Regence

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

Regence BlueShield of Idaho
1602 21st Avenue
Lewiston, Idaho 83501
Mail form to: PO Box 1106, MS-LB1
Lewiston, ID 83501

Individual Application Cover Sheet

(to be used with the Idaho Individual Application)

SECTION 1 - GENERAL INFORMATION

Applicant's Name (please print)_____

Social Security Number _____ Idaho Driver's License Number _____

(Note: If applying for underage child only, please list parent/legal guardian's Idaho Driver's License Number)

If you are currently eligible for Medicare, or will be on the requested effective date of coverage for which you are applying, you are not eligible for private individual or family health coverage and should not fill out this application cover sheet or the Individual Application.

Note: If you are requesting a change to your existing plan or deductible, your policy must be paid current in order for the change to be made.

The annual open enrollment period for 2014 is between October 1, 2013 and March 31, 2014. Thereafter, the annual open enrollment period is between October 15 and December 7 each year.

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 - MEMBER CARD (check one)

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

SECTION 4 - PLAN SELECTION (Detailed benefit information can be found online at regence.com)

MEDICAL PLANS (check one):

Deductibles are per member (family deductible is 2 times the individual amount)

☐ Regence Direct Bronze HSA $5,000
☐ Regence Direct Bronze HSA $5,000 with Dental, Vision, Individual Assistance Program (IAP)

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SECTION 5 - 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
(mm/dd/yyyy)	(mm/dd/yyyy)	(mm/dd/yyyy)
Date	Date	Date

SECTION 6 - PARENT OR GUARDIAN CONSENT
(Complete only if applicant is under age 18 and will be the only insured)

Notice is hereby given that _____ Social Security Number _____ who is under the age of eighteen years is making application for individual health care coverage, with my full knowledge and consent. I request that you consider the child for such health care coverage. I accept full responsibility for the payment of monthly premium and the contents of the application attached hereto.

Signature ▶ _____ Date (mm/dd/yyyy) _____

Print Name _____ Relationship to Child _____

Address _____ Phone Number ((xxx) xxx-xxxx _____

SECTION 7 - DEFINITION OF DEPENDENT

Dependent means: (1) The legal spouse or domestic partner of the Policyholder; and/or (2) the child of a Policyholder or Policyholder's spouse or domestic partner, up to the age of twenty-six (26); or (3) a child of any age who is medically certified as intellectually disabled or physically handicapped. The term “children” includes natural, step, or adopted children, or children in the process of adoption from the time placed with the Policyholder. ’Children’ also includes a child for whom a Policyholder or Policyholder’s spouse or domestic partner has court-appointed legal guardianship or is required to provide coverage by virtue of a qualified medical child support order (QMSCO).

SECTION 8 - CHILD CUSTODY INFORMATION

If natural parents are separated or divorced, please indicate below who has legal custody of the child(ren). Please use additional paper if needed. 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 carrier can determine whose coverage is primary.

Name of Child(ren)	Father	Mother	Joint	Other	Date awarded	Who is required to provide coverage for the child(ren)?
	☐	☐	☐	☐	(mm/dd/yyyy)	
	☐	☐	☐	☐	(mm/dd/yyyy)	
	☐	☐	☐	☐	(mm/dd/yyyy)	

SECTION 9 - CONTINUING COVERAGE

Will anyone listed on this application have other medical and/or dental insurance, including Medicare, while covered on this plan? ☐ Yes ☐ No

If answered yes above, please complete the following:

Policyholder of other coverage	Name of covered Members: Self and Dependent(s)	Insurance Company (Name & Phone Number)	Policy Number	Effective Date	Product and Coverage Type
		(xxx) xxx-xxxx		(mm/dd/yyyy)	**Coverage Type:** ☐ Group ☐ Individual **Product Type:** ☐ Medical ☐ Dental **Medicare:** ☐ PartA ☐ PartB ☐ PartD
		(xxx) xxx-xxxx		(mm/dd/yyyy)	**Coverage Type:** ☐ Group ☐ Individual **Product Type:** ☐ Medical ☐ Dental **Medicare:** ☐ PartA ☐ PartB ☐ PartD
		(xxx) xxx-xxxx		(mm/dd/yyyy)	**Coverage Type:** ☐ Group ☐ Individual **Product Type:** ☐ Medical ☐ Dental **Medicare:** ☐ PartA ☐ PartB ☐ PartD
		(xxx) xxx-xxxx		(mm/dd/yyyy)	**Coverage Type:** ☐ Group ☐ Individual **Product Type:** ☐ Medical ☐ Dental **Medicare:** ☐ PartA ☐ PartB ☐ PartD
		(xxx) xxx-xxxx		(mm/dd/yyyy)	**Coverage Type:** ☐ Group ☐ Individual **Product Type:** ☐ Medical ☐ Dental **Medicare:** ☐ PartA ☐ PartB ☐ PartD
		(xxx) xxx-xxxx		(mm/dd/yyyy)	**Coverage Type:** ☐ Group ☐ Individual **Product Type:** ☐ Medical ☐ Dental **Medicare:** ☐ PartA ☐ PartB ☐ PartD

Reason for Medicare Entitlement (if applicable): ☐ Age ☐ Disability ☐ Dual Entitlement ☐ ESRD

SECTION 10 - ACKNOWLEDGEMENT

By signing the attached Individual Application, you understand and agree to the terms and conditions set forth on this cover sheet as well as the terms and conditions set forth on the attached application. If you are declined the coverage you applied for, the carrier must offer the High Risk Pool (HRP) Plans.

I certify that all statements contained herein are true to the best of my knowledge. I understand that any misrepresentation, omission, or inaccurate information required herein shall prevent recovery under the policy if such answer is fraudulent or materially affects the risk assumed by Regence. I understand this request will be underwritten to determine the extent of my eligibility, and that Regence will consider all medical information currently on file. I hereby expressly authorize any physician or hospital, or any other health care provider, to disclose to Regence any information obtained by having attended me or hereafter attending or examining me, and I understand that Regence will not disclose any information so obtained, except as permitted by law.

SECTION 11 - YOUR PRIVACY

For information about the use and disclosure of health information, including uses and disclosures required by law, please refer to the Regence Consumer Privacy Notice. A copy is available on our Web site at **regence.com.**

SECTION 12 – PREMIUM BILLING OPTIONS

BILLING ADDRESS (Complete only if billing should be sent to an address other than the Mailing Address listed on the application.)

Name (First, Last)	County (*Required)

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):

If no payment option is checked, your policy will automatically default to Monthly Billing.

☐ 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 Regence BlueShield of Idaho, Lewiston, Idaho. 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)

▶ _____ (mm/dd/yyyy)

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

SECTION 13 - CONSENT TO ELECTRONIC DISTRIBUTION

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

By my signature below 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 myRegence.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 myRegence.com account where they are posted, or a paper copy of any particular communication may be requested at any time using myRegence.com or by contacting Regence 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 myRegence.com or by contacting Regence Customer Service as described in the previous bullet.

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

☐ 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.

Signature ▶ _____ Date _____ (mm/dd/yyyy)

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)

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) *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) *mm/dd/yyyy*

SECTION 2 APPLICANT INFORMATION

1. **Legal** first name, middle name, last name *(and suffix, if applicable)*

2. Street Address

3. City	4. State	5. Zip Code	6. County

7. Mailing Address *(Street, Route, P.O. Box) (if different than street address)*

8. City	9. State	10. Zip Code	11. County

12. Billing Address *(if different than mailing address)*

13. City	14. State	15. Zip Code	16. County

17. Preferred **Daytime** Phone Number (xxx) xxx-xxxx	18. Alternate Phone Number (xxx) xxx-xxxx	19. Date of Birth *(mm/dd/yyyy)* (mm/dd/yyyy)

20. Gender ☐ Male ☐ Female	21. Social Security Number **(required)**	22. Marital Status ☐ Single ☐ Married ☐ Other _____

23. Email address

Email address

FOR OFFICE USE ONLY	Electronic System ID

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 *(and suffix, if applicable)*

2. Relationship
☐ **Legal** Spouse ☐ Child
☐ Step-Child
☐ Other _____

3. Gender
☐ Male ☐ Female

4. Date of Birth *(mm/dd/yyyy)*
(mm/dd/yyyy)

5. Social Security Number **(required)**

6. Does dependent 1 live at the same address as you? ☐ Yes ☐ No

Dependent 2

1. **Legal** first name, middle name, last name *(and suffix, if applicable)*

2. Relationship
☐ **Legal** Spouse ☐ Child
☐ Step-Child
☐ Other _____

3. Gender
☐ Male ☐ Female

4. Date of Birth *(mm/dd/yyyy)*
(mm/dd/yyyy)

5. Social Security Number **(required)**

6. Does dependent 2 live at the same address as you? ☐ Yes ☐ No

Dependent 3

1. **Legal** first name, middle name, last name *(and suffix, if applicable)*

2. Relationship
☐ **Legal** Spouse ☐ Child
☐ Step-Child
☐ Other _____

3. Gender
☐ Male ☐ Female

4. Date of Birth *(mm/dd/yyyy)*
(mm/dd/yyyy)

5. Social Security Number **(required)**

6. Does dependent 3 live at the same address as you? ☐ Yes ☐ No

Dependent 4

1. **Legal** first name, middle name, last name *(and suffix, if applicable)*

2. Relationship
☐ **Legal** spouse ☐ Child
☐ Step-Child
☐ Other _____

3. Gender
☐ Male ☐ Female

4. Date of Birth *(mm/dd/yyyy)*
(mm/dd/yyyy)

5. Social Security Number **(required)**

6. Does dependent 4 live at the same address as you? ☐ Yes ☐ 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: _____

   _____

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. _____

FOR OFFICE USE ONLY	Electronic System ID

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 *(check all that apply)* ☐ Group ☐ COBRA ☐ Individual ☐ HRP ☐ Medicare ☐ Medicaid ☐ Other _____	5. Coverage Start Date *mm/dd/yyyy* (mm/dd/yyyy)	6. Is this coverage terminating? ☐ Yes (complete #7) ☐ No	7. Coverage End Date *mm/dd/yyyy* (mm/dd/yyyy)

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 *(check all that apply)* ☐ Group ☐ COBRA ☐ Individual ☐ HRP ☐ Medicare ☐ Medicaid ☐ Other _____	5. Coverage Start Date *mm/dd/yyyy* (mm/dd/yyyy)	6. Is this coverage terminating? ☐ Yes (answer #7) ☐ No	7. Coverage End Date *mm/dd/yyyy* (mm/dd/yyyy)

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.

FOR OFFICE USE ONLY	Electronic System ID

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)* (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) *mm/dd/yyyy*

Signature of Spouse _____ Date (mm/dd/yyyy) *mm/dd/yyyy*
(if applying for coverage)

SECTION 12 INDEPENDENT PRODUCER (AGENT) INFORMATION

Agent's Name Kevin Wright NPN # 3120877 ID No. 0001467-0001

Signature of Agent _____ Date (mm/dd/yyyy) *mm/dd/yyyy*

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