



IDAHO INDIVIDUAL APPLICATION COVER SHEET FOR ENROLLMENT OUTSIDE OF THE IDAHO EXCHANGE

To apply for **medical** and/or **dental** coverage for 2014, complete this cover sheet and the Idaho Individual Universal Application. Plan information is available at shoppers.bcidaho.com.

Instructions: Please complete pages 1 and 2 of the cover sheet and return it with the completed Idaho Individual Application to Blue Cross of Idaho. This completed application must be received by Blue Cross of Idaho no later than the 15th of the month for a first of the following month effective date. The first month's premium payment must be received by the 20th of the month prior to the effective date. Incomplete information will delay processing of the application. Keep a copy for your records.

SECTION 1 ENROLLMENT INFORMATION

1. Are you: a new applicant (adult) Responsible party (if you are not applying for coverage for yourself but are enrolling children for coverage you are considered the responsible party and not the applicant.

Name of responsible party: _____

Please list each family member enrolling in medical coverage and indicate if they are enrolling in dental. You may choose to exclude yourself or certain family members on the dental plan. The applicant may be a child if no adults are enrolling for coverage.

	DENTAL
Applicant	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent 1	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent 2	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent 3	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent 4	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 2 SELECT A MEDICAL PLAN *(Choose one medical plan from 2.A., 2B. or 2.C. below.)*

2.A. QUALIFIED HEALTH PLAN (QHP)

- Bronze Choice \$6350 Silver Choice \$4000 Gold Choice \$1000
- Bronze HSA Saver \$5000 Silver Choice – No Deductible
- Covered Choice *(Catastrophic)*

2.B. CONNECT PLANS (QHP)

- Bronze Connect \$6350 Silver Connect – No Deductible Gold Connect \$1000
- Silver Connect \$4000 Platinum Connect \$550 (Southwest Only)
- Covered Connect *(Catastrophic)*

Each person enrolled on a Connect Plan must have a designated Primary Care Physician (PCP). If you chose a Connect Plan, please indicate the region of Idaho you live in: **Southwestern** **Eastern**

To help you choose a PCP, you may view the provider directory for the region you live in on our website. For southwestern Idaho, please visit bcidaho.com/SaintAlphonsus and for eastern Idaho, please visit bcidaho.com/Portneuf.

Please indicate each person's Primary Care Physician (PCP) below. If you have more dependents to include, make a copy of this page and attach.

REQUIRED INFORMATION	NAME OF PRIMARY CARE PHYSICIAN (PCP)	PCP ID #
Applicant		
Dependent 1		
Dependent 2		
Dependent 3		
Dependent 4		

P.O. Box 6948 Boise, ID 83707-0938 Sales: 1-888-365-2345 Fax: 208-331-7582

SECTION 3 SELECT A DENTAL PLAN

DENTAL – Please choose the dental plan you wish to enroll in:

- Dental Choice
- Dental Choice Plus
- No Dental*

* Pediatric dental is an essential health benefit and must be included for all plan members under the age of 19. As an issuer of qualified coverage, Blue Cross of Idaho is required to offer a pediatric dental qualified health plan (QHP) for purchase or obtain reasonable assurance from you that you have a pediatric dental QHP provided under other dental coverage. If you are opting to not purchase the Blue Cross of Idaho Dental Choice product, please provide that assurance below:

If you are not selecting dental coverage for any family member under age 19, by signing below, you attest that qualified pediatric dental coverage is provided by other dental coverage.

Signature _____ Date _____

Name of dental carrier _____ Effective date of other dental coverage _____

SECTION 4 TERMINATION OF OTHER COVERAGE

If you have existing coverage that will be replaced by your Blue Cross of Idaho plans, be sure to terminate the other coverage on the applicable date.

Are you currently enrolled in **other Blue Cross of Idaho** medical or dental coverage?

- No** If No, please sign and date below.
- Yes** If Yes, do you wish to terminate this coverage? **Medical** Yes No **Dental** Yes No

Blue Cross of Idaho Identification Number(s) _____

If you are currently enrolled in monthly automatic bank withdraw to pay your monthly premium payment, we will transfer the account information to your new policy.

To view and print a Summary of Benefits and Coverage (SBC) for our standard individual health insurance plans and the uniform glossary, visit our website at bcidaho.com/SBC or contact your local district office at 800-365-2345.

SIGNATURES

Signature _____ Date _____
Applicant or Responsible Party

Signature _____ Date _____
Spouse, if applying for coverage

IDAHO INDIVIDUAL APPLICATION FOR ENROLLMENT OUTSIDE OF THE IDAHO EXCHANGE

Please type or print legibly in black ink and complete all applicable sections.

SECTION 1	ENROLLMENT INFORMATION (check all that apply)
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1. Are you: a new applicant adding dependents enrolling during the annual open enrollment
2. If you are enrolling **outside** of the annual open enrollment or adding dependents, what is the reason
(documentation may be required)? marriage divorce birth adoption involuntary loss of
employer coverage involuntary loss of **individual** coverage involuntary loss of Medicaid
 court order (copy of court order required) other _____
Date of event _____
mm/dd/yyyy
3. Are you a resident of the state of Idaho? Yes No If yes: _____ years _____ months
4. Requested effective date (subject to approval): _____
mm/dd/yyyy

SECTION 2	APPLICANT INFORMATION
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1. **Legal** first name, middle name, last name (and suffix, if applicable)

2. Street Address

3. City	4. State	5. Zip Code	6. County
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7. Mailing Address (Street, Route, P.O. Box) (if different than street address)

8. City	9. State	10. Zip Code	11. County
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12. Billing Address (if different than mailing address)

13. City	14. State	15. Zip Code	16. County
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17. Preferred Daytime Phone Number	18. Alternate Phone Number	19. Date of Birth <small>(mm/dd/yyyy)</small>
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20. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	21. Social Security Number (required)	22. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other _____
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23. Email address

FOR OFFICE USE ONLY	Electronic System ID
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SECTION 3**DEPENDENT INFORMATION** (List all eligible dependents you wish to enroll, including any child who is under the age of 26; or who is medically certified as disabled and dependent on parent for support (copy of certification required). If you have more dependents to include, make a copy of this page and attach.)**Dependent 1**

1. Legal first name, middle name, last name <i>(and suffix, if applicable)</i>		2. Relationship <input type="checkbox"/> legal spouse <input type="checkbox"/> child <input type="checkbox"/> step-child <input type="checkbox"/> Other _____
3. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	4. Date of Birth <i>(mm/dd/yyyy)</i>	5. Social Security Number (required)
6. Does dependent 1 live at the same address as you? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Dependent 2

1. Legal first name, middle name, last name <i>(and suffix, if applicable)</i>		2. Relationship <input type="checkbox"/> legal spouse <input type="checkbox"/> child <input type="checkbox"/> step-child <input type="checkbox"/> Other _____
3. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	4. Date of Birth <i>(mm/dd/yyyy)</i>	5. Social Security Number (required)
6. Does dependent 2 live at the same address as you? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Dependent 3

1. Legal first name, middle name, last name <i>(and suffix, if applicable)</i>		2. Relationship <input type="checkbox"/> legal spouse <input type="checkbox"/> child <input type="checkbox"/> step-child <input type="checkbox"/> Other _____
3. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	4. Date of Birth <i>(mm/dd/yyyy)</i>	5. Social Security Number (required)
6. Does dependent 3 live at the same address as you? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Dependent 4

1. Legal first name, middle name, last name <i>(and suffix, if applicable)</i>		2. Relationship <input type="checkbox"/> legal spouse <input type="checkbox"/> child <input type="checkbox"/> step-child <input type="checkbox"/> Other _____
3. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	4. Date of Birth <i>(mm/dd/yyyy)</i>	5. Social Security Number (required)
6. Does dependent 4 live at the same address as you? <input type="checkbox"/> Yes <input type="checkbox"/> No		

SECTION 4**OTHER INFORMATION**

1. Are you or any dependent listed on this application receiving Worker's Compensation payments or are now eligible to receive such payments? Yes No
If **yes**, give person's name, specific type and details: _____
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2. Has any person listed on this application used a tobacco product on average four or more times a week within no longer than the past six months (anyone age 18 or older)? No Yes If **yes**, list names below:
1. _____ 3. _____
2. _____ 4. _____

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Electronic System ID

Form No.

SECTION 5**OTHER COVERAGE INFORMATION** (Please complete the section below if you have other coverage that will remain in effect. If you have more policies to include, make a copy of this page and attach.)

If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation that shows who is responsible for the dependent(s)' health care insurance so that the insurance carrier can determine whose coverage is primary.

Policy 1

1. Other Insurance Carrier Information: Insurance Carrier Name, Policy Number, Phone Number

2. Policy Holder Name		3. Names of Covered Members	
4. Types of Coverage <i>(check all that apply)</i> <input type="checkbox"/> Group <input type="checkbox"/> COBRA <input type="checkbox"/> Individual <input type="checkbox"/> HRP <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other _____	5. Coverage Start Date <i>mm/dd/yyyy</i>	6. Is this coverage terminating? <input type="checkbox"/> Yes (complete #7) <input type="checkbox"/> No	7. Coverage End Date <i>mm/dd/yyyy</i>

Policy 2

1. Other Insurance Carrier Information: Insurance Carrier Name, Policy Number, Phone Number

2. Policy Holder Name		3. Names of Covered Members	
4. Types of Coverage <i>(check all that apply)</i> <input type="checkbox"/> Group <input type="checkbox"/> COBRA <input type="checkbox"/> Individual <input type="checkbox"/> HRP <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other _____	5. Coverage Start Date <i>mm/dd/yyyy</i>	6. Is this coverage terminating? <input type="checkbox"/> Yes (answer #7) <input type="checkbox"/> No	7. Coverage End Date <i>mm/dd/yyyy</i>

SECTION 6**FEDERALLY ELIGIBLE INDIVIDUAL INFORMATION**

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), guaranteed availability of individual coverage means that if you are HIPAA eligible, you cannot be denied the right to buy individual coverage. In addition, a preexisting condition exclusion cannot be applied to your coverage.

You are HIPAA eligible, also called an "eligible individual," if **ALL** of the following are true at the time you apply for individual coverage in Idaho.

- You are not covered under another group health plan
- Your most recent coverage was not cancelled because you did not pay your premiums or because you committed fraud
- You are not currently eligible for Medicare or Medicaid

If you are HIPAA eligible, you will lose your right to get individual coverage without an exclusion unless you submit an application for individual coverage within 63 days after the day your group coverage or continuation coverage ends. Act promptly to protect your rights.

SECTION 7**AFFIRMATION**

I affirm the answers in this "Idaho Individual Application" are complete and correct. I am providing these answers as part of the application procedure required by this insurance carrier to enroll in its insurance coverage. I understand that the insurance carrier will rely on each answer in making its determination to extend coverage and to determine the type of coverage offered. I understand if I have made any misstatement or omission in this application, the insurance carrier may take any action available by law, including but not limited to, retroactive adjustment of premiums or claims. Further, I understand that any fraud or intentional misrepresentation of material fact in my completion of this application is cause for retroactive termination of coverage by the insurance carrier and/or other action available at law. I will promptly inform the insurance carrier in writing if anything happens before my coverage takes effect that makes an answer on this application incomplete or incorrect. Following receipt of a fully-executed application, coverage will be in force as of the effective date determined by the insurance carrier under applicable law.

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Electronic System ID

Form No.

SECTION 8**STATEMENT OF UNDERSTANDING**

By signing this application, I represent that all my answers are complete and accurate to the best of my knowledge and belief and that I understand and agree to the following conditions:

- No independent producer, agent or employee of the insurance carrier can change any part of this application or waive the requirement that I answer all questions completely and accurately.
- The insurance carrier may terminate or rescind an insured's coverage for any intentional misrepresentation, omission of fact by, concerning, or on behalf of any insured that was or would have been material to the insurance carrier's acceptance of a risk, extension of coverage, provision of benefits or payment of any claim.
- If this application is approved, coverage for me and any eligible persons named on this application will begin on the effective date assigned by the insurance carrier.
- I understand that this application will become part of the contract between the insurance carrier and me.
- I affirm that I have reviewed all answers given on this application and, regardless of whether an independent producer or other person has filled out the answers for me, I verify that the answers are true and complete.

SECTION 9**PREEXISTING CONDITION WAITING PERIOD (OVER 19 YEARS OF AGE)**

NOTICE OF PREEXISTING CONDITION LANGUAGE: I understand that until the first plan year beginning January 1, 2014 or later, a waiting period for preexisting conditions may apply. This means if you have a medical condition before coming to our plan, you might have to wait a specified period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a six-month period. Generally, the six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period began. This preexisting condition exclusion does not apply to pregnancy nor to individuals under the age of 19 years beginning upon the policy renewal on or after September 23, 2010, as provided in the Patient Protection and Affordable Care Act (PPACA).

This exclusion may last up to 12 months from your first day of coverage, or if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is considered creditable coverage and can be used to reduce the preexisting condition exclusion if you have experienced a break in coverage of at least 63 days. To reduce the 12-month exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

SECTION 10**PARENTAL OR GUARDIAN CONSENT TO APPLICATION**

By completing this section and signing this application, I represent that the person listed as the applicant on this application is under 18 years of age and is making application for health coverage with my full knowledge and consent. I hereby accept full responsibility for the payment of premiums and the answers and information provided in this application.

Print Name _____

Date (mm/dd/yyyy) _____

Address (if different than dependent) _____

SECTION 11**ACKNOWLEDGEMENT**

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are eligible for benefits coverage and are listed on the application) 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 group 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 acknowledgement does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

Signature of Applicant _____

Date _____
mm/dd/yyyy

Signature of Spouse _____
(if applying for coverage)

Date _____
mm/dd/yyyy

SECTION 12**INDEPENDENT PRODUCER (AGENT) INFORMATION**

Agent's Name **Kevin Wright - NPN # 3120877** _____

ID No. **008103BC** _____

Signature of Agent _____

Date _____
mm/dd/yyyy

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Electronic System ID _____

Form No.