



## Enrollment Guidelines

1. To be a member of CCHP, you must live or work in San Francisco County or northern San Mateo County
2. Applications are subject to medical underwriting, which takes 4-6 weeks.
3. The monthly rates shown are standard rates effective January 1, 2011. The rates shown are for people in good health. **Final rates may vary by medical underwriting classification. Rates are subject to change.**
4. Select the appropriate age group to determine your monthly rates. If you are applying with your spouse, and your spouse is younger than you are, you should use your spouse as the subscriber on the application. Rates are based on the age of the subscriber.
5. **Sign and date the application form and attach a deposit check in the amount of the applicable standard monthly rate.** The check will be cashed upon receipt of your application. If your application is approved at a higher rate tier, you will be informed of the reason in writing and billed for the balance due. If your application is declined, we will refund your deposit.
6. **Select a primary care physician** for you and each covered family member from the CCHP Provider Directory.
7. If you have recently cancelled your health coverage, please attach a copy of the Certificate of Creditable Coverage from your previous carrier

Mail your application form and the applicable standard monthly rate deposit check to:

**CCHP Sales Department  
445 Grant Avenue, Suite 700  
San Francisco, CA 94108**

If you have any questions, please contact Sales Department at **415.955.8800 / 888.681.3888** or by email at [mktginfo@cchphmo.com](mailto:mktginfo@cchphmo.com).

## 投保指引

1. 所有投保人必須在三藩市或聖馬刁縣北部內居住或工作。
2. 所有申請必須經由審核部作醫療審查，一般需時為四至六個星期。
3. 華人保健計劃標準月費表的生效日期為 2011 年 1 月 1 日，但最終的保費是按照申請者的醫療狀況由審核部分類後而作出決定。
4. 請選擇合適的投保年齡，如閣下與配偶一同投保，保費標準將以年輕的一位申請者來計算。請在申請表上填上年輕的配偶為**第一申請者**。
5. 請在申請表上簽署及填寫日期並按照標準月費表的首月保費以支票形式一起寄回。我們會將該支票兌現，若閣下的申請獲批准但保費是高於標準收費，我們將以書面方式提供理由及通知閣下所需支付的餘下款項。如閣下的申請不被接納，首月的保費將全數退回。
6. 申請者及其家屬必須在『華人保健計劃』的醫生名錄內**選擇一位家庭醫生**。
7. 如閣下最近終止了醫療保障，請附上由前保健公司發出的保健證明信副本。

請將申請表連同首月的標準保費以支票形式一起寄往：

**CCHP Sales Department**  
華人保健計劃營業部  
**445 Grant Avenue, Suite 700**  
**San Francisco, CA 94108**

如有任何疑問，請致電 415.955.8800 或免費電話 888.681.3888，或電郵到 [mktginfo@cchphmo.com](mailto:mktginfo@cchphmo.com) 與華人保健計劃營業部聯絡。