

Washington Individual Enrollment Application

Effective January 1, 2014 (Non-grandfathered)



This application is for health care coverage purchased directly from Premera Blue Cross (Premera). 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 Premera Sales Department at 888-304-4755.

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 _____ or domestic partner
(marriage date)

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 Premera Blue Cross 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 Premera 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 premera.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: <input type="checkbox"/> M <input type="checkbox"/> F
	Date of Birth / /	I used tobacco in the last 12 months: <input type="checkbox"/> Y <input type="checkbox"/> N	
Legal Spouse or Domestic Partner (Last, First, Middle Initial)	Social Security Number		Gender: <input type="checkbox"/> M <input type="checkbox"/> F
	Date of Birth / /	I used tobacco in the last 12 months: <input type="checkbox"/> Y <input type="checkbox"/> N	
Dependent Child—under 26 only (Last, First, Middle Initial)	Social Security Number		Gender: <input type="checkbox"/> M <input type="checkbox"/> F
	Date of Birth / /		
Dependent Child—under 26 only (Last, First, Middle Initial)	Social Security Number		Gender: <input type="checkbox"/> M <input type="checkbox"/> F
	Date of Birth / /		
Dependent Child—under 26 only (Last, First, Middle Initial)	Social Security Number		Gender: <input type="checkbox"/> M <input type="checkbox"/> F
	Date of Birth / /		
Dependent Child—under 26 only (Last, First, Middle Initial)	Social Security Number		Gender: <input type="checkbox"/> M <input type="checkbox"/> F
	Date of Birth / /		
Dependent Child—under 26 only (Last, First, Middle Initial)	Social Security Number		Gender: <input type="checkbox"/> M <input type="checkbox"/> 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 Premera Blue Cross Preferred health plan (check only one option):

PPO Plans

Gold 1000 w/Kids Dental

Gold 1500 w/Kids Dental

Silver 2000 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

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

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 Premera 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. Premera 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 Premera may: a) Make or modify the terms of the application or contract; or b) Waive any of the Premera 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.

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 Premera 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 Premera know of my decision. Any change will be effective five (5) business days after Premera 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 Premera to make decisions, which will not be affected by its revocation.

Redisclosure: Premera Blue Cross 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 Premera Blue Cross 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) X	Date of Signature / /
Signature of Spouse/Domestic Partner X	Date of Signature / /
Signature of Dependent Child age 18 or older X	Date of Signature / /
Signature of Dependent Child age 18 or older X	Date of Signature / /

Mail completed application to: Premera Blue Cross
PO Box 91120, MS 295
Seattle, WA 98111-9220

Sales: 888-304-4755
Customer Service: 800-722-1471
Fax: 425-918-5278

premera.com

Please return this page.

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

Kevin Wright

Premera Blue Cross Producer Number

76475

Producer Address

118 S. Washington Newport, WA 99156

Producer Telephone Number

(**509**) **447-0426**

Producer E-mail Address

riverbend@povn.com

Producer Signature

X

Date

/ /

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

Please return this page.