



**Chinese
Community
Health
Plan**

CCHP

445 Grant Avenue, Suite 700, San Francisco, CA 94108
Tel: (415) 955-8800 • Fax: (415) 955-8819 • cchphmo.com

Applicant's Name 申請人姓名 _____

Application Number 申請編號 _____

Individual and Family Plan Enrollment Application 個人及家庭計劃申請表

CCHP will provide translations or other language assistance free of charge in completing the application. The application, together with the Disclosure Form/Evidence of Coverage ("Agreement") constitutes the plan contract, and that applicants may request a copy of the Agreement prior to enrollment to learn the terms and conditions of the plan contract. 如有需要，華人保健計劃可以提供免費翻譯及其它語言幫助填寫該申請表。這申請表連同保障說明書構成為計劃合約，申請人在提交申請表前可索取保障說明書了解計劃詳情。

REASON FOR APPLICATION 申請原因 (Please check one):

New Applicant, applying for Individual/Family Plan 首次申請

Please Select a Plan 請選擇一個計劃

- Copayment 25 Plan Active Choice Deductible Plan
 Jade Copayment Plan Amber Deductible Plan
 Optional VSP Vision Plan

Current Member My Member ID #: _____

Adding family member(s) to my existing individual plan
加家庭成員 Spouse 配偶 Child(ren) 子女

Status change from dependent to subscriber 從家屬轉為投保人

A. PRIMARY APPLICANT'S INFORMATION 申請人資料

Last Name 姓	First Name 名	MI 中間名	SS# 工咭號碼	Height 身高 _____ ft _____ in	Weight 體重 _____ lbs
Home Address 住址			Date of Birth (MM/DD/YY) 出生日期	Age 年齡	Sex 性別 <input type="checkbox"/> M 男 <input type="checkbox"/> F 女
			Marital Status 婚姻狀況 <input type="checkbox"/> Single 單身 <input type="checkbox"/> Married 已婚		
City 城市	State 州	Zip 郵區號碼	Please select a Primary Care Physician (PCP) from CCHP's Provider Directory 請在 CCHP 醫生名錄內選擇一位主治醫生:		
Day Tel. 日間電話		Home Tel. 住宅電話		Are you a current patient of this PCP? 您是否此醫生的現時病人? <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否	
Work Tel. 公司電話		E-mail 電子郵件		Preferred Written Language <input type="checkbox"/> Chinese 中文 <input type="checkbox"/> English 英文 <input type="checkbox"/> Other 其他 _____	
Name of Employer 公司名稱			Work Address 公司地址		

We will send all correspondence to your home address. If you have concerns about receiving confidential and private medical information at your home address, designate an address below where you want to receive such notices: 所有書信會寄至您的住址，如果您希望將需要保密或隱私的醫療資料寄往其他地址，請於下列填寫新地址：

B. LIST ALL DEPENDENTS TO BE COVERED 如家屬一起投保，請填寫 B 部份

<input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Domestic Partner 同居伴侶				SS# 工咭號碼				
Last Name 姓	First Name 名	MI 中間名	Date of Birth 出生日期 (MM/DD/YY)	Age 年齡	Height 身高 ____ ft ____ in	Weight 體重 ____ lbs	Sex 性別 <input type="checkbox"/> M 男 <input type="checkbox"/> F 女	
Please select a Primary Care Physician (PCP) from CCHP's Provider Directory 請在醫生目錄內選擇一位主治醫生:			Is this person a current patient of this PCP? 申請人是否此醫生的現時病人? <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否		Preferred Written Language <input type="checkbox"/> Chinese 中文 <input type="checkbox"/> English 英文 <input type="checkbox"/> Other 其他 _____			

Dependent 家屬 #1				SS# 工咭號碼				
Last Name 姓	First Name 名	MI 中間名	Date of Birth 出生日期 (MM/DD/YY)	Age 年齡	Height 身高 ____ ft ____ in	Weight 體重 ____ lbs	Sex 性別 <input type="checkbox"/> M 男 <input type="checkbox"/> F 女	
Please select a Primary Care Physician (PCP) from CCHP's Provider Directory 請在醫生目錄內選擇一位主治醫生:			Is this person a current patient of this PCP? 申請人是否此醫生的現時病人? <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否		Preferred Written Language <input type="checkbox"/> Chinese 中文 <input type="checkbox"/> English 英文 <input type="checkbox"/> Other 其他 _____			

Dependent 家屬 #2				SS# 工咭號碼				
Last Name 姓	First Name 名	MI 中間名	Date of Birth 出生日期 (MM/DD/YY)	Age 年齡	Height 身高 ____ ft ____ in	Weight 體重 ____ lbs	Sex 性別 <input type="checkbox"/> M 男 <input type="checkbox"/> F 女	
Please select a Primary Care Physician (PCP) from CCHP's Provider Directory 請在醫生目錄內選擇一位主治醫生:			Is this person a current patient of this PCP? 申請人是否此醫生的現時病人? <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否		Preferred Written Language <input type="checkbox"/> Chinese 中文 <input type="checkbox"/> English 英文 <input type="checkbox"/> Other 其他 _____			

Dependent 家屬 #3				SS# 工咭號碼				
Last Name 姓	First Name 名	MI 中間名	Date of Birth 出生日期 (MM/DD/YY)	Age 年齡	Height 身高 ____ ft ____ in	Weight 體重 ____ lbs	Sex 性別 <input type="checkbox"/> M 男 <input type="checkbox"/> F 女	
Please select a Primary Care Physician (PCP) from CCHP's Provider Directory 請在醫生目錄內選擇一位主治醫生:			Is this person a current patient of this PCP? 申請人是否此醫生的現時病人? <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否		Preferred Written Language <input type="checkbox"/> Chinese 中文 <input type="checkbox"/> English 英文 <input type="checkbox"/> Other 其他 _____			

C. PRIOR HEALTH COVERAGE INFORMATION 前醫療保健資料

1. Has any applicant been a member of CCHP within the last 5 years 申請人在過去 5 年曾否是華人保健計劃的會員? Yes 是 No 否
2. Has any applicant had health insurance coverage in the last 63 days? 申請人在過去 63 天裏否是有醫療保險? Yes 是 No 否

Applicant 申請人	Current/Most Current Carrier Name and Policy No. 現時或前醫療保健公司名稱	Coverage start date 保障開始日期	Coverage end date 保障終止日期
<input type="checkbox"/> Self 本人			
<input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Domestic Partner 同居伴侶			
<input type="checkbox"/> Dependent 家屬 #1			
<input type="checkbox"/> Dependent 家屬 #2			
<input type="checkbox"/> Dependent 家屬 #3			

HIPAA GI / Conversion Plan Applicants ONLY: HIPAA GI / Conversion 計劃申請者專用 :

I understand that I am applying for an Individual/Family Plan, if I do not qualify for the Individual/Family Plan, I would like to be considered for coverage under:

我明白我現正申請個人及家庭計劃，如我不符合申請資格，我會考慮以下保健計劃：

- HIPAA Guaranteed Issued Coverage
- Conversion Plan

I understand that no underwriting (medical history review and determination of coverage) is required for both HIPAA/Conversion coverage, that if I am applying for HIPAA/Conversion coverage only I do not need to complete a Statement of Health (Section D) and the rates may be higher than for the Individual/Family Plans. If I qualify, please offer the HIPAA/Conversion coverage and send complete detail regarding my options and rates.

我明白 HIPAA/Conversion 保健計劃不需經過醫療審批或醫療報告評估，不需填寫健康聲明（D 部分）。保費會高於個人及家庭計劃。如我符合申請資格，請提供 HIPAA/Conversion 保健計劃詳細的選擇及保費資料。

1. HIPAA GI Plan Applicants ONLY: HIPAA GI 計劃申請者專用 :

If you do not qualify for an Individual or Family Plan, you may be considered for coverage under a HIPAA guaranteed issue plan, which makes it easier for people covered under existing group health plans to maintain coverage regardless of pre-existing conditions when they change jobs or are unemployed for brief periods of time. In order to be eligible for guarantee issue in accordance with HIPAA, all five statements below must be true:

如果您不符合申請個人及家庭計劃，您可考慮加入 HIPAA guaranteed issue 計劃。這計劃是給現時投保在公司團體保險的人仕更容易去保持醫療保障。不論是否有投保前存在病症，當在轉換工作或暫時失業的時候都可得到醫療保障。要符合申請 HIPAA GI 計劃的資格，必須符合以下五種情況：

1. I have at least 18 months of creditable coverage without a break in coverage of more than 63 days at a time.
我有最少 18 個月的醫療保健，當中並沒有超過連續 63 日的間斷期。
2. My most recent health care coverage was through a group health plan, governmental plan, or church plan.
我最近期的醫療保健是由公司、政府或教會提供。
3. I have both elected and exhausted all continuation health care coverage available under COBRA and Cal-COBRA.
我已選擇及用盡所有由 COBRA 及 Cal-COBRA 提供的延續保健

4. I do not currently have other health care coverage and I am not eligible for coverage under any group health plan, government plan, church plan, state-administered Medicaid program, or Medicare.
我現時沒有其他醫療保健，同時不符合公司團體保健、教會保健、州政府的醫療補助計劃或聯邦保健計劃的申請資格。
5. My most recent coverage was NOT terminated for fraud or failure to pay premiums.
我最近期的醫療保健不是因為過錯或欠付保費而中止。

- All five statements are true. I want to be enrolled in HIPAA if I do not qualify for a CCHP individual or family plan.
以上五項的情況都正確，如我不符合申請個人及家庭計劃，我想加入HIPAA計劃。

Select a HIPAA plan 選擇一個HIPAA 計劃: copay25 active choice

- Please attach certificate(s) of creditable coverage or other proof of creditable coverage. Note: rates may be higher than for the individual/family plan. 請附上醫療保健證書或其他醫療保健證明。注意：保費會高於個人及家庭計劃。
- All five statements are true. However, if I do not qualify for a CCHP Individual or Family plan, I do NOT want to be enrolled in HIPAA. 所有五項都正確。但是，如我不符合申請個人及家庭計劃，我不想申請HIPAA計劃。
- One or more of the five statements is false. I do not qualify for HIPAA. 有其中一項或多項不正確，我不符合申請HIPAA資格。

2. Conversion Plan Applicants ONLY: Conversion 計劃申請者專用:

Former CCHP Employer Group Name
投保在華人保健計劃的前僱主公司名稱:

Former CCHP member ID#
華人保健計劃會員號碼:

Your coverage under former group begin date
閣下前公司健保的開始日期:

Your coverage end date 閣下健保的終止日期:

HEALTH HISTORY 健康歷史

D. Include information on ALL family members you wish to enroll. ALL QUESTIONS MUST BE ANSWERED. Give COMPLETE details of any Yes answers in Section F.
資料包括所有投保人，必須回答每一個問題。如有任何“是”的答案，請在 F 部份解釋。

Please indicate if any person listed on this application, in the last 5 years, had any signs or symptoms, seen a health care provider, had treatment recommended including prescription medications, received treatment, or been hospitalized for any of the following conditions as stated in questions 1 through 25.

California law prohibits an HIV test from being required or used by health care service plans as a condition of obtaining coverage.

Rescission: It is very important to provide complete and truthful responses to the application's health history questions. When in doubt, it is better to offer the information or ask to speak to a health plan representative to ensure you understand the question and answer correctly. You must provide true, accurate and complete health history information, for yourself or any dependents, to the best of your knowledge. You must also advise CCHP of any changes or updates to health history information that may occur after you submit the application and prior to the effective date of coverage.

If you misrepresent your health history, such as failing to report a past medical condition, or omit information in the health history questionnaire, or fail to provide updated information as to your health history prior to the effective date of coverage, CCHP may have a basis to rescind your health coverage. A rescission of health coverage means your coverage ends retroactively back to the original effective date of coverage and you are responsible to pay any medical bills for services dating back to the effective date of coverage.

CCHP completes a review of your medical history based on your responses to the health history questionnaire and must make reasonable efforts to verify the accuracy and completeness of your answers in deciding to offer you a health care policy. This is called medical underwriting. CCHP must also resolve all reasonable questions that may arise from your application responses. If CCHP does not complete its medical underwriting, and issues you health care coverage, CCHP may only rescind the coverage if CCHP can support a claim that misinformation or omitted information on your health history application was willfully misrepresented and no rights of third parties would be prejudiced.

If after your enrollment, CCHP investigates information on your application; CCHP must notify you of this investigation, the basis for the investigation and offer you an opportunity to respond.

If CCHP decides to rescind your policy, CCHP will send you a written notice of its decision including an explanation as to why coverage was rescinded and how to appeal the decision. The notice will advise you that all members other than the individual whose coverage is rescinded may continue to remain covered under the current health care contract or a new individual plan contract that provides equal benefits without medical underwriting. CCHP will revise the premiums to reflect the number of members that remain under the contract. Members who remain covered must still meet any requirements under contract relating to pre-existing condition periods.

You have the right to appeal CCHP's decision to rescind your coverage. If CCHP denies your appeal, you have the right to seek assistance from the Department of Managed Health Care. The Department of Managed Health Care will review the final decision and confirm CCHP has met its obligations under the law.

請注明如有任何申請人在過去 5 年內，有任何列在 1-25 號問題內的症狀，見過醫務人員、接受過治療、使用藥物、需要接受治療或住院。

加州法例禁止醫療保健公司要求申請人作愛滋病測試，而作為得到醫療保障的條件。

撤銷：提供完整及真實的健康歷史是非常重要的。您必須為自己或家屬提供真實，準確和完整的健康歷史。如有疑問，最好提供所有資料或聯絡業務代表，以確保您理解問題及提供準確答案。如果提交申請之後至保障生效日前，任何申請人的健康有變動或更新，您必須將資料提供給華人保健計劃。

如果您在保障生效日前提供不實的健康歷史，如不報告過去的醫療症狀，或在健康史調查表內省略資料，或未能提供最新的資料，本計劃可能取消您的健康保障。撤銷保障會追溯到原來的生效日期，您需支付所有從生效日期起的醫療費用。

華人保健計劃會根據您提交的健康歷史進行醫療審查並作出是否承保的決定。這就是所謂的醫療審核。在審核過程中，本公司還須解決所有申請過程中可能出現的問題。如果華人保健計劃沒有完成審核而提供您醫療保障，本公司只能撤銷您提供不實資料部份的保障。

如果華人保健計劃在您的保障生效之後需要再調查您的申請，本計劃會通知您該調查及調查的原因，並給您回應的機會。

如果華人保健計劃決定撤銷您的醫療保障，本公司會寄給您一份書面通知，包括解釋撤銷的原因及如何提出上訴。家屬會員可繼續使用現時的醫療保障或一個同等保障免審核的個人計劃。華人保健計劃會修正家屬的保費，以反映仍在合同內的會員數目。這些會員仍須符合合約規定保障等候期的所有要求。

您有權對撤銷提出上訴。如果華人保健計劃拒絕您的上訴，您有權向 Department of Managed Health Care 要求幫助。Department of Managed Health Care 會進行上訴復核及對本公司是否有例行法律責任作出決定。

If answer Yes, please circle the symptoms:	如答“是”，請圈出症狀	Please Indicate 請選擇	Yes 是	No 否
1. Brain/Nervous - frequent and/or severe headaches, migraines, seizures, epilepsy, dizziness, weakness, fainting, numbness/tingling, head injury, paralysis, stroke, confusion, memory loss, loss of consciousness, sleep apnea, use of a sleep monitoring device, etc.	腦部 / 神經 —經常性及 / 或嚴重的頭痛、偏頭痛、羊癲瘋、癲癇、頭暈、虛弱、昏厥、麻木 / 針刺痛、頭部受傷、癱瘓、中風、錯覺、失憶、失去意識、失眠、使用睡眠監視器等。	<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Domestic Partner 同居伴侶 <input type="checkbox"/> Dep. 家屬 #1 <input type="checkbox"/> Dep. 家屬 #2 <input type="checkbox"/> Dep. 家屬 #3	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
2. Heart/Circulatory - chest pain, angina, high or low blood pressure, heart disease, heart attack, heart murmur, palpitations, valve replacement, pacemaker, defibrillator; or blood clot, phlebitis, varicose veins, enlarged lymph nodes, blood/bleeding disorder, etc.	心臟 / 血液循環系統 —胸痛、心絞痛、高或低血壓、心臟疾病、突發性心臟病、心雜音、心律不整、節律器、人工瓣膜、去纖維顫動器或血凝塊、靜脈炎、靜脈曲張、淋巴肥大、流血不止等。	<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Domestic Partner 同居伴侶 <input type="checkbox"/> Dep. 家屬 #1 <input type="checkbox"/> Dep. 家屬 #2 <input type="checkbox"/> Dep. 家屬 #3	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3. Lungs/Respiratory - allergies, infections, sinusitis, asthma, bronchitis, emphysema, pneumonia, tuberculosis, difficulty breathing, shortness of breath, chronic cough, spitting/coughing up blood, etc.	肺 / 呼吸 —過敏、感染、鼻腔過敏、氣喘、支氣管炎、肺氣腫、肺炎、肺結核、呼吸困難、呼吸不順、慢性咳嗽、咳血等。	<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Domestic Partner 同居伴侶 <input type="checkbox"/> Dep. 家屬 #1 <input type="checkbox"/> Dep. 家屬 #2 <input type="checkbox"/> Dep. 家屬 #3	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
If answer Yes, please circle the symptoms:	如答“是”，請圈出症狀	Please Indicate 請選擇	Yes 是	No 否
4. Digestive - jaw/chewing problems, gastric reflux, ulcers, hernia, colitis, chronic diarrhea, rectal problems/ bleeding, polyps, hemorrhoids, gallbladder, pancreatitis, appendicitis, liver disease, cirrhosis, hepatitis, jaundice, unexplained weight loss, etc.	消化系統 —下顎問題、胃病、潰瘍、疝氣、大腸炎、腹瀉、直腸毛病 / 出血、息肉、痔瘡、膽結石、胰臟炎、闌尾炎、肝病、肝硬化、肝炎、黃疸、無故體重減輕等。	<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Domestic Partner 同居伴侶 <input type="checkbox"/> Dep. 家屬 #1 <input type="checkbox"/> Dep. 家屬 #2 <input type="checkbox"/> Dep. 家屬 #3	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

If answer Yes, please circle the symptoms:	如答“是”，請圈出症狀	Please Indicate 請選擇	Yes 是	No 否
5. Urinary - kidney, bladder, urinary tract infections, stones, urinary incontinence, blood in urine, etc.	泌尿 —腎臟、膀胱、尿道感染、結石、失禁、便尿出血等。	<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Domestic Partner 同居伴侶 <input type="checkbox"/> Dep. 家屬 #1 <input type="checkbox"/> Dep. 家屬 #2 <input type="checkbox"/> Dep. 家屬 #3	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
6. Musculoskeletal - bone, joint and/or muscle pain, injury or disorder of joint/tendon/ligament/disc, weakness of back/ spine/joint, amputation, polio, arthritis, gout, prosthesis, joint replacement, internal fixations (i.e., pins, plates, screws), fractures, TMJ, etc.	肌骨 —骨頭、關節及／或肌肉痛、關節／筋／韌帶／骨受傷或疾病、背／脊骨／關節衰弱、切除、小兒麻痺、關節炎、痛風、義肢、人工關節、骨頭打釘、顎骨等。	<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Domestic Partner 同居伴侶 <input type="checkbox"/> Dep. 家屬 #1 <input type="checkbox"/> Dep. 家屬 #2 <input type="checkbox"/> Dep. 家屬 #3	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
7. Endocrine/Metabolic a) Diabetes, thyroid, anemia, adrenal disorders, pituitary disorders, lupus, immune disorders, scleroderma, Epstein-Barr/chronic fatigue syndrome, etc. b) Is any applicant a candidate for, or a recipient of an organ or bone marrow transplant? If yes, Name: _____ c) Is any applicant on the waiting list to donate an organ or bone marrow (excluding DMV donor card) transplant? If yes, Name: _____	內分泌／新陳代謝系統 a) 糖尿病、甲狀腺、貧血、腎上腺激素疾病、腦下垂體疾病、狼瘡、免疫疾病、硬皮病、Epstein-Barr／慢性疲勞併發症等。 b) 有任何申請人是器官或骨髓移植捐贈或接納者？姓名 _____ c) 有任何申請人是在捐贈器官或骨髓名單中（DMV 捐贈者除外）？姓名： _____	<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Domestic Partner 同居伴侶 <input type="checkbox"/> Dep. 家屬 #1 <input type="checkbox"/> Dep. 家屬 #2 <input type="checkbox"/> Dep. 家屬 #3	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
8. Has any applicant ever had cancer, tumor/growth, leukemia, cyst? If yes, specify: <input type="checkbox"/> Cancer <input type="checkbox"/> Tumor <input type="checkbox"/> Leukemia <input type="checkbox"/> Cyst <input type="checkbox"/> AIDS/ARC	是否有申請人曾經罹患癌症、腫瘤、白血球過多、囊腫？若有，請註明： <input type="checkbox"/> 癌症 <input type="checkbox"/> 腫瘤 <input type="checkbox"/> 白血球過多 <input type="checkbox"/> 囊腫 <input type="checkbox"/> 愛滋病	<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Domestic Partner 同居伴侶 <input type="checkbox"/> Dep. 家屬 #1 <input type="checkbox"/> Dep. 家屬 #2 <input type="checkbox"/> Dep. 家屬 #3	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
9. Skin disorders/Problems - cancer, melanoma, pre - cancerous lesion, psoriasis, warts, 2nd or 3rd degree burns, acne, fungal infections, eczema, dermatitis, herpes, scars/keloids, or revisions of cosmetic or reconstructive surgery, infections, etc.	皮膚病 / 問題 —癌症、黑色素瘤、非癌症皮膚龜裂、牛皮癬、疣、2-3 級燙傷、青春痘、黴菌感染、濕疹、皮膚炎、泡疹、瘤 / 疙瘩、美容或重整外科手術、感染等。	<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Domestic Partner 同居伴侶 <input type="checkbox"/> Dep. 家屬 #1 <input type="checkbox"/> Dep. 家屬 #2 <input type="checkbox"/> Dep. 家屬 #3	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
10. Eyes, Ears, Nose and Throat - diseases or problems of the eyes or sight, ears or hearing, nose or breathing, throat or swallowing - such as: infections, crossed eyes, glaucoma, cataracts, detached retina, nasal polyps, deviated nasal septum, excessive snoring, tonsillitis, sleep apnea, etc.	眼、耳、鼻、喉 —眼睛或視力疾病、耳朵或聽力、鼻子及呼吸、喉嚨及吞食—例如感染、鬥雞眼、青光眼、白內障、視網膜剝離、鼻息肉、鼻炎、嚴重打鼾、扁桃腺炎、失眠等。	<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Domestic Partner 同居伴侶 <input type="checkbox"/> Dep. 家屬 #1 <input type="checkbox"/> Dep. 家屬 #2 <input type="checkbox"/> Dep. 家屬 #3	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

If answer Yes, please circle the symptoms:	如答“是”，請圈出症狀	Please Indicate 請選擇	Yes 是	No 否
11. Congenital Abnormalities, Birth Defects - cleft lip/palate, club foot, webbed fingers or toes, mental retardation, developmental delay, Down's syndrome, heart/lung problems, skull/facial deformities, birthmark, physical handicap etc.	天生畸形、缺陷 —兔唇／缺唇、畸型足、畸型手指／腳指、心智障礙、成長遲滯、唐氏綜合症、心肺疾病、歪嘴斜眼、胎記等。	<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Domestic Partner 同居伴侶 <input type="checkbox"/> Dep. 家屬 #1 <input type="checkbox"/> Dep. 家屬 #2 <input type="checkbox"/> Dep. 家屬 #3	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
12. Has any applicant consulted a provider for any condition or symptom(s) in the last 5 years , for which a diagnosis has not been established?	申請人曾否在 過去五年中 曾經被診療過，但病症未能確定？	<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Domestic Partner 同居伴侶 <input type="checkbox"/> Dep. 家屬 #1 <input type="checkbox"/> Dep. 家屬 #2 <input type="checkbox"/> Dep. 家屬 #3	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
13. Has any applicant ever had an abnormal physical exam, laboratory results, x-rays, EKG, MRI, CT scan or been advised to undergo further testing, surgery or treatment?	申請人 曾否有 不正常的報告有關身體測試、化驗、放射、心電圖、腦部掃描、身體掃描或被建議做進一步檢驗、手術或醫療？	<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Domestic Partner 同居伴侶 <input type="checkbox"/> Dep. 家屬 #1 <input type="checkbox"/> Dep. 家屬 #2 <input type="checkbox"/> Dep. 家屬 #3	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
14. Are you or any applying family members presently receiving any medical treatment?	你或您的家人目前是否正接受任何醫藥治療？	<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Domestic Partner 同居伴侶 <input type="checkbox"/> Dep. 家屬 #1 <input type="checkbox"/> Dep. 家屬 #2 <input type="checkbox"/> Dep. 家屬 #3	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
15. Have you been absent from your job due to injury or sickness more than 5 days within the past 12 months?	過 12 個月內您曾否因生病或受傷而不能工作超過五天	<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Domestic Partner 同居伴侶 <input type="checkbox"/> Dep. 家屬 #1 <input type="checkbox"/> Dep. 家屬 #2 <input type="checkbox"/> Dep. 家屬 #3	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
16. Within the past 5 years, have you or any family member been in a hospital or institution for observation, testing, or treatment or undergone surgery?	過去五年內，您或您的家人曾否留院或在醫療機構作觀察，檢查治療或做過手術？	<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Domestic Partner 同居伴侶 <input type="checkbox"/> Dep. 家屬 #1 <input type="checkbox"/> Dep. 家屬 #2 <input type="checkbox"/> Dep. 家屬 #3	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
17. Has any applicant had any condition that is expected to require hospitalization?	申請人有否因任何情況下將會需要安排住院治療？	<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Domestic Partner 同居伴侶 <input type="checkbox"/> Dep. 家屬 #1 <input type="checkbox"/> Dep. 家屬 #2 <input type="checkbox"/> Dep. 家屬 #3	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
18. Has any applicant ever seen, received treatment from or consulted any doctor, or any other person providing health care services for any other condition or symptom(s) not listed on this application? If yes, complete E below.	申請人有否曾經見過或諮詢過任何醫生或其他提供醫療服務的人員有關自己的身體健康問題，而未有在以上的問題上提及到？如有請填寫 E 項內容。	<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Domestic Partner 同居伴侶 <input type="checkbox"/> Dep. 家屬 #1 <input type="checkbox"/> Dep. 家屬 #2 <input type="checkbox"/> Dep. 家屬 #3	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

Female Applicant Only 女申請人填寫	如答“是”，請圈出症狀	Please Indicate 請選擇	Yes 是	No 否
19. Female Reproductive - Breast disorder, cyst, lump, tumors, endometriosis, pelvic pain, menstruation disorders, abnormal/ absent menstrual bleeding, uterine fibroids, ovarian cysts, infertility, miscarriages, and sexually transmitted disease.	女性生殖 —乳房疾病，腫塊、隆乳、腺瘤、子宮內膜異位、骨盆疼痛、月經不順、月經不正常出血、子宮肌瘤、卵巢囊腫、不孕、流產、性病。	<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Domestic Partner 同居伴侶 <input type="checkbox"/> Dep. 家屬 #1 <input type="checkbox"/> Dep. 家屬 #2 <input type="checkbox"/> Dep. 家屬 #3	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20. Does any proposed female member menstruate?	有任何女性申請者有月經？	<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Domestic Partner 同居伴侶 <input type="checkbox"/> Dep. 家屬 #1 <input type="checkbox"/> Dep. 家屬 #2 <input type="checkbox"/> Dep. 家屬 #3	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
21. If yes, has it been more than 40 days since her/their last menstrual period? If yes, explain: _____	如果有，從上次來月經至今是否超過 40 天？如果是，請解釋： _____	<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Domestic Partner 同居伴侶 <input type="checkbox"/> Dep. 家屬 #1 <input type="checkbox"/> Dep. 家屬 #2 <input type="checkbox"/> Dep. 家屬 #3	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
22. Has any female applicant had a pelvic exam/Pap smear? If yes, complete below, date and result of last pelvic exam/Pap smear for each female over age 16. Name: _____ Mo/Day/Yr: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Name: _____ Mo/Day/Yr: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	任何 16 歲以上的女性申請人做過子宮/子宮膜片檢查，請填寫最近一次檢查的日期及結果。 姓名： _____ 年/月/日： _____ <input type="checkbox"/> 正常 <input type="checkbox"/> 不正常 姓名： _____ 年/月/日： _____ <input type="checkbox"/> 正常 <input type="checkbox"/> 不正常	<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Domestic Partner 同居伴侶 <input type="checkbox"/> Dep. 家屬 #1 <input type="checkbox"/> Dep. 家屬 #2 <input type="checkbox"/> Dep. 家屬 #3	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
23. Is any female applicant pregnant, or in the process of adoption or surrogate pregnancy?	有任何女性申請人懷孕，或正在領養或為代母？	<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Domestic Partner 同居伴侶 <input type="checkbox"/> Dep. 家屬 #1 <input type="checkbox"/> Dep. 家屬 #2 <input type="checkbox"/> Dep. 家屬 #3	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

Male Applicant Only 男申請人填寫	如答“是”，請圈出症狀	Please Indicate 請選擇	Yes 是	No 否
24. Male reproductive system - Prostate problems, infertility, sexual dysfunction, penile or scrotal implant, sexually transmitted disease, herpes, genital warts, undescended testes, etc.	男性生殖系統 —前列腺、不孕、性功能衰退、陰莖擴張、性病、疱疹、疣、隱睾等。	<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Domestic Partner 同居伴侶 <input type="checkbox"/> Dep. 家屬 #1 <input type="checkbox"/> Dep. 家屬 #2 <input type="checkbox"/> Dep. 家屬 #3	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
25. Is any male applicant listed on this application an expectant father, even if the mother is not listed on this application?	是否有任何男性申請人即將成為父親，即使母親並不在此份申請表內？	<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Domestic Partner 同居伴侶 <input type="checkbox"/> Dep. 家屬 #1 <input type="checkbox"/> Dep. 家屬 #2 <input type="checkbox"/> Dep. 家屬 #3	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

E. Last doctor visit 最近見醫生的記錄:

Applicant 申請人	Name of Doctor 醫生姓名	Date of Last Visit 就診日期	Address and Phone No. of Doctor 醫生診所的地址及電話
<input type="checkbox"/> Self 本人			
<input type="checkbox"/> Spouse 配偶			
<input type="checkbox"/> Domestic Partner 同居伴侶			
<input type="checkbox"/> Dependent 家屬 #1			
<input type="checkbox"/> Dependent 家屬 #2			
<input type="checkbox"/> Dependent 家屬 #3			

F. If the answer to any question in Section D is Yes, please provide detail below:

如果在 D 部份有“是”的答案，請在以下部份解釋。

Question # 編號	Name of Family member 家庭成員姓名	Name of condition 狀況	Onset/ Treat- ment date 治療開 始日期	Treat- ment end date 治 療結束 日期	Type of treatment 治療方法	Still under treatment 仍在治療 中?	Attending physician / Hospital / Clinic Name, Phone & Address 醫生及醫院名稱，電話及地址
						Y 是 <input type="checkbox"/> N 否 <input type="checkbox"/>	
						Y 是 <input type="checkbox"/> N 否 <input type="checkbox"/>	
						Y 是 <input type="checkbox"/> N 否 <input type="checkbox"/>	
						Y 是 <input type="checkbox"/> N 否 <input type="checkbox"/>	

G. PRESCRIPTION MEDICATIONS - List all medications taken within the last 12 months by any family member listed on this application. 處方藥物：請列出在過去 12 個月內服用過的藥物名稱。

Family Member 家庭成員	Medication/Dosage/Frequency 藥物名稱/用量/次數	Date Prescribed (Mo/Yr) 配藥日期 (月/年)	Date Discontinued (Mo/Yr) 停藥日期 (月/年)	Name and Phone No. of Physician or Hospital 醫生/醫院名稱及電話

H. How did you hear about CCHP? 您怎樣知道「華人保健計劃」?

1 <input type="checkbox"/> Radio 電台	2 <input type="checkbox"/> TV 電視 Channel 頻道	3 <input type="checkbox"/> Direct Mail 宣傳郵件	4 <input type="checkbox"/> Newspaper 報紙 Name 名稱
5 <input type="checkbox"/> Yellow Pages 黃頁分類	6 <input type="checkbox"/> Agent/Broker 經紀	7 <input type="checkbox"/> Referrals 介紹	8 <input type="checkbox"/> CCHP Website 華人保健計劃網頁
9 <input type="checkbox"/> Dr. Office 醫生介紹	10 <input type="checkbox"/> Events 街會/活動		

I. Fill out this section if applicant is using an insurance agent or broker

如果申請人委托代理/經紀人，請填寫此部份。

Agent/Broker Name 代理/經紀人姓名: _____

I understand that the broker of record may receive monetary and/or non-monetary payments from CCHP in connection with the purchase of this coverage. 本人明白當經紀人在協助我購買此醫療保險後，可能得到華人保健計劃的報酬。

Note 請注意:

Premiums are the same whether or not you use an agent/broker. 不論您是否使用代理/經紀人，您的會費是不變。

X _____

Applicant's Signature 申請人簽名

Today's Date 日期

INSURANCE AGENT/BROKER ATTESTATION 保險代理/經紀人資料 (AB2569, Cal H&S §1389.8)

To be completed by your agent or broker after completion of this application

I, _____, assisted the applicant in submitting this application. All information in the health questionnaire was completed by applicant. I advised the applicant to answer all questions completely and truthfully and that no information requested should be withheld. I explained that withholding information may result in cancellation of coverage in the future.

To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation.

Notice to agent: If you have assisted the applicant in submitting this application, the law requires that you attest to this assistance. If, in making this attestation, you state as true any material fact you know to be false, you will be subject to a civil penalty of up to ten thousand (\$10,000) dollars, as authorized under California Health and Safety Code section 1389.8(c) or Insurance Code section 10119.3, in addition to any other applicable penalties or remedies available under current law.

Agent/Broker Name

Agent/Broker Signature

Agent/Broker #

Date

Agent/Broker Company Name

Address

City, State, Zip

Phone

Email

CONDITIONS OF APPLICATION please carefully read and fully understand the following:
申請規章：請詳細閱讀並完全明白以下內容。

General Conditions

Chinese Community Health Plan reserves the right to reject any application for enrollment. This application and all medical information or examination reports shall become a part of the Plan Contract.

1. I understand that CCHP has the right to deny my application and if so, I will be notified in writing.
2. I understand that I have no coverage under this application until notified by CCHP that I am accepted.
3. If I am accepted, this application will become part of the agreement between CCHP and myself. Enrolled family members and I agree to be bound by the arbitration clause in the CCHP contract instead of trial by a court or jury.
4. I understand that willful misrepresentation can result in rescission of my coverage, and not that of any other applicants. The Plan can only rescind for a material misrepresentation or omission if 1) the misrepresentation or omission is willful or 2) the plan makes reasonable efforts to ensure the subscriber's application is accurate and complete as part of the pre-contract underwriting process.
5. If my coverage is terminated retroactively, the providers will bill me for all services I received through CCHP.

申請條件：

『華人保健計劃』保留拒絕接受申請投保的權利。這申請表格及全部醫療資料或檢查報告將成為投保合約的一部份。

1. 本人明白『華人保健計劃』有權拒絕我的申請。如本人的申請被拒絕時，本人將會接到『華人保健計劃』的書面通知。
2. 本人明白在申請期間是不會有任何醫療保障。直至收到『華人保健計劃』的投保批准通知書
3. 如果申請被接受，這份申請表格將會成為申請人及『華人保健計劃』的投保合約的一部份。如有任何訴訟，本人及家人同意遵照和採納由仲裁人提出的方法解決，而並非由陪審團或法庭裁決
4. 本人明白，如在此申請表格內有意填報不實的資料，『華人保健計劃』是有權取消該申請人，而不是任何其他申請人。本公司只能撤銷申請人的保障如果 1) 填報的資料是不實或遺漏是故意的，2) 在申請審核過程中本公司已盡力確保該申請人提供的資料是準確和完整的。
5. 如果本人的保障被取消，本人需要負責所有通過『華人保健計劃』得到的醫療服務的費用，而這些費用是追溯到最初的生效日期起。

Acknowledgment and Agreement 同意書:

I hereby subscribe for myself and any enrolled dependents to the health plan designated here and agree to abide by all terms, conditions and provision of this Individual Membership Contract. I have read and understand the terms on this application and my signature below indicates my acceptance of these terms and that the information entered in this Application is complete, true and correct. I agree to notify Chinese Community Health Plan promptly of any facts or circumstances which arise before the effective date of coverage under CCHP which make any of the statements supplied herein incorrect. I understand that neither my family nor I will be eligible for coverage if any information is false or incomplete, and that coverage may be revoked based on such finding. I understand that any incorrect statements made in or material omissions from this application constitute the basis for termination from the Program and termination or cancellation of coverage retroactive to the effective date of enrollment.

本人及所有申請人現申請投保『華人保健計劃』，我們同意遵守及履行保健計劃契約上的守則及規定，本人經已閱讀並明白此申請表的內容，本人下列的簽署是表示我們願意接受上述的條件及規定，同時本人亦保證次申請表上填寫的資料均為真實及正確。本人同意如果在生效日期前，本人或家屬的健康狀況有所改變，而與原來填報的資料不相符，本人必須即時通知『華人保健計劃』。

本人明白在此申請表內填報的資料如有不正確，不實，或有漏報等情況，一經查實，『華人保健計劃』有權取消本人的會員資格及所有保障福利，而且取消日期可以追溯到最初的生效日期。

Arbitration Agreement 仲裁協議:

I understand that (except for Small Claims cases) any and all disputes, including claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), which may arise under the agreement between me and my dependents enrolled in the plan and CCHP and any of its affiliates shall be determined by submission to binding arbitration as provided by California law. Any such dispute will not be resolved by a lawsuit or resort to court process except as applicable law provides for judicial review of arbitration proceedings. ALL PARTIES TO THIS CONTRACT, BY ENTERING INTO IT, ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION. For more information regarding binding arbitration, please refer to your Evidence of Coverage.

本人已瞭解（除小額理賠情況外）任何所有由本人和投保家屬與華人保健計劃及其所屬機構引起的協議爭議，包括醫療過失理賠（即不論本保健計劃提供的任何醫療服務是非必要或未經批准的，或為不適當、疏忽、或判斷失當），均應依加州法規提交仲裁解決，而不提出訴訟或訴諸法庭程序，除非法律有仲裁程序司法審查的規定。簽署本合約之各方放棄其交由陪審團法庭解決爭議的憲法權利，並接受採用提交具有約束力的仲裁。關於具有約束力的仲裁詳情，請查閱保障說明書。

Applicant Signature 申請人簽署

Print Your Name 請用正楷填寫姓名

Date 日期

Spouse / Domestic Partner Signature
配偶/同居伴侶簽署

Print Your Name 請用正楷填寫姓名

Date 日期

Signature Required for Dependents Age 18 or over (18 歲或以上家屬簽署)

Dependent 家屬簽署 #1

Print Your Name 請用正楷填寫姓名

Date 日期

Dependent 家屬簽署 #2

Print Your Name 請用正楷填寫姓名

Date 日期

Dependent 家屬簽署 #3

Print Your Name 請用正楷填寫姓名

Date 日期

Authorization to Release Medical Information 提供醫療資料授權：

I authorize any provider of health care, health care facility, or any other medically related facility or professional who has provided services to me or any of my dependents to disclose to CCHP or its designated agents, all medical information, including any alcohol/substance abuse, AIDS-related information and/or psychiatric disorders, regarding any applying family member or me. I understand that such medical information may be requested and used for the purposes of evaluating my application and determining eligibility for coverage. This authorization is effective on the date the application is signed and will remain in effect for a period of twenty-four (24) months, except that it will remain in effect for use by CCHP in connection with the review or evaluation of any claim for benefits if applicant is still a member of CCHP. A photocopy of this authorization is as valid as the original. Signature by parent or legal guardian represents authorization for himself/herself as well as authorization for minor children.

I understand that if I refuse to provide this authorization, CCHP will not make an eligibility determination, and I will not be considered for membership in a CCHP plan.

I may revoke this authorization at any time prior to its expiration. However, revocation is not effective to the extent that CCHP has already taken action in reliance on it, or for so long as CCHP may contest my enrollment or any claim for benefits.

本人授權任何醫療機構、護理機構，或任何其他醫療相關機構、或為本人及家屬提供醫療服務的專業人仕，向華人保健計劃及其指定代理提供所有本人及家屬的醫療資料，包括任何酒精/毒品濫用，愛滋病相關資料，及/或精神狀態。本人瞭解此類醫療資料將被要求並用來審核本人的申請，以及裁斷是否符合保障條件。此授權由簽署之日開始生效，並持續 24 個月有效，除非華人保健計劃在申請人仍為會員時，用以復審或評估任何相關的保險理賠。此授權的複印版本與原件同樣有效。父母或法律監護人的簽署代表他/她本人的授權，以及其未成年子女的授權。

本人瞭解如果本人拒絕提供此授權，華人保健計劃將不會審核本人的申請，因此本人也無法成為華人保健計劃的會員。

本人可以在此授權逾期之前對其撤銷。然而，撤銷華人保健計劃已經對於此授權而作出的行動無效，此外，只要華人保健計劃對本人的申請或保險理賠持有爭議，撤銷授權也對其無效。

Signature of Applicant

Print Your Name 請用正楷填寫姓名

Date 日期

Spouse / Domestic Partner Signature
配偶同居伴侶簽署

Print Your Name 請用正楷填寫姓名

Date 日期

Important: required signatures 簽署要求

All Applicants age 12 and over must sign and date this Authorization to Release Medical Information.

所有 12 歲及以上的申請人必須在此醫療資料授權書上簽署姓名及日期。

Dependent 家屬簽署 #1

Print Your Name 請用正楷填寫姓名

Date 日期

Dependent 家屬簽署 #2

Print Your Name 請用正楷填寫姓名

Date 日期

Dependent 家屬簽署 #3

Print Your Name 請用正楷填寫姓名

Date 日期