Washington Individual Enrollment Application

Effective January 1, 2014 (Non-grandfathered)

LifeWise

This application is for health care coverage purchased directly from LifeWise Health Plan of Washington (LifeWise). If you wish to purchase coverage through the Washington Healthplanfinder, you must make application directly through them. Contact them at 855-923-4633 (TTY/TTD 855-627-9604) or www.wahbexchange.org or our LifeWise Sales Department at 888-304-0693.

Please print your answers clearly in ink so we can process your application quickly. Be sure to return all pages to us. Omissions or incomplete answers will result in the return of your application and may cause a delay in the effective date of your coverage, except for sections marked "optional."

1 My Enrollment Information

☐ I am a new applicant

☐ I am a current member. My subscriber ID# is _____ (see your ID card)

I want to →

☐ add my spouse _____ (marriage date) or domestic partner

☐ add my newborn or newly-adopted/placed for adoption child(ren): _____ (placement date)

☐ add my dependent child(ren)

☐ change my plan

2 Am I Eligible?

You're eligible to apply for a LifeWise plan if you are:

- A resident of and have a principal residence in the state of Washington.
- Not entitled to Medicare. If you are 65 or older but not eligible for Medicare, please submit a "Not Eligible for Medicare" document from the Social Security Administration.
- Are applying during an open enrollment period or when you have a qualifying event as described below.

Eligible dependents that can enroll on your plan include your:

- spouse or domestic partner
- natural or legally adopted/placed child(ren) under the age of 26

Open Enrollment Periods

Individuals may apply for enrollment in a LifeWise plan during an open enrollment period. An open enrollment period is the timeframe set by the state of Washington when applicants can enroll. Please refer to **lifewisewa.com** for the dates of an open enrollment period. The completed enrollment application must be postmarked or received electronically before the end of the open enrollment period.

Qualifying Events

Applicants can apply outside of an enrollment period if they experience certain qualifying events. Refer to the table on the next page to determine if your situation qualifies and the documentation you must submit as proof.

2 Am I Eligible? (continued)

Qualifying Events (Application must be received within 31 days of the qualifying event)	Submit a Copy of the Following Document(s). Supporting documents must be received within 31 days of the qualifying event. (60 days for newborns, adopted children, and legal wards.)
Newborn child of the subscriber or enrolled spouse	The completed enrollment application must be received within 60 days of the date of birth.
A child placed for adoption with the subscriber or enrolled spouse	The completed enrollment application must be received within 60 days of the date of placement for adoption.
A child who is designated as the legal ward of the subscriber or enrolled spouse (court-appointed guardianship).	The completed enrollment application and copy of guardianship orders must be received within 60 days of the date of the court order.
A loss of employer sponsored coverage	Your COBRA offer letter **or** a letter from your employer listing each applicant that experienced a loss of coverage.
A loss of Medicaid or other public program providing health benefits	The letter from Medicaid or other program indicating ineligibility **or** loss of coverage.
A loss of coverage due to a dissolution of marriage	The divorce decree **or** annulment paperwork.
A loss of coverage due to a change in residence and your existing health plan does not provide coverage in your new area.	A utility bill from your prior address within the last 90 days **and** a verification letter from your prior carrier.
Loss of COBRA benefits	Your Certificate of Creditable Coverage from your prior carrier showing 18 months of coverage **or** a letter from your prior employer or administrator indicating loss of COBRA benefits.

3 I want to enroll my…

Self (Last, First, Middle Initial)	Social Security Number	Gender: ☐ M ☐ F
	Date of Birth / /	I used tobacco in the last 12 months: ☐ Y ☐ N
Legal Spouse or Domestic Partner (Last, First, Middle Initial)	Social Security Number	Gender: ☐ M ☐ F
	Date of Birth / /	I used tobacco in the last 12 months: ☐ Y ☐ N
Dependent Child—under 26 only (Last, First, Middle Initial)	Social Security Number	Gender: ☐ M ☐ F
	Date of Birth / /	
Dependent Child—under 26 only (Last, First, Middle Initial)	Social Security Number	Gender: ☐ M ☐ F
	Date of Birth / /	
Dependent Child—under 26 only (Last, First, Middle Initial)	Social Security Number	Gender: ☐ M ☐ F
	Date of Birth / /	
Dependent Child—under 26 only (Last, First, Middle Initial)	Social Security Number	Gender: ☐ M ☐ F
	Date of Birth / /	

Home Address (not P.O. Box) **required**	City / State / ZIP	County	Home Telephone Number ( )
Mailing Address (if different from Home Address)	City / State / ZIP	County	Work Telephone Number ( )
Billing Address (if different from Mailing Address)	City / State / ZIP	County	Cell Telephone Number ( )
E-mail Address of Primary Applicant			
Primary language(s), **if other than English (Primary Applicant)**:			

* "Tobacco use" means use of any tobacco product on average four or more times per week within the past 6 months. Tobacco use does not include religious or ceremonial use.

4 Selecting my plan

I want this plan to begin on the ☐ 1st **or** ☐ 15th of _____ (no more than 60 days after the application is signed)
(enter month)
Effective dates for plan changes are on the first of each month.

Health Plan

I want to enroll in the following LifeWise Essential health plan (check only one option):

PPO Plans

- ☐ Gold 1000 w/Kids Dental
- ☐ Silver 2000 w/Kids Dental
- ☐ Silver 3000 w/Kids Dental
- ☐ Bronze 5500 w/Kids Dental
- ☐ Bronze 6350 w/Kids Dental

HSA Plans

- ☐ Silver HSA 2500 w/Kids Dental
- ☐ Bronze HSA 5250 w/Kids Dental

Individual Dental Copay Plan* (check one).

- ☐ $50 deductible plan
- ☐ $75 deductible plan
- ☐ I do not want dental coverage.

* Since children under age 19 enrolled in a medical plan above have dental coverage, this Individual Dental Copay Plan is only for those you are enrolling age 19 and older. You are eligible to enroll adults on the dental copay plan at your first enrollment with LifeWise, and during the annual add-on period. Visit **[lifewisewa.com]** for more information.

Please note: All medical plans on this application include comprehensive dental coverage for enrolled children under age 19.

5 Paying for my health plan (select one) Don't send payment with this application

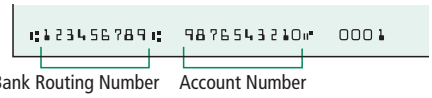
A government agency or any other third party may not sponsor or pay for your individual health plan, except as required by law.

☐ Monthly paper bill by mail (move on to Section 6)

☐ Automatic monthly withdrawal from my bank account. Here's my account information:

I have selected automatic monthly withdrawal and I hereby authorize LifeWise to initiate funds transfer from the bank or financial institution account indicated below. I authorize my financial institution to honor these transfers.

Account Holder's Name (print)	Financial Institution or Bank Name
Financial Institution/Bank City, State, ZIP	☐ Checking ☐ Savings
Bank Routing Number (see picture below, number cannot begin with a "5")	Account Number (see picture below)



Bank Routing Number Account Number

Attach your **voided** check HERE

Additional Terms and Conditions:

- Funds are transferred on the 1st business day of each month to pay for that month's coverage. (For example, the deduction on February 1st pays for coverage in February.)
- I understand that if I choose the 15th of the month as my effective date, my first transfer amount will cover 15 days of the current month PLUS the next full month. Subsequent transfers will be for a full month of coverage.
- It may take as long as 45 days to set up the funds transfer. I may receive a paper bill to cover the initial month(s) while the transfer is being set up.
- I understand that my monthly subscription charges will be automatically withdrawn from my bank account each month until I notify LifeWise that it should be cancelled. To ensure prompt cancellation, I must notify LifeWise no later than the 20th of the month to be effective for the following month's automatic withdrawal. I have the right to stop payment of a specific bank transfer at least 3 days prior to the next scheduled withdrawal date.

Account Holder Signature X _____ Date of Signature ____ / ____ / ____

6 My Other Health Coverage

Do you have other health care coverage?

☐ Yes (complete the information below) ☐ No (move on to Section 7)

Do you intend to continue this current coverage if you are accepted by LifeWise?

☐ Yes ☐ No (Once accepted by LifeWise, remember to cancel your current health plan, including our corporate affiliates.) If you have other coverage in addition to LifeWise coverage, we will coordinate benefits between the multiple health plans.

Prior Coverage?

Remember to attach your Certificate of Creditable Coverage or other documents that verifies your prior coverage beginning and end dates. You can get it from your previous employer or health plan carrier.

Name of Your Previous or Current Health Plan Carrier	Telephone Number ( )
Name of Subscriber (contract holder)	Subscriber ID # (include 3 letter prefix if applicable)
Names of All Enrollees on Prior Coverage	
Date Coverage Began / /	**Date Coverage Ended** / /
Deductible Amount (Circle one) $ individual / family per year	Out-of-Pocket Maximum (Circle one) $ individual / family per year
Type of Coverage ☐ Individual ☐ Group ☐ Healthy Options ☐ Basic Health Plan ☐ WSHIP	Type of Benefits (check all that apply): ☐ Medical ☐ Hospital Only ☐ Accident Only ☐ Prescription Drug ☐ Dental ☐ Vision

7 Health Information (Optional)

To assist you in managing your health, LifeWise provides a range of support programs. In an effort to identify the program appropriate for you or your dependents, please provide the following information. This information is not used to make a decision on your eligibility for coverage. If you need to, please attach an additional piece of paper for information on additional dependents.

Please write names of all those you are enrolling >> and answer the questions below for each person.	Your Name: _____	Dependent: _____	Dependent: _____	Dependent: _____	Dependent: _____
How would you describe your overall health? (Please indicate an "E" for Excellent, "G" for Good, "F" for Fair or "P" for Poor for each the applicant and all listed dependents)					
Please answer the following questions with a "Y" for Yes or a "N" for No for each the applicant and any listed dependents					
Have you thought about doing any of the following to improve your health: stop smoking, lose weight, or getting more exercise?					
If Yes, would you like help with any of these?					
Do you or any of your dependents applying for coverage have diabetes, asthma, heart failure, coronary artery disease, chronic obstructive lung disease (COPD) or any other condition that is treated with medicine, or limits activities?					
If Yes, do you or your dependents see a doctor regularly about the condition?					
Is there anything that stops you or your dependents from taking care of your health as well as you would like?					
In the last three months, have you or your dependents gone to the hospital or emergency room for a condition other than an accident?					

If you answered "Yes," to any questions in Section 7, please provide details below:

Applicant Name (first, last)	Describe the condition

8 Basic Terms of Enrollment

1) I understand and agree that this application is not an offer of coverage, and coverage does not begin until: a) This application is received, reviewed, and accepted by LifeWise and an effective date of coverage is assigned; and b) My complete and correct payment is received. Submission of this application does not guarantee I will receive coverage.
2) I understand and agree that this application becomes a part of my plan and to the extent that the application is inconsistent with the plan, the plan will govern.
3) I understand that this plan will not provide benefits for organ and bone marrow transplants for a period of 12 months from the effective date of my coverage. This waiting period may be credited or waived based on prior health care coverage.
4) I understand that no benefits are available under this plan for services or supplies related to an inpatient confinement that began prior to the effective date of coverage, unless the applicant is an "eligible individual" as defined by Federal law.
5) I understand that acceptance for coverage is dependent on: a) Persons listed on this application must be residents of the state of Washington in order to apply for and maintain coverage under this plan; and b) No one listed on this application is 65 years of age or older and eligible for Medicare on the date coverage would begin. "Resident" means a person who lives in the state of Washington, and intends to live in the state permanently or indefinitely. In no event will coverage be extended to an applicant who resides here for the primary purpose of obtaining healthcare coverage. The confinement of a person in a nursing home, hospital or other medical institution shall not by itself be sufficient to qualify such person as a resident. LifeWise may require proof of residency from time to time. Such proof shall include, but not be limited to, the street address of the individual's residence and not a post office box.
6) I understand and agree that only LifeWise may: a) Make or modify the terms of the application or contract; or b) Waive any of the LifeWise rights or requirements. I understand that I may receive benefits which are less than the amount billed by my provider when treatment is not received from a contracted provider.
7) I understand and agree that this coverage is issued as individual health coverage, is not sold or issued for use as a government, or third party sponsored health plan, and is not partially or fully paid for by a government agency or third party payer, either directly or indirectly, except as required by law.
8) For Dental Copay Plans Only: I understand that dental copay plans have a waiting period for major services (as defined in the contract) of 12 months from the effective date of coverage. This waiting period may be reduced or waived based on prior dental coverage with Premera Blue Cross, LifeWise Health Plan of Washington, LifeWise Health Plan of Oregon, or Premera Blue Cross Blue Shield of Alaska. I understand that pediatric dental (for enrolled members under age 19) is included in the medical plan. I understand that I must maintain current enrollment on a LifeWise Health Plan of Washington individual medical plan in order to enroll in a LifeWise dental plan. If I cancel my LifeWise individual medical plan or lose coverage for any reason, my dental coverage will also end at the same time.

9 Notice of Information Use and Disclosure

Type of Information to be Disclosed: I (We) authorize: any physician, health care provider, hospital, insurance or reinsurance company, pharmacy benefits manager or third party benefits administrator to disclose a copy of my (our) personal health information, including any and all diagnostic, procedural, treatment, claim, prescription or other health related information including records concerning alcohol and/or chemical dependency, reproductive health (including abortion), sexually transmitted diseases, HIV, AIDS, psychiatric disorders, mental illness to LifeWise or its representatives as allowed by law.

Purpose of Disclosure: I (We) understand that personal information will be used for evaluating enrollment in the health plan, determining eligibility for benefits and paying claims.

Timeframe of Release: Unless I revoke it, this release will remain valid for twenty-four (24) months from the date of my signature below.

Revocation of Release: I understand that I may change my mind and revoke this release at any time. I will do this by letting LifeWise know of my decision. Any change will be effective five (5) business days after LifeWise receives my written notice at the address listed on this form. I understand that some or all of this information may already have been used by LifeWise to make decisions, which will not be affected by its revocation.

Redisclosure: LifeWise Health Plan of Washington may be required to redisclose this information to another party that is not subject to state and federal privacy rules.

Effect of Not Authorizing: This authorization is a condition of your enrollment in our health plan or your eligibility for benefits. If you decide not to sign this authorization, we may decline to enroll you in our health plan or to give you benefits.

Please Note: You or your authorized representative will receive a copy of this authorization.

10 My final checklist:

Omissions or incomplete answers will result in the return of your application and may cause a delay in the effective date of your coverage, except for sections marked as "optional."

Did I remember to:

- ☐ Indicate in Section 3 whether my spouse/domestic partner or I use tobacco? This will ensure I pay the correct rate.
- ☐ Choose an effective date in Section 4?
- ☐ Select only one plan option in Section 4?
- ☐ Provide information about my other coverage (if applicable) in Section 6?

Remember to have all applicants age 18 or older sign this application in Section 12.

11 Signatures

I hereby apply for enrollment with LifeWise for myself and family members listed on this application for coverage under the Individual contract indicated on this form. I understand I will have the right to examine and return the contract within 10 days of its delivery to me. I certify that:

a) I have read this form, agree to its terms and I have supplied all of the required information on this form.

b) I have received and read a product information packet containing plan summaries and understand that a complete list of exclusions and limitations is detailed in the contract. If there is a conflict, the terms of the contract prevail.

c) I declare that, to the best of my knowledge, all of the information on all forms necessary for enrollment is true and complete, and that all of the persons for whom I am requesting enrollment are eligible for coverage. I understand that, if I have made false, incomplete, or misleading statements or answers on behalf of myself or any family members, all entitlements to benefits are void and this contract may be cancelled or modified retroactively to its effective date. I further understand that it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Approved applications postmarked or received by the 14th day of the month will be effective on the 15th of that month. A prorated subscription charge will apply for the partial month of coverage. Approved applications postmarked or received by the last day of the month will be effective on the first day of the following month. This does not apply to applicants enrolling during open enrollment.

Important! Signatures are required for all applicants age 18 or older.

Signature of Primary Applicant (Parent/Legal Guardian)	Date of Signature
X	/ /
Signature of Spouse/Domestic Partner	Date of Signature
X	/ /
Signature of Dependent Child age 18 or older	Date of Signature
X	/ /
Signature of Dependent Child age 18 or older	Date of Signature
X	/ /

Mail completed application to:

LifeWise Health Plan of Washington
PO Box 91120, MS 295
Seattle, WA 98111-9220

Phone: 800-592-6804
Fax: 425-918-5278
lifewisewa.com

Please return this page.

12 Your Household Information (optional)

The following information is collected for statistical purposes only, and is not used to determine your eligibility for coverage.

Total Number Of Individuals In Household (includes those not applying for coverage): _____

Household Income (check one)**:**

☐ $0 to $19,999 ☐ $20,000 to $39,999 ☐ $40,000 to $59,999
☐ $60,000 to $74,999 ☐ $75,000 to $99,000 ☐ $100,000 or more

Completion of this section BY THE PRODUCER is required if the producer wishes to be considered as producer of record for the applicant. All producer information must be provided below to ensure credit/commission for the application.

Agency Name	
M.H.R.W. Inc dba: Riverbend Insurance Agency	
Producer Name	LifeWise Producer Number
Kevin Wright - NPN # 3120877	**76475**
Producer Address	
118 S. Washington Newport, Wa 99156	
Producer Telephone Number	Producer E-mail Address
(**509**) **447-0426**	**riverbend@povn.com**
Producer Signature	Date
X	/ /

Please Note: Producers who do not have a current appointment with LifeWise are not authorized to offer LifeWise products.

Please return this page.