Individual and Family Plan – Off Exchange Enrollment Application Form

Tel: 1-888-371-3060 I Fax: 1-415-955-8819

Balance by CCHP will provide translation 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.

Reason for application

Please Select One	☐ New Application (during open enrollment period November 1, 2023 – January 31, 2024)
	☐ Special Enrollment (during February 1, 2024 – October 31, 2024, please attach attestation & proof of the qualifying event)
	☐ Adding Spouse/Domestic Partner ☐ Adding Child(ren) Current Member ID#_____ Current Plan_____

Proposed Effective Date (MM/DD/YY): / /

Please select a plan

Medical Plans Options

☐ Jade[15] HMO Platinum ☐ Amber[50] HMO Silver ☐ ActiveChoice PPO Silver ☐ Platinum[90] HMO ☐ Gold[80] HMO

☐ Silver[70] Off Exchange HMO ☐ Bronze[60] HMO ☐ Bronze[60] HDHP HMO ☐ Minimum Coverage HMO

Optional Riders ☐ Adult Vision (VSP) ☐ Adult Dental (Delta Dental)

One Medical ☐ YES, I want to JOIN One Medical. **If 'YES' we will assign you a PCP. You are free to change if you decide later.**

A. Primary applicant's information

Last Name:	First Name:	M.I.:	SSN:
Date of Birth (MM/DD/YY): / /	Age:	Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married
Email:	Cell Phone:		Home Telephone:
Home Address, City, State, ZIP (No P.O. Box):			
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. You may be able to have medical information sent to you in an alternate format. Please contact Balance for more information.			
Mailing Address, City, State, ZIP (if different than home address):			
Primary Care Physician (PCP):	Medical Group: (*Leave blank if not known*)		Are you a current patient of this PCP? ☐ Yes ☐ No
Name of Employer:			Work Phone:
Work Address, City, State, ZIP			

Optional Questions

What is your race? (Check all that apply)

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White/Caucasian
- ☐ Other, please specify: _____
- ☐ Unknown
- ☐ Decline to state

What is your ethnicity? (Check all that apply)

- ☐ African American
- ☐ American
- ☐ Arab
- ☐ Asian Indian
- ☐ Black
- ☐ Chinese
- ☐ European
- ☐ Filipino
- ☐ Hispanic/Latino
- ☐ Iranian
- ☐ Korean
- ☐ Latin American
- ☐ Mexican
- ☐ Russian
- ☐ Vietnamese
- ☐ Other, please specify: _____
- ☐ Unknown
- ☐ Decline to state

What is your preferred language for health care?

WRITTEN	SPOKEN	
	☐	American Sign Language (ASL)
☐	☐	Arabic
☐	☐	Bulgarian
☐	☐	Chinese (Written) / Cantonese (Spoken)
☐	☐	Chinese (Written / Mandarin (Spoken)
☐	☐	English
☐	☐	Korean
☐	☐	Khmer
☐	☐	Laotian
☐	☐	Persian
☐	☐	Polish
☐	☐	Punjabi
☐	☐	Russian
☐	☐	Spanish
☐	☐	Tagalog
☐	☐	Vietnamese
☐	☐	Other, please specify: _____
☐	☐	Unknown
☐	☐	Decline to state

What is your assigned sex at birth?

☐ Female ☐ Male ☐ Unknown ☐ Decline to state

What is your current gender identity?

- ☐ Female
- ☐ Male
- ☐ Transgender male/ trans man/ female-to-male (FTM)
- ☐ Transgender female/ trans woman/ male-to-female (MTF)
- ☐ Genderqueer (neither exclusively male nor female)
- ☐ Additional gender category or other, please specify: _____
- ☐ Decline to state

What is your sexual orientation?

- ☐ Lesbian or gay or homosexual
- ☐ Straight or heterosexual
- ☐ Bisexual
- ☐ Something else, please describe: _____
- ☐ Do not know
- ☐ Decline to state

B. List all family member(s) to be covered

☐ **Spouse** ☐ **Domestic Partner**	Last Name:	First Name:	M.I.:
Date of Birth (MM/DD/YY): / /		SSN:	
Primary Care Physician (PCP)		Medical Group: (*Leave blank if not known)*	Existing Patient? ☐ Yes ☐ No

What is your race? (Check all that apply)

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White/Caucasian
- ☐ Other, please specify: _____
- ☐ Unknown
- ☐ Decline to state

What is your ethnicity? (Check all that apply)

- ☐ African American
- ☐ American
- ☐ Arab
- ☐ Asian Indian
- ☐ Black
- ☐ Chinese
- ☐ European
- ☐ Filipino
- ☐ Hispanic/Latino
- ☐ Iranian
- ☐ Korean
- ☐ Latin American
- ☐ Mexican
- ☐ Russian
- ☐ Vietnamese
- ☐ Other, please specify: _____
- ☐ Unknown
- ☐ Decline to state

What is your preferred language for health care?

WRITTEN	SPOKEN		WRITTEN	SPOKEN		WRITTEN	SPOKEN	
	☐	American Sign Language (ASL)	☐	☐	Khmer	☐	☐	Tagalog
☐	☐	Arabic	☐	☐	Laotian	☐	☐	Vietnamese
☐	☐	Bulgarian	☐	☐	Persian	☐	☐	Other, please specify:
☐	☐	Chinese (Written)/Cantonese (Spoken)	☐	☐	Polish			
☐	☐	Chinese (Written /Mandarin (Spoken)	☐	☐	Punjabi	☐	☐	Unknown
☐	☐	English	☐	☐	Russian	☐	☐	Decline to state
☐	☐	Korean	☐	☐	Spanish			

What is your assigned sex at birth?

☐ Female ☐ Male ☐ Unknown ☐ Decline to state

What is your current gender identity?

☐ Female ☐ Male ☐ Transgender male/ trans man/ female-to-male (FTM) ☐ Transgender female/ trans woman/ male-to-female (MTF) ☐ Genderqueer (neither exclusively male nor female)	☐ Additional gender category or other, please specify: _____ ☐ Decline to state

What is your sexual orientation?

☐ Lesbian or gay or homosexual ☐ Straight or heterosexual ☐ Bisexual	☐ Something else, please describe: _____ ☐ Do not know ☐ Decline to state

Dependent # 1	Last Name:	First Name:	M.I.:
Date of Birth (MM/DD/YY): / /		SSN:	
Primary Care Physician (PCP):		Medical Group: (*Leave blank if not known)*	Existing Patient? ☐ Yes ☐ No

What is your race? (Check all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander	☐ White/Caucasian ☐ Other, please specify: _____ ☐ Unknown ☐ Decline to state

What is your ethnicity? (Check all that apply

☐ African American	☐ Chinese	☐ Korean	☐ Other, please specify: _____
☐ American	☐ European	☐ Latin American	
☐ Arab	☐ Filipino	☐ Mexican	☐ Unknown
☐ Asian Indian	☐ Hispanic/Latino	☐ Russian	☐ Decline to state
☐ Black	☐ Iranian	☐ Vietnamese	

What is your preferred language for health care?

WRITTEN	SPOKEN		WRITTEN	SPOKEN		WRITTEN	SPOKEN	
	☐	American Sign Language (ASL)	☐	☐	Khmer	☐	☐	Tagalog
☐	☐	Arabic	☐	☐	Laotian	☐	☐	Vietnamese
☐	☐	Bulgarian	☐	☐	Persian	☐	☐	Other, please specify:
☐	☐	Chinese (Written) / Cantonese (Spoken)	☐	☐	Polish			
☐	☐	Chinese (Written / Mandarin (Spoken)	☐	☐	Punjabi	☐	☐	Unknown
☐	☐	English	☐	☐	Russian	☐	☐	Decline to state
☐	☐	Korean	☐	☐	Spanish			

What is your assigned sex at birth?

☐ Female ☐ Male ☐ Unknown ☐ Decline to state

What is your current gender identity?

☐ Female
☐ Male
☐ Transgender male/ trans man/ female-to-male (FTM)
☐ Transgender female/ trans woman/ male-to-female (MTF)
☐ Genderqueer (neither exclusively male nor female)

☐ Additional gender category or other, please specify: _____
☐ Decline to state

What is your sexual orientation?

☐ Lesbian or gay or homosexual
☐ Straight or heterosexual
☐ Bisexual

☐ Something else, please describe: _____
☐ Do not know
☐ Decline to state

Dependent # 2	Last Name:	First Name:	M.I.:
Date of Birth (MM/DD/YY): / /		SSN:	
Primary Care Physician (PCP):		Medical Group: (*Leave blank if not known)*	Existing Patient? ☐ Yes ☐ No

What is your race? (Check all that apply)

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander

☐ White/Caucasian
☐ Other, please specify: _____
☐ Unknown
☐ Decline to state

What is your ethnicity? (Check all that apply)

☐ African American	☐ Chinese	☐ Korean	☐ Other, please specify: _____
☐ American	☐ European	☐ Latin American	☐ Unknown
☐ Arab	☐ Filipino	☐ Mexican	☐ Decline to state
☐ Asian Indian	☐ Hispanic/Latino	☐ Russian	
☐ Black	☐ Iranian	☐ Vietnamese	

What is your preferred language for health care?

WRITTEN	SPOKEN		WRITTEN	SPOKEN		WRITTEN	SPOKEN	
	☐	American Sign Language (ASL)	☐	☐	Khmer	☐	☐	Tagalog
☐	☐	Arabic	☐	☐	Laotian	☐	☐	Vietnamese
☐	☐	Bulgarian	☐	☐	Persian	☐	☐	Other, please specify: _____
☐	☐	Chinese (Written) / Cantonese (Spoken)	☐	☐	Polish	☐	☐	Unknown
☐	☐	Chinese (Written / Mandarin (Spoken)	☐	☐	Punjabi	☐	☐	Decline to state
☐	☐	English	☐	☐	Russian			
☐	☐	Korean	☐	☐	Spanish			

What is your assigned sex at birth?

☐ Female ☐ Male ☐ Unknown ☐ Decline to state

What is your current gender identity?

☐ Female
☐ Male
☐ Transgender male/ trans man/ female-to-male (FTM)
☐ Transgender female/ trans woman/ male-to-female (MTF)
☐ Genderqueer (neither exclusively male nor female)

☐ Additional gender category or other, please specify: _____
☐ Decline to state

What is your sexual orientation?

☐ Lesbian or gay or homosexual
☐ Straight or heterosexual
☐ Bisexual
☐ Something else, please describe: _____
☐ Do not know
☐ Decline to state

Dependent # 3	Last Name:	First Name:	M.I.:
Date of Birth (MM/DD/YY): / /		SSN:	
Primary Care Physician (PCP):		Medical Group: (*Leave blank if not known)*	Existing Patient? ☐ Yes ☐ No

What is your race? (Check all that apply)

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander
☐ White/Caucasian
☐ Other, please specify: _____
☐ Unknown
☐ Decline to state

What is your ethnicity? (Check all that apply)

☐ African American	☐ Chinese	☐ Korean	☐ Other, please specify: _____
☐ American	☐ European	☐ Latin American	☐ Unknown
☐ Arab	☐ Filipino	☐ Mexican	☐ Decline to state
☐ Asian Indian	☐ Hispanic/Latino	☐ Russian	
☐ Black	☐ Iranian	☐ Vietnamese	

What is your preferred language for health care?

WRITTEN	SPOKEN		WRITTEN	SPOKEN		WRITTEN	SPOKEN	
	☐	American Sign Language (ASL)	☐	☐	Khmer	☐	☐	Tagalog
☐	☐	Arabic	☐	☐	Laotian	☐	☐	Vietnamese
☐	☐	Bulgarian	☐	☐	Persian	☐	☐	Other, please specify: _____
☐	☐	Chinese (Written) / Cantonese (Spoken)	☐	☐	Polish	☐	☐	Unknown
☐	☐	Chinese (Written / Mandarin (Spoken)	☐	☐	Punjabi	☐	☐	Decline to state
☐	☐	English	☐	☐	Russian			
☐	☐	Korean	☐	☐	Spanish			

What is your assigned sex at birth?

☐ Female ☐ Male ☐ Unknown ☐ Decline to state

What is your current gender identity?

☐ Female
☐ Male
☐ Transgender male/ trans man/ female-to-male (FTM)
☐ Transgender female/ trans woman/ male-to-female (MTF)
☐ Genderqueer (neither exclusively male nor female)
☐ Additional gender category or other, please specify: _____
☐ Decline to state

What is your sexual orientation?

☐ Lesbian or gay or homosexual
☐ Straight or heterosexual
☐ Bisexual
☐ Something else, please describe: _____
☐ Do not know
☐ Decline to state

Dependent # 4	Last Name:	First Name:	M.I.:
Date of Birth (MM/DD/YY): / /		SSN:	
Primary Care Physician (PCP):		Medical Group: (*Leave blank if not known)*	Existing Patient? ☐ Yes ☐ No

What is your race? (Check all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander	☐ White/Caucasian ☐ Other, please specify: _____ ☐ Unknown ☐ Decline to state

What is your ethnicity? (Check all that apply)

☐ African American ☐ American ☐ Arab ☐ Asian Indian ☐ Black	☐ Chinese ☐ European ☐ Filipino ☐ Hispanic/Latino ☐ Iranian	☐ Korean ☐ Latin American ☐ Mexican ☐ Russian ☐ Vietnamese	☐ Other, please specify: _____ ☐ Unknown ☐ Decline to state

What is your preferred language for health care?

WRITTEN	SPOKEN		WRITTEN	SPOKEN		WRITTEN	SPOKEN	
	☐	American Sign Language (ASL)	☐	☐	Khmer	☐	☐	Tagalog
☐	☐	Arabic	☐	☐	Laotian	☐	☐	Vietnamese
☐	☐	Bulgarian	☐	☐	Persian	☐	☐	Other, please specify: _____
☐	☐	Chinese (Written) / Cantonese (Spoken)	☐	☐	Polish	☐	☐	Unknown
☐	☐	Chinese (Written / Mandarin (Spoken)	☐	☐	Punjabi	☐	☐	Decline to state
☐	☐	English	☐	☐	Russian			
☐	☐	Korean	☐	☐	Spanish			

What is your assigned sex at birth?

☐ Female ☐ Male ☐ Unknown ☐ Decline to state

What is your current gender identity?

☐ Female ☐ Male ☐ Transgender male/ trans man/ female-to-male (FTM) ☐ Transgender female/ trans woman/ male-to-female (MTF) ☐ Genderqueer (neither exclusively male nor female)	☐ Additional gender category or other, please specify: _____ ☐ Decline to state

What is your sexual orientation?

☐ Lesbian or gay or homosexual ☐ Straight or heterosexual ☐ Bisexual	☐ Something else, please describe: _____ ☐ Do not know ☐ Decline to state

C. Fill out this section if applicant is using an insurance Agent or Broker

I understand that the broker of record may receive monetary and/or non-monetary payments from Balance in connection with the purchase of this coverage.
I understand my premiums are the same whether or not I use an agent or broker.

Applicant's Signature X	Broker Name:	Date (MM/DD/YY): / /

D. Insurance agent/broker attestation (AB2569, Cal H&S §1389.8)

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

I _____, assisted the applicant in submitting this application. 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.

Agent/Broker Signature X	Agent/Broker Name:		Date (MM/DD/YY): / /
Phone:	Fax:	Email:	CA License Number:
Agent/Broker Company Name:			Note(s) (Balance Use Only):
Agent/Broker Address:			

E. Conditions of application – Please carefully read the following:

I. General Conditions

Balance by CCHP reserves the right to reject any application for enrollment.

1. I understand that I have no coverage under this application until notified by Balance that I am accepted.
2. If I am accepted, this application will become part of the agreement between Balance and myself. Enrolled family members and I agree to be bound by the arbitration clause in the Balance contract instead of trial by a court or jury.
3. I understand that willful misrepresentation can result in rescission of my coverage. Balance can only rescind for a material misrepresentation or omission if the misrepresentation or omission is willful.

II. Acknowledgment and Agreement:

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 Balance promptly of any facts or circumstances which arise before the effective date of coverage under Balance which make any of the statements supplied herein incorrect. I understand that coverage may be cancelled if Balance demonstrates I have been fraudulent or intentionally misrepresented material fact in my application.

III. Disclosure of Personal and Health Information

Balance understand the importance of keeping your and your dependents' personal and health information private. Balance protects this information in electronic, written, and oral forms when used throughout our company. Balance will not disclose this information without your authorization except as permitted by law.

For the purpose of administering your Balance coverage, Balance is permitted by state and federal law to obtain your and your dependents' health information from a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent. Also, by state and federal law, Balance is permitted to disclose your and your dependents' health information to a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent.

A complete explanation of Balance policies and procedures ("Notice of Confidentiality and Privacy Practices") for preserving the confidentiality of your personal and health information is available and will be furnished to you upon request by calling the Customer Service Department or by accessing Balance's website.

IV. Arbitration Agreement:

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 Balance 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.

Applicant Signature X	Print Your Name:	Date (MM/DD/YY): / /
Spouse or Domestic Partner Signature X	Print Your Name:	Date (MM/DD/YY): / /
Signature Required for Dependents Age 18 or over		
Dependent #1 Signature X	Print Your Name:	Date (MM/DD/YY): / /
Dependent #2 Signature X	Print Your Name:	Date (MM/DD/YY): / /
Dependent #3 Signature X	Print Your Name:	Date (MM/DD/YY): / /
Dependent #4 Signature X	Print Your Name:	Date (MM/DD/YY): / /

Marketing Source:

☐ TV ☐ DM ☐ Email Ad ☐ Mobile Ad ☐ Radio ☐ Newspaper ☐ Referrals ☐ Street Fair/Event

☐ Others _____

Balance by CCHP Use Only:

Sales _____ Manager _____ Payment Type: CC / Bill / Check#_____ Amount _____ Date _____

Rec'd by Enrollment _____ Packet Sent Date_____

Privacy Protection of Data

CCHP and Balance by CCHP are required to comply with various State and Federal laws to protect, secure, retain, and maintain confidentiality of your sensitive and personal information. These laws include, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Centers for Medicare and Medicaid Services (CMS), and the California Consumer Privacy Act (CCPA). Balance has put in place policies and procedures to ensure that access to or use of your personal information is secure.

Policies and processes include standards on how Balance manages access to and the utilization of identified race, ethnicity, preferred language, gender identity and sexual orientation information collected for current or prospective health plan members. Balance discloses its procedures for managing access to and the use of collected race, ethnicity, preferred language, gender identity and sexual information at a minimum, at the time of data collection and on Balance's website Compliance Privacy page at balancebycchp.com/confidentiality-and-compliance-notice/.
For questions on these policies, please call the Balance Compliant Hotline at 415-955-8810 or email to CCHPComplianceDept@cchphealthplan.com.

CCHP complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Special Enrollment Attestation Form

You may enroll in an individual health plan only during the open enrollment period from Nov. 1st to Jan. 31st. There are exceptions that may allow you to enroll outside of this period. Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for Special Enrollment Period privileges. If you later determine that this information is incorrect, you may be disenrolled.

Name of Applicant:	**Effective Date Requested (MM/DD/YY):** / /

Completing this form does not guarantee acceptance of the exception request, please provide the required documentation.
I am certifying I qualify for Special Enrollment due to (check box the reason that best applies):

- ☐ Got married or entered into domestic partnership
- ☐ Divorce, legal separation, dissolution of domestic partnership, or death
- ☐ A child is born, adopted or received into foster care
- ☐ Dependent turns 26 years old
- ☐ Attainment of citizenship
- ☐ Loss of Medi-Cal
- ☐ Loss of Group Coverage (e.g. death of an employee, termination of employment, deduction of hours) Loss of CORBA
- ☐ Loss of Student Health Insurance
- ☐ Ineligible for tax credits or cost-sharing reductions under Covered California
- ☐ Permanently moved into Balance Service Area
- ☐ Misconduct or misinformation occurred during your enrollment
- ☐ Released from jail or prison
- ☐ Returned from active duty military service
- ☐ Received a certificate of exemption for hardship exception from Health & Human Services
- ☐ Court ordered provision of health insurance
- ☐ Federally Recognized American Indian/Alaska Native
- ☐ Other (Please provide an explanation):_____

Required Documentation for Special Enrollment Periods

A person enrolling as the result of a qualifying life event should provide the proof that the triggering event occurred and the date the event occurred. Most special enrollment periods last **60 days** from the date of the qualifying life event.

Event	Supporting Documentation
Marriage	Marriage certificate
Divorce	Divorce decree document
Birth/Adoption/Legal Guardianship of Child	Birth certificate or hospital discharge paperwork
Dependent Child reaches age 26	Proof of previous health insurance
Death of policyholder	Death certificate
Eligible Immigration Status or US Citizenship	Valid US passport, Green Card, or legal supporting documentation
Loss of Employer Coverage	Proof of previous group health insurance
Loss of Coverage Through Spouse's Employer	Proof of previous group health insurance
Loss of COBRA	Loss of COBRA letter
Loss of Medi-Cal	Loss of Medi-Cal document
Ineligible for cost-sharing reductions under Covered CA	Covered CA letter
Relocation / Move into Balance Service Area	Proof of old and new address, such as utility bill, credit card statement, insurance statement, bank statement, driver's license or education institution document. Both document must indicate permanent move occurred within 60 days of application.

Applicant Signature	**Date (MM/DD/YY):**
X	/ /