Regence BlueShield is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueShield
1800 Ninth Avenue
Seattle, Washington 98111-3267
Mail form to: PO Box 1107
Lewiston, ID 83501

Individual Application

SECTION 1 - INSTRUCTIONS

- Please read carefully.
- Use ink to complete and sign this application. An application completed in pencil will be returned to you.
- Make sure all sections of the application are answered completely.
- If you need assistance completing this application, please contact your insurance producer or call Individual Marketing at 1-888-REGENCE.

☐ Yes ☐ No I want to do my part for the environment and reduce waste. Please send my Explanation of Benefits (and when possible, other communications) electronically.

EFFECTIVE DATE: Complete applications received in our office by 5:00 PM Pacific Time on the last business day of the month will be eligible for an effective date of the first of the following month, unless otherwise indicated. Incomplete applications may receive a later effective date.

Requested Effective Date____________________

I am applying for:
☐ New enrollment ☐ Change to existing individual plan or deductible ☐ Addition of a spouse/domestic partner and/or dependent child to my existing policy

SECTION 2 - PLAN SELECTION (Detailed benefit information can be found online at www.regence.com)

BASE PLANS (select ONE medical plan)

Enrollment in a catastrophic health plan may not provide portability if you later decide to enroll in another individual health plan. "Portability" means that you will receive credit for a plan's preexisting condition waiting period based on prior coverage. By enrolling in a catastrophic plan, you may lose portability rights and have to satisfy the nine-month preexisting waiting period, should you later change to another individual health plan.

Evolve Core
- ☐ $2,500 deductible per member (maximum of 3 deductibles per family) - Catastrophic
- ☐ $5,000 deductible per member (maximum of 3 deductibles per family) - Catastrophic
- ☐ $7,500 deductible per member (maximum of 3 deductibles per family) - Catastrophic
- ☐ $10,000 deductible per member (maximum of 3 deductibles per family) - Catastrophic

Evolve Plus
- ☐ $1,000 deductible per member (maximum of 3 deductibles per family) - Comprehensive
- ☐ $2,500 deductible per member (maximum of 3 deductibles per family) - Catastrophic
- ☐ $5,000 deductible per member (maximum of 3 deductibles per family) - Catastrophic
- ☐ $7,500 deductible per member (maximum of 3 deductibles per family) - Catastrophic

Evolve HSA
- ☐ $2,000 self-only deductible / 50% coinsurance - Catastrophic
- ☐ $2,000 self-only deductible / 80% coinsurance - Catastrophic
- ☐ $3,500 self-only deductible / 50% coinsurance - Catastrophic
- ☐ $3,500 self-only deductible / 80% coinsurance - Catastrophic
- ☐ $4,000 family deductible / 50% coinsurance - Catastrophic
- ☐ $4,000 family deductible / 80% coinsurance - Catastrophic
- ☐ $7,000 family deductible / 50% coinsurance - Catastrophic
- ☐ $7,000 family deductible / 80% coinsurance - Catastrophic

Evolve HSA 100
- ☐ $5,000 self-only deductible - Catastrophic
- ☐ $10,000 family deductible - Catastrophic

DENTAL OPTIONS (select ONE of the following dental options)

- ☐ **Dental Option 1 -** 100/80/50; $750 annual maximum benefit that may increase over time to $1,500
- ☐ **Dental Option 2 -** 100% of first $200 and 50% of next $1,100 ($750 annual maximum benefit)
- ☐ **No Dental**

SECTION 3 - ENROLLMENT INFORMATION

LIST ALL ELIGIBLE FAMILY MEMBERS TO BE COVERED

Eligible family members include a spouse/domestic partner, and/or any unmarried child who is under age 25 or who is medically certified as disabled and dependent upon you for support. Copy of certification required.

Last Name	First Name, MI	Relationship to Subscriber	Gender	Age	Height	Weight	Birthdate	Social Security Number
		SUBSCRIBER						
		☐ Spouse ☐ Non-Registered Domestic Partner* ☐ Registered Domestic Partner						

*Non-Registered Domestic Partners must submit an Affidavit of Domestic Partnership

WASHINGTON RESIDENCE ADDRESS

To be eligible to apply for our individual plans, you must reside in our service area for at least 30 days prior to submitting your application and continue to live in our service area for six months out of the year. A photocopy of a valid Washington state driver's license, identification card, or current utility bill with name and address may be requested as proof of residency.

Residence Street Address	Mailing Address (if different than residence street address)

City, State, ZIP Code	E-Mail Address (will not be disclosed outside of the company)

Home Phone Number	Work Phone Number	County

What type of member card would you like to receive? ☐ Family Level Card (all members listed on the same card)
☐ Member Level Card (each member on a separate card)

SECTION 4 - OTHER COVERAGE INFORMATION

1. Are you or any dependents who are applying for coverage currently covered on any group, individual or self-insured medical plan? ☐ Yes ☐ No
   If yes, do you intend to replace your current plan with this contract? ☐ Yes ☐ No
2. Are you currently enrolled in an Regence BlueShield Individual medical plan and wish to cancel that coverage? ☐ Yes ☐ No
   If you answered yes, please sign the statement below:
   I wish to terminate my current individual medical coverage from Regence BlueShield on the effective date of this individual policy.

   Signature ▶ ______________________ Date ______________

Regence BlueShield Individual Plans contain a 9-month preexisting condition limitation period. In certain circumstances, we will waive or credit this waiting period based on current or prior coverage. For consideration of waiting period credit, applications must be received in our office within 63 days of prior coverage ending. Please provide the following information for all applicants, and attach a copy of your Certificate of Coverage from your current or prior carrier or a similar document showing the beginning and ending dates of your current coverage, if applicable.

Name (First Last)	Insurance Company	Policy Number	Dates of Coverage		Type of Coverage
			Date Coverage Began MM/DD/YYYY	Date Coverage Ended (indicate Active if you are currently covered) MM/DD/YYYY	◆ Employer Group ◆ Individual ◆ Medicare ◆ COBRA ◆ High Risk Pool ◆ Other (describe)
1.					
2.					
3.					
4.					
5.					

Deductible amount $ __________ per individual per year   Deductible amount $ __________ per family per year

Out-of-pocket (stoploss) amount $ __________ per individual per year   Out-of-pocket (stoploss) amount $ __________ per family per year

SECTION 5 - EXCEPTIONS FOR THE STANDARD HEALTH QUESTIONNAIRE

Please read the full explanation of the exceptions listed on the Standard Health Questionnaire (SHQ). Additional conditions and requirements may apply.

Name of person(s) not required to complete the SHQ ______________________

Do your circumstances match any of the exceptions described in the SHQ? If so, please complete this section (check one):

ATTENTION: If you are currently eligible for Medicare, or will be on the requested effective date of coverage for which applying, you are not eligible for private individual or family health coverage; and you should not fill out this questionnaire. Medicare is a federally sponsored program for individuals age 65 or older, or who have end-stage renal disease, or are disabled as defined by Social Security. Medicare and Medicaid are different. Medicaid is a state-sponsored program for individuals and families who qualify based on income and other criteria.

☐ **1. Relocation:** You changed residences from one part of Washington state to another part where your current health plan is not offered and you are submitting your application within 90 days of this event. *Include a copy of a utility bill in your name from the prior address dated within the last 90 days and a letter of verification from your prior carrier verifying that because you have moved, you no longer reside in their service area and they cannot provide health insurance at your new location.*

☐ **2. Provider Cancellation:** The health provider from whom you have received service during the last 12 months has left the provider network on your current individual medical plan and you are submitting the application within 90 days of your provider leaving your current health plan's network. This provider must be within the Regence BlueShield provider network. *Include a letter of verification from the provider or carrier verifying service in the last 12 months and the date the provider left the network.*

☐ **3. COBRA Exhaustion:** You are applying within 90 days of using up your COBRA coverage, or you lost coverage due to your employer going out of business or discontinuing its health plan while you were on COBRA. *Include a letter from the COBRA Administrator verifying that you have exhausted your COBRA benefits. Include a letter of certification from your employer or carrier that is going out of business or discontinuing its health plan while you were on COBRA.*

☐ **4. Employer's Plan Not Subject to COBRA:** You have lost or are losing coverage under an employer's plan that was not subject to COBRA coverage and you are applying within 90 days of an event which would qualify you for COBRA if your employer had not been exempt from COBRA and had at least 24 months of continuous group coverage before such loss. *Include a letter of verification of COBRA exemption and the reason for your loss of coverage from your employer and a certificate of coverage for proof of 24 months of continuous group coverage.*

☐ **5. COBRA Termination:** You are terminating your COBRA coverage and you had at least 24 months of continuous group coverage prior to termination. (Not applicable to BHP applicants.) *Include a letter of verification from your employer addressing your termination of COBRA and a certificate of coverage for proof of 24 months of continuous group coverage.*

☐ **6. COBRA Eligible:** You are applying within 90 days of an event which qualifies you for COBRA, and you had at least 24 months of continuous group coverage prior to such event but you chose not to take COBRA coverage. (Not applicable to BHP applicants.) *Include a letter of verification from your employer addressing your COBRA eligibility and a certificate of coverage for proof of 24 months of continuous group coverage.*

☐ **7. Loss of Basic Health Plan (BHP) Coverage:** You have lost or are losing BHP coverage and you had at least 24 months of continuous BHP coverage before such loss and you are submitting your application within 90 days of disenrollment. *Include a letter of verification from your carrier with dates of coverage for proof of your 24 months of eligibility from BHP, or a certificate of coverage.*

SECTION 5 - EXCEPTIONS FOR THE STANDARD HEALTH QUESTIONNAIRE (continued)

☐ 8. **Loss of Group Coverage Due to Business Closure:** You are applying within 90 days of losing your group coverage due to business closure and you had at least 24 months of continuous group insurance coverage immediately prior to your insurance being discontinued. *Include a letter of certification from your employer for proof of 24 months of continuous group coverage. If the certificate of coverage is not available, provide a copy of your pay stub within the last 90 days, or a letter of verification from your company confirming you had group insurance coverage.*

In addition to the exceptions listed on pages 2 and 3, the SHQ is not required for the **subscriber's** natural newborn or newly adopted child if the Company receives the application for coverage within 60 days of birth or placement of adoption (to be effective from date of birth or placement of adoption if the subscriber has active coverage **on** the date of birth or placement of adoption).

Are you adding a newborn to your existing policy? ☐ Yes

Are you adding a newly adopted child to your existing policy? ☐ Yes (include documentation indicating date of placement.)

SECTION 6 - PRODUCER CERTIFICATION

If you have a producer, that producer may receive bonuses, commissions, administrative service fees, or other compensation, including non-cash compensation, from Regence BlueShield. Incentives may be based on any of several factors, including the products you buy, your producer's volume of business with Regence BlueShield, and the other services your producer provides you. These incentives may have an indirect impact on your rates. For more information, please contact your producer.

FOR PRODUCER USE ONLY

I, (the producer) certify I have explained the eligibility provisions to the applicant. I have not made any statements about benefits, conditions or limitations of the contract except through written material furnished by Regence BlueShield. I have informed the applicant that the effective date of coverage is assigned only by Regence BlueShield.

I CERTIFY THAT THE INFORMATION SUPPLIED TO ME BY THE APPLICANT HAS BEEN TRULY AND ACCURATELY RECORDED HERE.

Producer Name (please print or type)	Regence Producer Number
Producer's Signature (Required) **X**	Date (Required)

Producer: COLLECT NO PREMIUM WITH APPLICATION

SECTION 7 - NON-SMOKER CERTIFICATION STATEMENT

Complete this section only if you or your spouse/domestic partner are applying for a non-smokers' discount.

Have you smoked cigarettes, cigars, pipes, or used chewing tobacco, smokeless tobacco, or any other form of tobacco or illegal drug substance within the past 12 months?

Applicant ☐ Yes ☐ No

Spouse/Domestic Partner ☐ Yes ☐ No

PLEASE NOTE: The Company reserves the right to cancel coverage and collect claims payments or other damages if false information is submitted. If you fail to notify us you are no longer eligible for the non-smoker discount, we reserve the right to change the non-smoker discount to the regular rate.

SECTION 8 - CERTIFICATION, AUTHORIZATION AND SIGNATURE

Be sure to sign and date the application below. Spouse/Domestic Partner and/or dependent's (age 18 - 25) signature is required, if applicable. Signature applies to both "Certification of Completeness and Correctness" and "Authorization for Use and Disclosure of Protected Health Information":

CERTIFICATION OF COMPLETENESS AND CORRECTNESS

I affirm that the answers given in this application are true, complete, and correct. I am providing these answers as part of the application procedure required by Regence BlueShield to enroll in their coverage. I understand that Regence BlueShield will rely on each answer in making coverage and rating determinations. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. If coverage is rescinded for fraud or intentionally misleading statements, Regence BlueShield will reimburse premium less any claims paid and will pursue reimbursement for claims paid exceeding any premium. I will promptly inform Regence BlueShield in writing if anything happens before my coverage takes effect that makes this application incomplete or incorrect. I understand and agree that no coverage shall be in force until approved by Regence BlueShield. Regence BlueShield may phone me to clarify answers on this application. As the applicant, I understand I have the right to inspect the information in my file.

I further affirm that I received a disclosure statement from Regence BlueShield or its authorized insurance producer.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the application form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits, or as required by law.*

Health information requested or disclosed may be related to treatment or services performed by:

- a physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- a clinic, hospital, long-term care or other medical facility;
- any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or;
- an insurance carrier or health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). A separate authorization will be required for psychotherapy notes.

I understand that if this application contains any material misstatements or omissions, Regence BlueShield may deny coverage, modify or cancel coverage and/or take any other legal action available to us by law.

* For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Regence Consumer Privacy Notice. A copy is available on our Web site at **www.wa.regence.com** or by telephone request at **1 (800) 365-3155.**

THIS AUTHORIZATION MAY NOT BE USED FOR PSYCHOTHERAPY NOTES
(Notes recorded and separately maintained by a mental health professional documenting or analyzing the contents of a conversation during a counseling session.)

SIGNATURES

Signature of applicant, parent or legal guardian if applicant is under 18 years of age or legally incompetent *	Relationship	Date
X		
Signature of applicant's legal spouse or eligible domestic partner *		Date
X		
Signature of dependent(s) between 18 and 25 years of age *		Date
X		
Signature of dependent(s) between 18 and 25 years of age *		Date
X		

*** If signature by a personal representative of the member/enrollee please complete the following:**

Personal Representative's Name (please print) ______________________________

Relationship to Individual ______________________________ (Attach legal documentation if other than parent of a minor child)

If additional health information is required to qualify you or a family member for coverage, we may send you a separate authorization form for the purpose of obtaining medical information.

SECTION 9 – PREMIUM BILLING OPTIONS (if application is approved)

BILLING ADDRESS (complete only if billing should be sent to an address other than the Residence Street Address listed on the front of the application.)

Name	Relationship to Applicant

Address	City, State, ZIP Code

☐ Yes ☐ No Is your employer reimbursing or paying for any portion of this policy's premium? Individual benefit plans are not intended for sale as an employer-sponsored health benefit plan for employees.

Please indicate which billing option you want to use. (If billing option is left blank, your policy will automatically default to Monthly Billing).

☐ Monthly Billing
☐ Quarterly Billing
☐ Surepay (monthly automatic bank deduction)

Note: If selecting Surepay, please fill out the information below.

SUREPAY is a simple and convenient way to keep your health coverage in force. If you select the SUREPAY option of paying for your Regence BlueShield health insurance the payment will be deducted automatically on the draft date you choose below. This will provide several advantages to you:

- Your payment will always be made on time (if funds are available in your account).
- You won't have to worry about your coverage accidentally lapsing due to overlooked payments.
- Your monthly bank statement will show a withdrawal notation. This will serve as receipt of payment.
- Claims will be paid promptly due to your policy always being paid current.

GETTING STARTED IS EASY by mail or phone:

1. **Complete,** date and sign the Surepay Authorization information below.
2. **Write** "void" on one of your checks and return your "voided" check with this application (not a deposit slip). *For savings account please provide proof of ownership of the account.*

SUREPAY AUTHORIZATION

Please indicate which day you want your payment made.

☐ **5th of the month** - will pay the current month's charges
☐ **15th of the month** - will pre-pay the next month's charges
☐ **25th of the month** - will pre-pay the next month's charges

NOTE: Due to application processing times, it is possible that two months of premium may be deducted from your bank account during the first 31 days of coverage in order to get your account paid to a current status.

AUTHORIZATION TO MY BANK

☐ **Checking Account** ☐ **Savings Account**

As a convenience and on behalf of the Account Holder identified below, I/we hereby request and authorize you to pay and charge to the account identified below, checks or electronic debits drawn on the account by and payable to the order of Regence BlueShield, Seattle, WA. I/we agree that your rights to each such check or electronic debit shall be the same as if it were an actual check drawn on you and signed by me/us. This authority is to remain in effect until revoked by me/us in writing, and until you actually receive such notice, I/we agree that you shall be fully protected in honoring any such check. I/we further agree that if any checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. A photocopy of this executed authorization shall be as valid as the original.

Financial Institution	Transit/Routing Numbers	Account Number

Account Holder's Name (please print)

Account Holder's Authorized Signature(s) - as it appears on bank records

Date