



Application for Health Coverage

State of Tennessee · Department of Finance and Administration

Return applications to:

1 Cameron Hill Circle, Chattanooga TN 37402

AccessTN is administered by BlueCross BlueShield of Tennessee, Inc.
- an Independent Licensee of the BlueCross BlueShield Association

Complete all sections in blue or black ink or type and sign. Mail this application to the above address, or fax it toll free to 1-866-636-0161 (secure fax). You should keep a copy of this application and all supporting papers. AccessTN will not return copies. We may request additional information. Missing information will delay enrollment.

Important – You do not have to fill this out by yourself! Help is available.

If you need someone to fill out this application with you or for you, call us toll free at 1-866-636-0080. Try to have your basic medical and medicine information with you when you call.

There is financial help available in paying your premium.

Persons with family income up to \$75,000 a year may qualify for help paying their premiums, as funds are available. You must pick Plan One (\$1000 deductible) to receive this help.

If you want help paying your premium, fill out the enclosed Application for State Premium Assistance and send it in with this Application for Health Coverage. You can also get one by calling 1-866-636-0080 or online at www.AccessTN.gov. Premium assistance funding is limited. When all premium assistance money is in use, we will only award new premium assistance as funds become available.

If you are seeking financial help with your premium, be sure to attach copies of the income records we ask for. If you apply for premium assistance separately from your Application for Health Coverage, your premium assistance start date will be based on when you send and we approve your Application for State Premium Assistance.

Section A - Your Applicant Information				AccessTN is all individual coverage	
Last Name	First Name	MI	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth (mm/dd/yy)	Social Security Number
Home Address (attach one proof of residency)		City		State	Zip Code
Note: You must send one proof of your residency with this application. It can be a copy of a driver's license, utility bill, etc. If you do not send a proof of residency, your application will be denied.					
TN resident for at least six months? <input type="checkbox"/> Yes <input type="checkbox"/> No		How long have you lived at this address? _____ If less than six months, list prior address:			
Mailing Address (if different from home address)		City		State	Zip Code
Home Phone, with area code ()	Work Phone, with area code ()	Cell Phone ()		Email address	
State and # of most recent Driver's License:	Citizenship status: U.S. Citizen <input type="checkbox"/> Qualified Legal Alien <input type="checkbox"/> If not a U.S. citizen, attach papers to prove your immigration status – see form in the packet or at www.AccessTN.com			Primary language (optional) <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____	
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Racial/ Ethnic Heritage (for Title VI purposes) <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native American/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Mixed Ethnicity/Other _____				

Section B - Benefit Plan

Choose your benefit plan- These plans are available for each eligibility category in Section E.

- \$1,000 deductible – Plan One
Premium assistance is available for Plan One only.
- \$3,000 deductible – Plan Two
Qualifies for use with a health savings account (HSA)
- \$5,000 deductible – Plan Three
- See detail in plan papers or online at www.AccessTN.gov

Section C - Required Premium Information

Height	Weight
Have you used tobacco products during the past 6 months?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	

You will be billed a monthly premium if approved for coverage. You can estimate your premium using the rate tables in the AccessTN information booklet, or see www.AccessTN.gov.

Section D – How Are You Eligible?

You should mark Yes to either box D1 or D2 to be eligible.

All eligibility categories require you to be a Tennessee resident. When you finish Section D, you will need to mark one of the boxes in Section E on the next page to pick your eligibility category.

One Category – HIPAA Portability – does NOT require you to have pre-existing medical conditions or show that you are uninsurable. All other categories require you to be uninsurable (see below). **Pre-existing means medical conditions you have before your health coverage begins.**

D1. Do you qualify for HIPAA Portability? Yes No

Mark “Yes” IF you are applying within 63 days of prior group coverage and:

- (a) you have eighteen (18) or more months of combined health coverage with no break in coverage of more than 63 days;
- (b) your most recent coverage was under an employer-sponsored GROUP health plan;
- (c) you are not eligible for employer coverage where you work, Medicare or Medicaid, and you do not have other health coverage;
- (d) your most recent coverage was not terminated for nonpayment of premiums or fraud; and
- (e) if eligible for COBRA or group continuation, you must have taken and completed your full COBRA eligibility.

Note: This is for new HIPAA Portability only. This category is not available to those already on guaranteed issue HIPAA plans.

- If you marked “Yes” above, go on to Section E and mark Box E3 – HIPAA Portability.
- If you marked “No” above, go on to the question below to show you are uninsurable. If uninsurable, you may qualify for either State Uninsurable (E1) or State Portability (E2) in Section E on the next page.

Uninsurable means you cannot get insurance because of pre-existing health reasons.

- If you qualify for HIPAA Portability above, there is no need to answer this part – go on to next page.

D2. Are you Uninsurable? Yes No

Check “Yes” only IF you can mark Box A or Box B to show how you are uninsurable, and then go on to the next page.

A. An insurance company denied you coverage due to health reasons – attach denial letter

Within the last 12 months, were you denied individual health insurance coverage due to any health reason? If “Yes”, you must attach a copy of the insurance denial letter.

A letter from an insurance agent is not sufficient; it must be an official letter from the insurance company. This method to qualify does not require a doctor’s statement and can be based on ANY health condition.

B. You have one of our listed medical conditions – attach a physician’s statement

This way is based upon **specific health conditions** and requires a doctor’s statement. Within the last three years, have you had any treatment, diagnosis, or medical advice for any of the medical conditions listed on the **Attending Physician’s Statement**? If “Yes”, attach the signed statement from your doctor.

A copy of the **Attending Physician’s Statement** can be found at www.AccessTN.gov and one is in your application packet. Or you can attach a letter from your doctor telling us the diagnosis and billing code. If you have a medical condition that is not listed, you can still use an insurer denial above that does not require a doctor’s statement.

- If you marked “Yes” above, go on to Section E on the next page and mark the box that fits your situation.

Section E - Pick the Eligibility Category you are applying for (choose one)

Check the box below to pick the one category that fits your circumstances

E1. State Uninsurable (Regular coverage)

For **State Uninsurable** coverage, you must meet ALL of these rules (a) thru (d):

- (a) be a Tennessee resident for 6 months and a U.S. Citizen or qualified legal alien,
- (b) have a pre-existing medical condition which makes you uninsurable (see page 4);
- (c) not be eligible for employer coverage where you work, Medicare or Medicaid or have other health insurance; and
- (d) meet any required period without other insurance (called a go-bare period) or meet any approved exception to that requirement

The "go-bare" period without other insurance is **3 months** (see www.AccessTN.gov for the most recent information).

Regular plans have a **pre-existing conditions reduced benefit for the first 6 months of coverage**, during which medical services for pre-existing conditions pay as a 50% benefit, except outpatient mental health counseling and pharmacy.

Note: All State Uninsurable (Regular) coverage starts on the 1st of the month and applications must be approved and processed by the 15th of the prior month.

OR

E2. State Portability - IF you are applying within 63 days of prior coverage with

TennCare, CoverKids or other specified coverage*. You must meet ALL of these rules (a) thru (c):

- (a) be a Tennessee resident for 6 months and a U.S. citizen or qualified legal alien;
- (b) have a pre-existing medical condition which makes you uninsurable (see page 4); and,
- (c) not be eligible for employer coverage where you work, Medicare or Medicaid or have other health insurance.

State Portability has no required period without insurance (no "go-bare" period) and **NO pre-existing conditions period**.

* See AccessTN.gov for list of "other specified coverage," such as a company's ending its group coverage with no COBRA option

**You will need to send us your certificate of creditable coverage or other proof of your prior insurance.
You can apply before the end of your other coverage.**

Note: If you qualify for Portability coverage, your coverage must begin the day following the end of your prior coverage.

OR

HIPAA Portability does NOT require you to have pre-existing health conditions or be uninsurable

E3. HIPAA Portability - IF you are applying within 63 days of prior group coverage.

You must meet ALL of these rules (a) thru (e):

- (a) you are a Tennessee resident and U.S. Citizen or qualified legal alien and you have eighteen (18) or more months of combined health coverage with no break in coverage of more than 63 days;
- (b) your most recent coverage was under an employer-sponsored GROUP health plan;
- (c) you are not eligible for employer coverage where you work, Medicare or Medicaid, and you do not have other health coverage;
- (d) your most recent coverage was not terminated for nonpayment of premiums or fraud; and,
- (e) if eligible for COBRA or group continuation, you must have taken and completed your full COBRA eligibility.

HIPAA Portability means NO pre-existing conditions limitation and has NO required period without insurance- no "go-bare" period.

**You will need to send us your certificate of creditable coverage or other proof of your prior insurance.
You can apply before the end of your prior coverage.**

Note: If you qualify for Portability coverage, your coverage must begin the day following the end of your prior coverage.

Section F - Other Insurance Coverage

Are you eligible for Medicare now? Yes No Have you applied for Disability benefits? Yes No

If you have applied for disability, please tell us where you are in the application process. (Just tell us what you can - things like: Was it granted? Have you appealed? Or, Who is helping you with your application?)

Section F - Other Insurance Coverage (continued)

Please tell us in the boxes below what you know about other health coverage you have or have had recently.

Have you ever been in AccessTN? <input type="checkbox"/> Yes <input type="checkbox"/> No		Have you ever been in TennCare? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, when were you last employed? _____		
If yes, how are you employed? <input type="checkbox"/> Full-time <input type="checkbox"/> Contract worker <input type="checkbox"/> Temporary <input type="checkbox"/> Part-time				
Please complete the following for your current or most recent employer (if self-employed, say that)				
Name of Employer	Street Address	City	State	Zip Code
Does this employer offer group health coverage or pay the cost of insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, is the coverage CoverTN? <input type="checkbox"/> Yes <input type="checkbox"/> No If this employer has ANY group health plan and you are not covered, please tell why: _____				

Note: You can still qualify for AccessTN if you have certain other kinds of coverage, including:

- long-term care policies • nursing home coverage • cancer or disease-specific coverage
- accident or disability only coverage • liability insurance, including medical payments in an auto policy
- "fixed indemnity"- the type of insurance that pays you a set dollar amount if certain events happen, like a plan that pays you \$250 for each day you spend in the hospital • some short-term polices

Please tell us in the boxes below what you know about other health coverage you have or have had recently.

Are you covered now or have you been covered by any other insurance (including Medicare or TennCare) in the last 3 months? <input type="checkbox"/> No If No , go on to sections G and H. <input type="checkbox"/> Yes If Yes , you can apply before your other plan ends to avoid a break in coverage.		
Just tell us below what you can about any other health coverage you have had in the last 3 months. (You may attach a copy of the face pages of the policy, but doing so is not required unless we ask.) If you don't know the Policy # or other part of the requested information, just write "I don't know" in that box.		
Type of Policy: <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare <input type="checkbox"/> TennCare <input type="checkbox"/> COBRA <input type="checkbox"/> Group Continuation <input type="checkbox"/> If another type or you don't know, tell us what you can about the coverage: _____		
Primary Policy Holder		SSN or ID # of Policyholder
Name of Insurance Company	Policy #	Group #
Beginning Date of Coverage	Ending Date of Coverage	Reason Coverage Ended
If a Group or COBRA or group continuation Policy, provide name of employer _____		
If you marked "Group" above, were you eligible for: COBRA <input type="checkbox"/> Yes <input type="checkbox"/> No Group Continuation <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide the Begin Date _____ and End Date _____ of coverage. If no, why? _____		
If individual coverage and policy excludes a major body system like circulatory (heart), please describe the restriction: Note: The exclusion must be based on your personal medical history and must be a permanent exclusion of a whole body system. See the first column of the Attending Physician Statement for other examples. Please attach a copy of the exclusion to this application.		

Section G - Protected Health Information and Authorization

This section describes how AccessTN may use your personal information. Please read it carefully.

Protected Health Information (PHI) means facts and records about your health. PHI may include claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). It also includes facts like your address and date of birth. Federal and state laws protect the privacy of your health facts. Except as allowed by state and federal law, including for your medical treatment and AccessTN operations, privacy rules say AccessTN or your health providers can't give others information about you unless you give permission.

By signing this paper at Section J, you are giving your authorization for your providers, your employers, or any others you name in this application to provide information to AccessTN about you as part of your health plan enrollment or coverage. This includes TennCare if you were ever enrolled in TennCare.

Your signature on this application at Section J authorizes disclosure to and use by AccessTN, its contractors, or agents, of information on your health insurance coverage, health insurance applications, medical claims, TennCare or other Medicaid eligibility, and medical record information about you for any lawful purpose, including use by AccessTN to:

- a) determine eligibility for coverage;
- b) preauthorize or process claims for benefits;
- c) perform case management, including utilization or quality assurance reviews; or
- d) conduct an audit or investigate allegations of fraud.

Your signature at Section J authorizes any physician, health-care provider, hospital, health plan, insurance company, reinsurance company, or any insurance information bureau to disclose your health information to AccessTN, its contractors, agents, or representatives. This authorization includes the disclosure to and use by AccessTN of the following information, if any:

- a) records of alcohol or chemical dependency and my treatment for those conditions;
- b) records of any mental health treatment, excluding psychotherapy notes;
- c) records of my treatment for HIV/AIDS;
- d) records of genetic testing regarding any medical condition listed on this application IF you are using that genetic condition as a basis for medical eligibility or for care management of that condition.

AccessTN contractors include BlueCross BlueShield of Tennessee, Fort Dearborn Life Insurance Company, Health Assist Tennessee, Shared Health, Inc. and may include others. These contractors may change but all AccessTN contracts require them to keep your health facts private as required by state and federal rules.

You understand that your health facts, including personal and treatment information, may be maintained in an electronic clinical record that your medical providers or our operations may view through secure, encrypted internet access if they are approved to use the Shared Health Clinical Health Record® (CHR). This and other secure internet services may be used in your medical treatment or in our operations. Unauthorized users are not permitted to see this information. You understand you have a right to request that your health facts not be viewable in the CHR by signing an "opt-out" form. You may request more information or an opt-out form for the CHR at any time from the Plan Administrator by calling 1-866-636-0080.

Your authorization takes effect on the date you sign this application (Section J) and remains in effect for twelve (12) months thereafter, and if you are enrolled in AccessTN, for the duration of your AccessTN coverage, plus twelve (12) months, or for the duration of any medical claim, whichever is longer. A photocopy of this authorization is as valid as the original. You understand you may request a copy of your authorization pages. You may cancel this authorization at any time by sending a written request to AccessTN. Your cancellation of this authorization will not affect any action AccessTN took before it received your request, and will not affect its use of your PHI for AccessTN health care operations. If you do not revoke this authorization, it will automatically expire twelve (12) months after termination of your coverage with AccessTN unless you have a claim pending as above.

Federal law requires AccessTN to tell you, and you understand, that if the person or organization you authorize to receive your information is not a health plan or medical provider, state and federal privacy rules may no longer protect it. Alcohol and drug abuse records are protected against re-disclosure by special federal confidentiality rules (42 CFR, Part 2). Those regulations prohibit re-disclosure of alcohol and drug abuse record information without specific written authorization.

Section H - Health History

Please answer the following questions to the best of your knowledge. This will help AccessTN plan for your health care. (A five year time period is used to help identify more of your needs for care management.) This health questionnaire can be updated after the application is sent by mailing any changes to **AccessTN, c/o BlueCross BlueShield of Tennessee, 1 Cameron Hill Circle, Chattanooga TN 37402.**

Please be sure to complete all questions. Missing information will delay your enrollment.

Applicant Name	Date of Birth	Height	Weight
Have you used tobacco products during the past 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing tobacco <input type="checkbox"/> Pipe <input type="checkbox"/> Cigars		How Long?	How Often?
Have you gained or lost more than ten pounds in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <input type="checkbox"/> Gained weight <input type="checkbox"/> Lost weight		If yes, how much?	
If yes, tell the cause of the weight gain/loss if you know:			

Within the past five years, have you been counseled by, or consulted a medical provider or received treatment for any of the following? If you answer "yes" to any of the questions below, please list any facts that you remember, such as your doctor's name or date of treatment, in the space provided.	
1. Heart disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Ulcers, stomach or digestive system disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Urinary or kidney disorder, or gynecological problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Diabetes, connective tissue, pituitary, thyroid or endocrine system disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Allergies, asthma, or other respiratory system issue?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Arthritis, fibromyalgia, back/neck, joint/bone disorder or other musculoskeletal issue?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Brain disorder, aneurysm, paralysis, cerebral palsy, epilepsy or other seizures, headaches, multiple sclerosis, or other nervous system issue?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Cancer, tumor, or abnormal growth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Eye or ear disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Psychological disorder, or mental illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Organ or other type of transplant or implant (including breast implants)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Any other injury, surgery, illness or treatment for any condition not already listed; or been recommended to have a test or surgery which was not performed for any reason?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section H - Health History (continued)

13. During the past month, have you often been bothered by feeling down, depressed, or hopeless?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. During the past month, have you often been bothered by little interest or pleasure in doing things?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. In the past five years, have you been treated for alcoholism or chemical dependency; or joined any organization for alcoholism or chemical dependency; used illegal drugs; or been advised by a health care professional to reduce the use of alcohol or illegal drugs? If yes, please explain: _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. In the past five years, have you sustained an injury as a result of an auto or work-related accident? If yes, please explain: _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
17. In the past five years, have you been treated by a medical professional as having HIV/AIDS? We are NOT seeking HIV test results.	<input type="checkbox"/> Yes <input type="checkbox"/> No
18. Are you currently pregnant? If Yes, please indicate your due date:	<input type="checkbox"/> Yes <input type="checkbox"/> No
This is extra space if you need to write more on any question (tell us which number question), or for other information:	

Prescription History - If you are taking medication or were prescribed any medication during the past three years, please list it below. Tell us what you can in the space below about when you took it (for example, "three years ago" or "taking now"), what dosage if you know, and what medical condition is being treated by each medication if known.

Attach additional pages as needed. **Print your name on, then sign and date any additional pages.**

Name of drug	Condition drug prescribed for	Dosage & frequency of medication	Date(s) medication taken	Name and city of prescribing provider

Section I - Statement of Understanding and Affirmation

Please be sure to read this section carefully. It contains important terms of your coverage. By your signature at Section J, you are expressly affirming the following statements:

- I am applying to Access Tennessee (AccessTN) a non-profit entity of the State of Tennessee, for coverage of medical, surgical, prescription, and hospital services. I understand that this health plan will be partially supported by the State of Tennessee and possibly by federal funding. I understand that I do not have to sign this form. However, I understand if I do not complete and sign this form, or if I take back my permission in Section G, AccessTN may deny my eligibility. Incomplete or unsigned forms may be returned. If I submit an Application for State Premium Assistance, it is incorporated by reference in its entirety as an attachment to this application, as are any attached documents. I affirm by my signature below that I have read and understand these provisions, and that my answers on this application are complete and correct to the best of my knowledge. I understand that benefits, premium assistance, and care management guidelines are subject to change for all AccessTN plans by its Board of Directors (Board).
- I AFFIRM THAT THE INFORMATION PROVIDED ON THIS APPLICATION IS CORRECT UPON PENALTY OF CRIMINAL OR CIVIL PROSECUTION. I understand there are penalties for not providing correct information, for allowing someone else to use my benefits, and for other acts of fraud. I understand my duty to inform AccessTN in a timely manner about changes in my work, income, or access to other health insurance. I understand computer cross-checking with other state or federal agencies may be used to verify my information, and I will cooperate with requests for additional information. I can report suspected fraud and abuse by calling toll-free 1-866-795-1977 or by calling (615) 253-9955.
- I AFFIRM THAT NEITHER MY EMPLOYER(S) OR MY MEDICAL PROVIDER(S) HAVE PAID, NOR WILL THEY PAY FOR OR REIMBURSE MY PREMIUMS, except according to guidelines set by the Board and which may be changed from time to time. See guidelines for foundations or others. I understand that, apart from premium assistance, there are currently no restrictions on assistance I may receive from any source for my AccessTN deductibles, coinsurance, and copayments, subject to change by the Board. I will disclose any assistance with my AccessTN premiums I receive from any other person or organization, including my medical providers. I know I can check www.AccessTN.gov or call AccessTN member services at 1-866-636-0080 to get the most current guidelines and member materials.
- If this application contains material misstatements or omissions, I understand that AccessTN may do any or all of the following within two years from the date the policy was issued:
 - a) cancel the agreement as though it was never effective and refund premiums, less any claims paid;
 - b) deny benefits under the pre-existing conditions period and recover claims paid; or
 - c) take any other action available to it by law.

This time limit does not apply to fraudulent misstatements. My application is part of any policy issued by AccessTN. I understand the State Office of Inspector General (OIG) investigates for fraud in AccessTN. This provision also applies to my on-going duty to timely inform AccessTN about changes in my eligibility for benefits or premium assistance, and I will cooperate with any investigation conducted on behalf of AccessTN.

- I understand that a pre-existing condition includes any condition which, during a period six months immediately preceding the effective date of my coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment or for which medical advice, care, or treatment was recommended or received as to such condition. I understand the most current information about the pre-existing conditions waiting period is available at www.AccessTN.gov or 1-866-636-0080 toll free.
- I understand and agree, if I am granted AccessTN coverage, that, as approved by its Board and as permitted by law, AccessTN may vary deductibles, coinsurance, or treatment levels of its health plans for medical conditions according to criteria which it may establish, by severity of condition, by enrollee category or enrollee income level, or by other reasonable criteria. I understand and agree that AccessTN may vary benefit level according to clinical criteria, by level of enrollee compliance with AccessTN care management, health incentives, or by other Plan guidelines. I agree to cooperate with and adhere to AccessTN health promotion and disease prevention, including specifically AccessTN care management guidelines as periodically established by the Board. I agree that if I fail to comply with AccessTN care management guidelines, my AccessTN coverage may be affected, including but not limited to reduction or elimination of any incentive discount or premium assistance I may be receiving, and including reduction or termination of my health coverage. I agree that for this and all purposes related to my coverage, written notice mailed to my most recent address of record with AccessTN counts as notice to me, according to guidelines established by the Board.
- I understand that my coverage will become effective based on the notice of the Plan Administrator that I have been approved. My effective date will be on the first day of the month for Regular coverage or, for Portability coverage, on the day following the termination of my prior qualifying coverage, if I was an eligible Tennessee resident at that time. I understand that no coverage will be in effect until my application has been approved by AccessTN and the full correct initial premium is paid and processed, according to AccessTN policies and procedures. If I am not approved for coverage or if I do not pay my premium, AccessTN shall have no obligation to insure me.

Section I - Statement of Understanding and Affirmation (continued)

- For each successive month of coverage, I understand that my premium must be received by the Plan Administrator on or before the due date. If I arrange for automatic payment by bank draft or by credit or debit charge, such transaction will be made according to the schedule provided by the Plan Administrator, and may be before the due date. I shall have a grace period of thirty-one (31) days from the due date, inclusive. However, I UNDERSTAND THAT MY BENEFIT ELIGIBILITY MAY BE SUSPENDED BEGINNING THE FIRST DAY OF ANY MONTH IF THE PLAN ADMINISTRATOR HAS NOT RECEIVED AND CREDITED COLLECTED FUNDS TO MY ACCESSTN ACCOUNT BY THE DUE DATE, AND SHALL REMAIN SUSPENDED DURING MY GRACE PERIOD UNTIL SUCH FUNDS ARE RECEIVED AND PROCESSED. I UNDERSTAND THAT MY COVERAGE WILL BE TERMINATED AT THE END OF THE THIRTY-ONE (31) DAY GRACE PERIOD IF MY PAYMENT IS NOT RECEIVED AND PROCESSED. My coverage will also be terminated at the end of the thirty-one (31) day grace period if my check or other payment is disallowed by my financial institution without such payment funds being collected by the Plan Administrator. Any payments or termination, including a waiting period to reapply for coverage shall be subject to the policies of AccessTN. I understand that my thirty-one (31) day grace period does not begin on the date I receive notice, but shall begin on the due date according to the above schedule as set by AccessTN. I UNDERSTAND THAT ANY ACCESSTN MEMBER TERMINATED FOR NONPAYMENT MUST WAIT ONE YEAR BEFORE BEING ELIGIBLE, EXCEPT AS DEFINED BY ACCESSTN, IN A MANNER CONSISTENT WITH LAW.
- AccessTN does not support any practice that excludes participation in programs or denies program benefits on the basis of race, sex, religion, color, national or ethnic origin, age, disability, or military service. If you have a complaint involving discrimination, please call 1-800-253-9981 or (615) 741-4517.
- I understand that I have the right to appeal an enrollment decision. I can appeal through the AccessTN grievance process by calling 1-866-636-0080 and requesting for the Plan Administrator to send me an appeal form.

Section J – Applicant Signature

Your signature applies to the entire application and to any attachments. It expressly applies to Section G “Protected Health Information” and to Section I “Statement of Understanding and Affirmation.”

Be sure to read them. (“attachments” above specifically includes the Application for State Premium Assistance, if any)

Applicant’s Signature in ink (or by parent, legal guardian, or conservator, if applicant not legally competent or a minor)	Date
If signed by applicant, nothing is required in this block. If signed by parent, legal guardian or conservator for the applicant, please print name, address, phone number and relationship here.	

Section K – Fill out this section if someone helped you or can help us with this application.

To the Applicant: YOU are responsible for information in your application and are signing above that it is correct. You only need to fill out this part if a friend, family member, or other person helped you complete this application.

Helper Name	Organization, Company, or Relationship	Phone	
Helper Address	City	State	Zip Code
Also fill out and sign below if you give us your OK to talk to the helper above or to your family or friend about your health facts in this paper. Tell us their names and phone numbers.			
(Optional) If it is OK for us to talk about your health facts and application to the people checked here, sign in the box below:			
<input type="checkbox"/> the helper or organization named above <input type="checkbox"/> the additional persons listed (tell us their names, who they are - family, friends, etc.- and how to contact them) _____			
See sections G & J that allow us to contact your medical providers. You only need to list non-medical people here.			
Applicant's Signature goes here if OK for AccessTN to communicate with those checked above	Date here if signing on a day different than in section J		