Asuris Northwest Health
528 East Spokane Falls Boulevard
Suite 301
Spokane, WA 99202
Mail form to: PO Box 1106, MS-LB1
Lewiston, ID 83501

Individual Application

Please read carefully and make sure all sections of the application are answered completely. Use ink to complete, sign and date the application to avoid having it returned to you.

SECTION 1 - ELIGIBLE TO APPLY FOR COVERAGE?

You must reside in the plan 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 similar proof of residency acceptable to Asuris Northwest Health (Asuris) may be requested.

For more information, please contact your producer or call our Sales department toll-free at 1-866-704-2708.

SECTION 2 - EFFECTIVE DATE

Your effective date will be assigned in accordance with applicable law. Applications received during the annual enrollment period will be given the effective dates described below:

Application Received:	**Effective Date:**
Before December 15, 2013	January 1, 2014
December 16, 2013 through January 15, 2014	February 1, 2014
January 16 through February 15, 2014	March 1, 2014
February 16 through March 15, 2014	April 1, 2014
March 16 through March 31, 2014	May 1, 2014
April 1 through December 7, 2014	January 1, 2015
Before December 7 of a subsequent year	January 1 of the following year

Applications will not be regarded as received until they are complete.

SECTION 3 - TYPE OF APPLICATION (check one)

☐ **New enrollment** (applying to become a new Asuris member)
☐ **Addition of a spouse/domestic partner and/or child to my existing policy**
☐ **Change to existing individual plan or deductible** (existing Asuris member applying to change benefit plans)

Note: Your policy must be paid current in order for a plan change to be made. If your policy cancels due to non-payment, you will need to reapply by submitting a new Individual Application.

SECTION 4 - ENROLLMENT INFORMATION

List all eligible family members to be covered. Eligible family members include a spouse/domestic partner, and/or any child who is under age 26 or who is medically certified as disabled. Copy of certification required.

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

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

SECTION 5 - ADDRESS AND PHONE NUMBER

Residence Street Address		Mailing Address (if different than residence street address)
City, State, ZIP Code	County	E-Mail Address (will not be disclosed outside of the company)

Home Phone Number	Cell Phone Number	Work Phone Number
( )	( )	( )

SECTION 6 - MEMBER CARD (check one)

☐ **Family Level Card** (all members listed on the same card)
☐ **Member Level Card** (each member on a separate card)

SECTION 7 - MEDICAL PLAN CHOICES (Detailed benefit information can be found online at asuris.com)

Asuris Direct HSA
☐ Asuris Direct Bronze HSA

Asuris Direct HSA with Dental, Vision, Individual Assistance Program (IAP)
☐ Asuris Direct Bronze HSA with Dental, Vision, Individual Assistance Program (IAP)

Asuris Direct
☐ Asuris Direct Silver
☐ Asuris Direct Gold

Asuris Direct with Dental, Vision, Individual Assistance Program (IAP)
☐ Asuris Direct Silver with Dental, Vision, Individual Assistance Program (IAP)
☐ Asuris Direct Gold with Dental, Vision, Individual Assistance Program (IAP)

SECTION 8 - OTHER COVERAGE INFORMATION

1. Do you or any family members have other active health or medical coverage? ☐ Yes ☐ No
   If yes, do you intend to replace your current plan with this contract? ☐ Yes ☐ No
2. Are you currently enrolled in an Asuris 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 Asuris on the effective date of this new individual policy.

Signature ▶ _____ Date _____

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. If current coverage is still active, the Certificate of Coverage can be provided at a later date.

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.					

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 or Mailing Address listed in Section 5 of the application.)

Name (First, Last)

Address	City, State, ZIP Code

EMPLOYER CONTRIBUTION

☐ 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.

PAYMENT OPTIONS (check one):

☐ Monthly Billing ☐ Electronic Funds Transfer (EFT) - premium is automatically deducted from your bank account on the 5th of each month.

If selecting the EFT option:

1. Complete the following **Authorization To My Bank** section.
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.*

AUTHORIZATION TO MY BANK

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 Asuris Northwest Health, Spokane, Washington. 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 or Bank Name	Transit/Routing Numbers	Account Number

Check One: ☐ Checking Account ☐ Savings Account

Account Holder's Name (please print)

▶ _____ _____

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

SECTION 10 - PRODUCER CERTIFICATION

If you have a producer, that producer may receive bonuses, commissions, administrative service fees, or other compensation, including non-cash compensation, from Asuris. Incentives may be based on any of several factors, including the products you buy, your producer's volume of business with Asuris, 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 Asuris. I have informed the applicant that the effective date of coverage is assigned only by Asuris. **I CERTIFY THAT THE INFORMATION SUPPLIED TO ME BY THE APPLICANT HAS BEEN TRULY AND ACCURATELY RECORDED HERE.**

Producer Name (please print or type)	Asuris Producer Number
M.H.R.W. Inc dba: Riverbend Insurance Agency - Kevin Wright	**0102983-0001**

Producer's Mailing Address	Producer's E-mail Address	Producer's Phone Number
118 S. Washington Stree Newport, WA 99156	**riverbend@povn.com**	**509-447-0426**

Producer's Signature (Required)	Date (Required)
X	

Kevin Wright - National Producer # 3120877

SECTION 11 - TOBACCO ABSTINENCE CERTIFICATION STATEMENT

A surcharge is applied to the regular Periodic Rate for an enrolled individual who is Tobacco User. A Tobacco User is a person who may legally use tobacco and has used tobacco (in any form, but excluding any religious or ceremonial use) on average four or more times per week within the last six months.

By my signature below, I certify that I am not a Tobacco User.

PLEASE NOTE: An individual who has signed a tobacco abstinence certification statement and who subsequently becomes a Tobacco User must notify the Company immediately, and the surcharge then will apply to him or her. If false information about tobacco use is submitted or if you fail to notify the Company when changes in your tobacco use would subject you to the tobacco surcharge, the Company reserves the right to take any action available to it, including action to collect unpaid surcharge amounts and/or other damages.

Member Name	Member Name	Member Name
Date	Date	Date

SECTION 12 - CONSENT TO ELECTRONIC DISTRIBUTION

Asuris is engaged in efforts to increase the use of technology and curb the use of paper. In support of those efforts, Asuris has established a process under which communications to members can be posted to a secured account that a member establishes on myAsuris.com, with e-mail notice provided to a member-supplied e-mail account when a new communication is posted.

By my signature and unless I have expressly rejected electronic distribution by marking the checkbox below, I consent, on behalf of myself and any covered dependents, to the electronic distribution of communications related to the coverage applied for and understand that:

- To access electronically distributed communications, I and each of my covered dependents will need to establish myAsuris.com accounts for use on a system meeting the outlined requirements and I represent that we each have and will continue to have access to such a system or systems.
- Not all member communications are currently available electronically, but agree that my consent will apply to the following materials available, or as they become available, for electronic distribution, (i) notices of enrollment and/or effective date, (ii) acknowledgements of receipt of claims, requests for additional information related to claims and notices of associated delays in processing, and determinations on submitted claims, (iii) general informational disclosures required by law, including but not limited to notices of rights under the Women's Health and Cancer Rights Act, state patient protection acts, and privacy laws, (iv) communications regarding complaints, grievances, or appeals, including but not limited to acknowledgements of receipt, requests for additional information and notices of associated delays, and notices of determinations, (v) summaries of benefits and coverage and uniform glossary of terms, (vi) notices of benefit changes or policy modifications, (vii) renewal information, (viii) notices of discontinuation, (ix) notices of termination and continuation coverage rights, (x) certificates of creditable coverage, (xi) billing notices and statements.
- Until a type of communication can be distributed electronically, a paper copy will be provided.
- Once available in electronic form, any electronically distributed communications may be printed from the myAsuris.com account where they are posted, or a paper copy of any particular communication may be requested at any time using myAsuris.com or by contacting Asuris Customer Service at the number provided on my ID card.
- I may change the e-mail address for receipt of notice of electronic distributions or withdraw consent (returning to paper distribution) at any time and without charge using myAsuris.com or by contacting Asuris Customer Service as described in the previous bullet.

The e-mail address for receipt of notice of electronic distributions is _____

☐ I do not want electronic distribution. Unless my consent is not required for an electronic distribution, I elect to receive communications related to this coverage in a paper format.

SECTION 13 - CERTIFICATION, AUTHORIZATION AND SIGNATURE

Be sure to **sign** and **date** this application. Spouse/Domestic Partner and/or child's (age 18-25) signature is required, if applicable. Signature applies to "Consent to Electronic Distribution", "Certification of Completion and Correctness" and "Authorization for Use and Disclosure of Protected Health Information".

Certification of Completion and Correctness

I affirm that the answers given in this application are complete and correct. I am providing these answers as part of the application procedure required by Asuris to enroll in their coverage. I understand that Asuris 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, Asuris will reimburse premium less any claims paid and will pursue reimbursement for claims paid exceeding any premium. I will promptly inform Asuris 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 Asuris. Asuris may contact me to clarify answers on this application. As the applicant, I understand I have the right to inspect the information in my file.

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). **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). A separate authorization will be required.

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

SIGNATURES

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

*** 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)