CHC
Carolina Health Connections
2090 Gold Hill Rd · Fort Mill, SC 29716 · Phone: 704-512-0600 · Fax: 803-336-2300

INDIVIDUAL INFORMATION SHEET

Please print legibly and complete all sections in full.
Please return by secured email or fax completed form to 803.336.2300 or you can drop off the form at the office

APPLICANT INFORMATION

NAME: _____
(Last) *(First)*

PHYSICAL ADDRESS: _____
(Street) *(City)* *(State)* *(Zip)* *(County)*

MAILING ADDRESS: _____
(Street or PO Box) *(City)* *(State)* *(Zip)*

EMAIL: _____ **CELL PHONE:** _____ **HOME PHONE:** _____

HOW DID YOU HEAR ABOUT US? _____ **LAST DAY OF COVERAGE:** _____

FAMILY MEMBER	NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	GENDER	STATE OF BIRTH	TOBACCO USE LAST 6 MONTHS	COVERED BY VA, MEDICAID or MEDICARE?	COVERED BY OTHER HEALTH INSURANCE?
PRIMARY						□ Y □ N	□ Y □ N	□ Y □ N
SPOUSE						□ Y □ N	□ Y □ N	□ Y □ N
CHILD						□ Y □ N	□ Y □ N	□ Y □ N
CHILD						□ Y □ N	□ Y □ N	□ Y □ N
CHILD						□ Y □ N	□ Y □ N	□ Y □ N

FOLLOW UP

1. Would you like us to follow up after open enrollment regarding other insurance products? ☐ Y ☐ N If yes, which products are you interested in?

☐ Dental/Vision ☐ Life ☐ Disability ☐ Accident ☐ Cancer ☐ Critical Illness ☐ Long Term Care ☐ Medicare Supp
☐ Legal Services ☐ Identity Theft Protection

2. Do you authorize us to email you? ☐ Y ☐ N _____initial here 3. Do you authorize us to text you? ☐ Y ☐ N _____initial here

NON-DISCRIMINATION STATEMENT

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans when we enroll members or provide benefits. If you think we have not provided these services or have discriminated in any way, you can file a grievance by emailing contact@hcrcompliance.com or by calling the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD). I have read and understand this statement.

AUTHORIZATION TO ACT ON YOUR BEHALF

I have personally reviewed all information and am authorizing Michele Tedesco, NPN# 20329295 to act on my behalf for 365 days from the date of this notice. This applies to my Marketplace and/or Health Benefits application.

SIGNATURE: _____ **DATE:** _____

AUTHORIZATION TO USE INFORMATION AND STATEMENT OF UNDERSTANDING

I hereby authorize the use of any information given about myself or my dependents by Carolina Health Connections, LLC for the sole purpose of providing and applying for comprehensive benefits.

SIGNATURE: _____ **DATE:** _____

FFM ID#: _____ **CSR:** _____ **CARRIER:** _____ **PLAN:** _____

APPLICANT'S NAME: _____

INCOME

a. PRIMARY APPLICANT: _____

Employer: _____ Employer Phone #: _____

Wages: _____ Per: hr ☐ wk ☐ mo ☐ yr ☐

INCOME SOURCE 2

Employer: _____ Employer Phone #: _____

Wages: _____ Per: hr ☐ wk ☐ mo ☐ yr ☐

TOTAL WAGES = $ _____ PER _____

b. SPOUSE: _____

Employer: _____ Employer Phone #: _____

Wages: _____ Per: hr ☐ wk ☐ mo ☐ yr ☐

INCOME SOURCE 2

Employer: _____ Employer Phone #: _____

Wages: _____ Per: hr ☐ wk ☐ mo ☐ yr ☐

TOTAL WAGES = $ _____ PER _____

TOTAL FAMILY GROSS INCOME: _____ PER _____

(week - month – year)

CONFIDENTIAL HEALTH INFORMATION. *(OPTIONAL)* *This is only to help us make sure your doctors and medications are covered.*

1. List your family doctors if you want to continue seeing them. We can check to see if they are in network.

Primary Care Physician: _____ Specialist: _____ Specialist: _____

Primary Care Physician: _____ Specialist: _____ Specialist: _____

2. List all medications you and any family members to be covered are currently taking so we can check that your new plan will continue to cover them.

Applicant	Prescription Name	Diagnosis	How Long Taken	Last Date Taken

CERTIFICATION

Carolina Health Connections, LLC collects personal information directly from our clients. However, we may collect your information from other sources with your consent or as authorized by law. Only the personal information needed to provide services to our clients is requested. The services include, but are not limited to, enrollment, application, and consideration for benefit programs or policies. Personal information means information about an identifiable individual. This includes an individual's name, home address and phone number, age, sex, marital or family status, an identifying number, or financial information. We protect personal information in a manner appropriate for the sensitivity of the information following HIPAA laws. We make every reasonable effort to prevent any loss, misuse, disclosure or modification of personal information, as well as any unauthorized access to personal information. We use appropriate security measures when destroying personal information, including shredding paper records and permanently deleting electronic records. This information is never sold.

SIGNATURE: _____ DATE: _____