CCHP

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For office use only:

Language:	**English**	**Chinese**
Service Area:	**San Francisco**	**Northern San Mateo**

Check amt: ______________________________
Check #: ______________________________
Received by ______________________________

Conversion Plan Application

Former Employer Group Name:	**Former Employer Group No.:**
Your coverage under former group begin date:	**Your coverage end date:**

I. APPLICANT'S INFORMATION

Last Name	First Name	M.I.	Chinese Name	Social Security No.	
Home Address			City	State	Zip
Home Phone ( )	HT	WT	M F	Single Married	Date of Birth (MM/DD/YY)
Primary Care Physician (Family Doctor) Please select from the Provider Directory				Are you an existing patient? Yes No	

II. FAMILY MEMBER TO BE ENROLLED

(Dependent's age between 19 and 23 must be FULL time student to be eligible)

Relation	Last Name	First Name	Mi	HT	WT	AGE	Birth date Mo/Day/Yr	Social Security No.	Family Doctor	Existing Patient Yes/no
Spouse										
Son Daughter								FT student Yes No		
Son Daughter								FT student Yes No		
Son Daughter								FT student Yes No		
Son Daughter								FT student Yes No		

III. CONDITIONS OF APPLICATION – please carefully read and fully understand the following:

I hereby request (Check one) **Individual conversion coverage only**

Individual plus dependent conversion coverage

GENERAL CONDITIONS:

- Chinese Community Health Plan reserves the right to reject any application for enrollment.
- I understand that I have no coverage under this application until notified by CCHP that I am accepted.
- 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.
- I understand that if there is any intentional or unintentional non-disclosure or misstatement of fact in this application CCHP may terminate my coverage and my family's coverage retroactively to the effective date.
- If my coverage is terminated retroactively, I will be billed by the providers for all services I received through CCHP.

Acknowledgment and Agreement: I hereby apply for myself and any enrolled dependents to the CCHP conversion plan and agree to abide by all terms, conditions and provision of this Conversion 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, or material omissions from this application, constitute the basis for cancellation of coverage retroactive to the effective date of enrollment.

Applicant's Name ______________________________
Please print

Spouse's Name ______________________________
Please print

Signature ______________________________

Signature ______________________________

Date: ______________________________

Date: ______________________________