of the month in order for coverage to be effective the first of the month of the following month. If you apply between the 16th and last day of the month, coverage will be effective the first day of the second following month.
- Effective dates for Special Enrollment period may be different than during Open Enrollment (see Step 8).
- Full premium(s) must be paid by the due date before coverage becomes effective.
- To avoid being double billed, if you are enrolled in a plan through Covered California™, you must cancel your current Covered California plan on or before the effective date of your new L.A. Care Covered Direct™ plan.
- Please make sure you answer all question as completely and accurate as possible. If your application is incomplete, or we don't receive your first month's premium by the due date, it may delay your enrollment effective date or your application may be canceled.
- Submit ALL pages, including other supporting documents by mail or fax:

  Mail your signed application to:
  L.A. Care Health Plan Attn: Direct Response Unit – Application
  1055 West 7th Street, 10th Floor, Los Angeles, CA 90017
  Or send by secure fax to:
  L.A. Care Health Plan: 1.213.438.5699

Need help?

- For help completing this application, please call **1.855.222.4239** (TTY/TDD: **711**)
- We will provide language assistance at no cost to you.
- If you are working with a broker, please call him or her for assistance.

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Step 1: Tell Us When You're Applying (Boxes should be marked as follows X)

Select one option:

☐ Open Enrollment: ☐ New enrollment ☐ Benefit plan transfer ☐ Open Enrollment – add dependent(s) to existing coverage

☐ Special Enrollment/qualifying event-by checking this box, you are certifying that to the best of your knowledge, you are eligible for Special Enrollment.

Applicant requested effective date: _____ Date of qualifying event triggering Special Enrollment: _____

Please explain qualifying event type for Special Enrollment: (see Part 7 for qualifying events) _____

_____

_____

You must apply within 60 days from the triggering event to elect coverage under Special Enrollment.

If adding dependent(s) to existing coverage, please provide existing subscriber's L.A.Care member ID number: _____

Step 2: Choose Your Benefit Plan

Choose one (1) L.A. Care Covered Direct Plan™. If any dependents are applying for different benefit plans, please submit a separate application form for each plan. When a dependent(s) chooses a different benefit plan, that member will be covered under their own coverage contract.

L.A. Care Covered Direct™ Plans (check one box only):

☐ Platinum 90 HMO ☐ Gold 80 HMO ☐ Silver 70 HMO ☐ Bronze 60 HMO ☐ Minimum Coverage HMO

Minimum Coverage Plan HMO

We also offer a minimum coverage plan, a high deductible plan option for applicants under the age of 30 and certain persons age 30 and older. If you or any dependents are age 30 or older, each person may only apply for this plan if you submit with your completed application an Exception Certificate Number (ECN) for each person that indicates lack of affordable coverage or financial hardship.

Step 3: Enter Your Information
Primary applicant information (Subscriber)

Social Security number/Tax ID number: _____

Last Name: _____ First Name: _____ MI: _____

Gender: ☐ Male ☐ Female Married: ☐ Yes ☐ No Date of birth (month/day/year): _____

Home phone number: _____ Work phone number: _____ Cell phone number: _____

Email address: _____

Home address (No P.O. Box): _____ Apt. No: _____

City: _____ State: _____ ZIP code: _____

Mailing address (if different from home): _____

City: _____ State: _____ ZIP code: _____

Indicate spoken language preference: ☐ English ☐ Spanish ☐ Other: _____

Indicate written language preference: ☐ English ☐ Spanish ☐ Other: _____

Race/Ethnicity (optional) _____

Ethnicity – is the Subscriber Hispanic or Latino? ☐ Yes ☐ No

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The above question is about ethnicity, not race. No matter what you selected above, continue to answer the following by selecting one box to indicate what race you most closely identify with.

☐ American Indian/Alaskan Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other

Preferred method of contact (check one): ☐ Home phone ☐ Work phone ☐ Cell phone ☐ Email ☐ Standard mail

Check here if you have previously had coverage with L.A. Care. ☐

Primary Care Physician (PCP) / Clinic Name

Medical Group Name: Site ID:

Spouse/domestic partner information (skip if no spouse/domestic partner)

A domestic partner is a person registered and legally recognized as your domestic partner by California.

☐ Spouse ☐ Domestic partner Gender: ☐ Male ☐ Female Date of birth (month/day/year):

Social Security number/Tax ID number:

Last Name:

First Name: MI:

Is the spouse/domestic partner's residence the same as the primary applicant? ☐ Yes ☐ No

If no, spouse/domestic partner address, including state and ZIP code:

Primary Care Physician (PCP) / Clinic Name:

Medical Group Name: Site ID:

Dependents to Be Covered (skip to Step 4 if no dependents)

Dependent children must be under age 26. If more than four (4) dependents are applying for coverage, please attach a supplemental page providing all information listed below, your signature, and date. Check here if a supplemental page is attached. ☐

Dependent 01 information

Gender: ☐ Male ☐ Female Relationship (e.g. son/daughter): Date of birth (month/day/year):

Social Security number/Tax ID number:

Last Name:

First Name: MI:

Is the dependent's residence the same as the primary applicant? ☐ Yes ☐ No

If no, dependent address, including state and ZIP code:

Primary Care Physician (PCP) / Clinic Name

Medical Group Name: Site ID:

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Dependent 02 information

Gender: ☐ Male ☐ Female Relationship (e.g. son/daughter): Date of birth (month/day/year):

Social Security number/Tax ID number:

Last Name:

First Name: MI:

Is the dependent's residence the same as the primary applicant? ☐ Yes ☐ No

If no, dependent address, including state and ZIP code:

Primary Care Physician (PCP) / Clinic Name

Medical Group Name: Site ID:

Dependent 03 information

Gender: ☐ Male ☐ Female Relationship (e.g. son/daughter): Date of birth (month/day/year):

Applicant's Social Security number/Tax ID number:

Last Name:

First Name: MI:

Is the dependent's residence the same as the primary applicant? ☐ Yes ☐ No

If no, dependent address, including state and ZIP code:

Primary Care Physician (PCP) / Clinic Name

Medical Group Name: Site ID:

Dependent 04 information

Gender: ☐ Male ☐ Female Relationship (e.g. son/daughter): Date of birth (month/day/year):

Applicant's Social Security number/Tax ID number:

Last Name:

First Name: MI:

Is the dependent's residence the same as the primary applicant? ☐ Yes ☐ No

If no, dependent address, including state and ZIP code:

Primary Care Physician (PCP) / Clinic Name

Medical Group Name: Site ID:

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Step 4: Identify Financially Responsible Party

To be completed by the parent or legal guardian if the applicant is under age 18, or by the financially responsible party if this is someone other than the primary applicant.

Gender: ☐ Male ☐ Female Date of birth (month/day/year):

Last Name:

First Name:

Relationship to primary applicant: ☐ Spouse/Domestic partner ☐ Parent/Legal Guardian ☐ Other:

Same address as the primary applicant? ☐ Yes ☐ No

If no, provide address (no P.O. Box): Apt. No

City: State: ZIP code:

Main phone number:

Indicate spoken language preference: ☐ English ☐ Spanish ☐ Other:

Indicate written language preference: ☐ English ☐ Spanish ☐ Other:

Step 5: Sign the Application Agreement

Applicant verification of accuracy

Please read the following carefully. Each applying family member age 18 and older is required to review the completed application and provide his/her own signature. By signing, the financially responsible party agrees to be responsible for paying all premiums, copayments, coinsurance, and deductibles for all applicants listed on this form. Please keep a copy of this application for your records.

I alone am responsible for the accuracy and completeness of the information provided on this application. I have personally reviewed all information provided on this application, even if I did not fill out the application myself. To the best of my knowledge and belief, all information on this application is accurate, true, and complete. If L.A. Care determines that there is fraud (by act, practice, or omission) or an intentional misrepresentation of material fact in the information on this application, I understand that coverage may be rescinded, as allowed by law.

For applicants with a language preference other than English: If I indicated in Step 3 of this application that I have a language preference other than English and have completed the English version of this application (or version other than in my language preference), I confirm that I understand the questions on this application.

Primary applicant/parent or legal guardian	Today's date	Print name (and relationship if applicant is a minor)
Spouse/domestic partner (if applying)	Today's date	Print name
Dependent age 18 and over (if applying)	Today's date	Print name
Dependent age 18 and over (if applying)	Today's date	Print name
Dependent age 18 and over (if applying)	Today's date	Print name
Dependent age 18 and over (if applying)	Today's date	Print name

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Privacy Information

This application is for healthcare coverage with L.A. Care Covered Direct™ provided through L.A. Care. The information you provide is personal and confidential. L.A. Care requires the information to process your application and to administer our program.

L.A. Care will use and share your information with others as allowed and required by law. For information on how L.A. Care may use or share your information and your rights regarding your information, please log on to **www.lacarecovered.org** and click "Privacy" located at the bottom of the page to review our Notice of Privacy Practices or call **1.855.222.4239** (TTY/TDD: **711**).

Step 6: Sign the Authorizations Terms and Conditions

Please read the following terms and conditions carefully. Each applicant age 18 and older is required to review the completed application and provide his/her own authorization and signature. Please keep a copy of this application for your records.

1. **Application for coverage:** It is important to know that **L.A. Care** may decline your application for coverage if you do not meet the eligibility criteria. Your application must be approved by **L.A. Care**, and an effective date for coverage assigned, before coverage can become effective.

2. **First month's dues/premiums: L.A. Care** requires first month's dues/premium before coverage becomes effective. **L.A. Care** will mail your monthly premium invoice once your application is approved. The first initial payment is due within 30 days of the date on the invoice. The proceeding payments are due on the 26th day of the month. Refer to Step 4 for payment options. If you do not pay your first full premium by the due date within thirty (30) days from the date of your invoice, your application will be cancelled and you will be required to reapply for enrollment in L.A. Care Covered Direct™. Your monthly premium rate may also increase based on any updated information. If you miss your first month's dues/premiums, your effective date of coverage will then begin the first of the following month of the receipt of payment. Please note that processing any payment does not constitute approval of your application with **L.A. Care**. If you do not qualify for coverage, the dues/premium you submit to **L.A Care** will be returned.

3. **Dues/premiums:** Dues/premiums are to be paid in full by the due date. Coverage will be terminated for failure to pay dues/premiums in a timely manner as set forth in the health service agreement/policy and as allowed by law.

4. **Effective date of coverage:** If you qualify for coverage, **L.A. Care** will notify you of your effective date of coverage. If **L.A. Care** cannot honor your requested effective date, or is unable to issue coverage before your requested date, coverage will begin as soon as possible (coverage will begin on the first of the month after all requirements have been met). If additional dues/premiums are owed, payment must be received before coverage becomes effective. Any charges incurred for services received prior to your effective date or after termination of coverage are not covered. Effective dates for a Special Enrollment Period may be different than for an Open Enrollment Period. These effective dates are assigned by **L.A. Care** and may be as early as the 1st of the month following the receipt of the Special Enrollment Period, as required by regulation, or as early as the date of birth in the case of a newborn. For information on Special Enrollment Period application effective dates, please see Step 8).

5. **Acceptance of application:** You understand that only **L.A. Care** can accept your application and issue coverage for an Individual Family Plan requested on this application. Your agent or broker cannot enroll you for coverage or change any terms or conditions of coverage.

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6. **Parents/guardians:** If you are the parent or legal guardian of an applicant who is a minor, please sign below on behalf of the applicant. As the parent or legal guardian, you are identified as the person who may make inquiries and act on behalf of the applicant regarding this coverage (as allowed by law). In addition, you are agreeing to assume all responsibility for dues/premiums payments and for following the terms and conditions for coverage. If you are not the parent of the applicant, please attach the court documents that appoint you as the guardian of this minor. Mark one of the following boxes and identify the individual authorized to act on behalf of the minor (applicant):

   ☐ Legal guardian only _____ (include name and relationship). Or

   ☐ My designee _____ (include name and relationship). Or

   ☐ Qualified medical child support order designee _____ (include name and relationship).

   ☐ Mark this box if **L.A. Care** is to only make changes to the contract upon written request by the person identified above.

7. **Authorization for spouse/domestic partner to make changes:** If you are an applicant whose spouse/domestic partner is also applying for coverage, please specify if you authorize your spouse/domestic partner to make changes to the contract/policy on your behalf. You may discontinue this authorization at any time by sending a written request to **L.A. Care**. ☐ Yes ☐ No

8. **Authorization for your agent to provide/obtain information:** Check here if you do **not** authorize your insurance agent, broker, or producer (referred to as "your agent") to access all information on this application. ☐

9. **Process to authorize L.A. Care to release personal protected health information to a third party:** If you would like to authorize your spouse, domestic partner, or a third party to access your personal protected health information, please complete the form titled Authorization for Use and Disclosure of Protected Health Information to a Third Party. To obtain this form, contact us at 1.855.222.4239 (TTY/TDD: **711**).

10. **Response to requested information:** You agree to cooperate with **L.A. Care** by providing, or by providing access to, documents and other information requested (such as court orders to provide dependent coverage, etc.) to corroborate information provided in this application for coverage. You acknowledge and agree that failure or refusal to provide these documents or the information requested may be cause to rescind or cancel your coverage.

11. **Authorization to receive materials and communications electronically:** Check here if you agree to receive required benefit plan and coverage-related materials and communications via email (i.e. enrollment information, evidence of coverage and health service agreement/policy, explanation of benefits (EOB), annual privacy notice, etc) in place of mailed printed copies, unless required by law. ☐

I have reviewed all responses pertaining to me in this application. I have read the Summary of Benefits and Coverage (SBC), and the terms and conditions of coverage and authorizations set forth above. With my own signature below, I represent that the information provided in this application is complete and accurate to the best of my knowledge, and I understand and agree to the terms and conditions of coverage and the authorizations I have provided.
(Important: Each adult applicant must provide their own signature.) I understand that I must inform **L.A. Care** if anything changes or is different from what I listed on this application before my coverage with **L.A. Care** begins.

Primary applicant/parent or legal guardian	Today's date	Print name (and relationship if applicant is a minor)
Spouse/domestic partner (if applying)	Today's date	Print Name
Dependent age 18 and over (if applying)	Today's date	Print Name
Dependent age 18 and over (if applying)	Today's date	Print Name
Dependent age 18 and over (if applying)	Today's date	Print Name
Dependent age 18 and over (if applying)	Today's date	Print Name

Important: Return the application within 30 days of your date(s) and signature(s).
We must receive your application during the Open Enrollment Period or within 60 days from a Special Enrollment triggering event.

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Step 7 - Agent information: To be completed by an agent that is authorized by L.A. Care Health Plan.

1. Did you complete this application? ☐ Yes ☐ No
2. If yes, did you ask each question in this application exactly as set forth? ☐ Yes ☐ No
3. Are the answers recorded exactly as given to you? ☐ Yes ☐ No, attach explanation.

Agent name:

Telephone number:

General Agency Name: CA State License number:

Agent's signature (required) | Today's date | Print name

Agents: Please ensure each part of the application is complete. In the event of missing or incomplete information, **L.A. Care** may contact your applicant directly to obtain complete information.

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Step 8 - Special Enrollment Period

In addition to the open enrollment period, you and your dependents are eligible to enroll or change plans during a special enrollment period, which is within 60 days of certain qualifying events. Generally, for applications received between the 1st and 15th, coverage will be effective the first day of the month following submission of application. For applications received between the 16th and month's end, coverage will be effective the first day of the second month following submission of application. **Exceptions to these effective dates include birth, adoption or placement for adoption being effective the date of the qualifying event, and marriage or loss of minimum essential coverage being effective the first day of the following month**. The application must be received within 60 days of the qualifying event. Proof of the qualifying event is required. Please write in the applicable qualifying event below and the name of the person to whom it applies. For additional dependents, please attach a separate sheet of paper.

Qualifying event #(see chart below)	Date of event	Primary applicant	Spouse/ Domestic partner	Dependent 01	Dependent 02	Dependent 03	Dependent 04

Qualifying events for special enrollment periods for Individual & Family Plans

Qualifying event	Submit required proof of qualifying event
1) The qualified individual, or his or her dependent, loses minimum essential coverage, which could be due to one of the following reasons (not including voluntary termination of your previous coverage or termination due to failure to pay premium): A. The death of the covered employee. B. The termination or reduction of hours, of the covered employee's employment. C. The divorce or legal separation of the covered employee from the employee's spouse. D. The covered employee becoming entitled to benefits under Medicare. E. A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan. F. A proceeding in a case under Title 11 bankruptcy, commencing on or after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time. In this case, a loss of coverage includes a substantial elimination of coverage with respect to a qualified beneficiary (spouse/domestic partner, dependent child or surviving spouse/domestic partner) within one year before or after the date of commencement of the proceeding.	Copy of one of the following: • Loss of coverage notice from former insurance carrier. • Loss of coverage notice from employer. • Front and back of former insurance carrier's ID card.
G. Loss of minimum essential coverage for any reason other than failure to pay premiums or situations allowing for a rescission for fraud or intentional mis-representation of material fact.	Documentation would depend on circumstance.
H. Termination of employer contributions.	Notice from employer of contributions termination.
I. Exhaustion of COBRA continuation coverage.	COBRA paperwork reflecting exhaustion of coverage.
2) The qualified individual gains a dependent or becomes a dependent through marriage, domestic partnership, birth, adoption, or placement for adoption.	Court documentation, copies of official documents or discharge records.

3) The qualified individual's, or his or her dependent's, enrollment or non-enrollment in a health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange.	Documentation would depend on cicumstance.
4) The health plan in which the enrollee, or his or her dependent, is enrolled substantially violated a material provision of its contract.	Documentation would depend on cicumstance.
5) The qualified individual or enrollee, or his or her dependent, gains access to a new health plan as a result of a permanent move.	Copy of one of the following: • Lease. • Mortgage statement. • First utility or phone bill.
6) With respect to individuals enrolled in non-calendar year individual health insurance policies, a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy year ends in 2015.	Termination/Cancellation notice from prior coverage.
7) He or she (references to "he" or "she" are to a qualified individual or a dependent) is mandated to be covered as a dependent pursuant to a valid state or federal court order.	Court documentation.
8) He or she has been released from incarceration.	Probation or parole paperwork.
9) He or she was receiving services under another health benefit plan, from a contracting provider who is no longer participating in that health plan, for any of the following conditions: (a) an acute condition (a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration); (b) a serious chronic condition (a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration); (c) a terminal illness (an incurable or irreversible condition that has a high probability of causing death within one year or less); (c) a pregnancy; (d) care of a newborn between birth and 36 months; or (e) a surgery or other procedure that has been recommended and documented by the provider to occur within 180 days of the contract's termination date, or within 180 days of the effective date of coverage for a newly covered insured, and that provider is no longer participating in the health plan.	Dated letter from primary care physician (PCP).
10) He or she demonstrates to the Exchange, with respect to health benefit plans offered through the Exchange, or to the California Department of Managed Health Care, with respect to health benefit plans offered outside the Exchange, that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period available to the individual because he or she was misinformed that he or she was covered under minimum essential coverage.	Documentation would depend on circumstance.
11) He or she is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code.	Active duty status documentation.
12) Newly eligible or ineligible for advance payments of the premium tax credit, or change in eligibility for cost-sharing reductions.	Advanced Premium Tax Credit (APTC) paperwork that shows the premium assistance you are eligible for.
13) He or she loses medically needy coverage under Medicaid (not including voluntary termination of your previous coverage or termination due to failure to pay premium).	Medicaid documentation.
14) He or she loses pregnancy-related coverage under Medicaid (not including voluntary termination of your previous coverage or termination due to failure to pay premium).	Medicaid documentation.

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