-OFFICE USE ONLY-	
POLICY NUMBER	POLICY EFF. DATE

IDAHO INDIVIDUAL APPLICATION

Type of Enrollment:
☐ New Applicant
☐ Adding Dependents
Requested effective date:

_____
(Subject to insurance carrier approval)

Change current enrollment because of the following event:
☐ Marriage ☐ Divorce ☐ Birth
☐ Death ☐ Adoption
☐ Court order (copy of court order required)
☐ Other _____
Date event occurred _____
MM DD YYYY

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

APPLICATION INFORMATION

Applicant / Insured Name				Occupation	☐ Single ☐ Married ☐ Other _____
Street Address	City	State	Zip		Home Phone No.
Mailing Address	City	State	Zip		Work Phone No.
Billing Address	City	State	Zip		E-mail Address

List all family members you wish to enroll, including any unmarried child who is under age 21; or who is under age 25, a full-time student and financially dependent upon you; or who is medically certified as disabled and dependent upon you for support (copy of certification required).

Self and Dependent's Names (First, Initial, Last)	Relationship to Applicant	Date of Birth	Sex	Full-time Student?	Weight	Height	Social Security Number
Applicant / Insured	Self			☐ Yes ☐ No			
Spouse				☐ Yes ☐ No			
Child				☐ Yes ☐ No			
Child				☐ Yes ☐ No			
Child				☐ Yes ☐ No			

List all other eligible dependents not applying for coverage at this time:

_____

CURRENT / PRIOR COVERAGE INFORMATION

Please indicate for **EACH** person listed on this application any health insurance coverage (including Medicare, Medicaid, FEHBP, uniformed services, Indian Health Service, high risk pool or other creditable coverage) in effect within 12 months prior to the proposed effective date of this coverage. Each person applying for coverage must be listed below. If no health insurance coverage was in effect within the past 12 months, please indicate **NONE**. **If you have had coverage within 63 days of this coverage effective date, a *Certificate of Health Plan Coverage* or proof of existing coverage must be provided to accurately credit your waiting periods. If you have cancelled High Risk Pool (Basic, Standard, Catastrophic A or B, HSA) coverage within the past 12 months, you may not be eligible for coverage unless you are a federally defined eligible individual. Please read the *Notice of Federal Eligibility* on the bottom of page 3 of this application.**

Applicant's Name	Insurance Company (Policy # and Phone #)	Dates of Coverage MONTH / DAY / YEAR FROM	TO	Will continue any current coverage?	Type of Coverage
Applicant / Insured		MM / DD / YYYY	MM / DD / YYYY	☐ Yes ☐ No	☐ Group ☐ Individual ☐ High Risk Pool ☐ Cobra
Spouse				☐ Yes ☐ No	☐ Group ☐ Individual ☐ High Risk Pool ☐ Cobra
Child				☐ Yes ☐ No	☐ Group ☐ Individual ☐ High Risk Pool ☐ Cobra
Child				☐ Yes ☐ No	☐ Group ☐ Individual ☐ High Risk Pool ☐ Cobra
Child				☐ Yes ☐ No	☐ Group ☐ Individual ☐ High Risk Pool ☐ Cobra

List applicants eligible for coverage under any other plan (Group, Medicare, Medicaid, etc.) and type of plan eligiblity:

_____

_____

HEALTH STATEMENT

INSTRUCTIONS:

1.) Each medical question below applies to all persons listed on this application who desire coverage.
2.) The questions apply to both past and present symptoms, conditions, diseases, illnesses, accidental injuries, or deformities (health conditions).
3.) Answer the questions below either Yes or No. Each of the questions must be answered. Answer Yes to a question if you or any family member for whom you want to obtain coverage now has, or at any time in the past has experienced or received care for the health condition or event specified in that question.
4.) Answer each question accurately and explain any conditions you answered yes to in the boxes provided below.
5). Do not leave any question unmarked.
6.) No agent or any other person can waive these requirements or is authorized to set forth anything less than a complete and accurate response to each of the questions. The Insurance Carrier shall not be bound by an attempted waiver of complete answers to the questions set forth below.
7.) If you learn at any time before approval of coverage by the Insurance Carrier that any answer on this application is incomplete, you must advise the Insurance Carrier.

	Yes	No
1. Are you, your spouse, any eligible dependent child, or mate, whether or not listed on this application, now pregnant?	☐	☐
Due Date _____		
Complications anticipated?	☐	☐
Prior or anticipated multiple births?	☐	☐
2. Used any medication or drug within the past 12 months? (list below)	☐	☐
3. Positive test for HIV (Human Immunodeficiency Virus) infection	☐	☐
4. Acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC)	☐	☐
5. Alcoholism, drinking problem, drug abuse, or convicted of DUI/DWI	☐	☐
6. Allergies or Hay Fever	☐	☐
7. Anemia or blood condition	☐	☐
8. Arthritis or rheumatism	☐	☐
If yes, list type _____		
9. Asthma or chronic bronchitis	☐	☐
10. Attempted suicide	☐	☐
11. Back or joint condition	☐	☐
If yes, pins in place? _____		
12. Bladder or kidney condition	☐	☐
13. Bone infection	☐	☐

	Yes	No
14. Bodily deformity or congenital disease/defect	☐	☐
15. Breast condition or fibrocystic breast disease	☐	☐
16. Cancer	☐	☐
17. Colon / Bowel / Rectal condition	☐	☐
18. Depression	☐	☐
19. Diabetes	☐	☐
20. Disorders of the female reproductive organs/Infertility	☐	☐
21. Disorders of the male reproductive organs including the prostate/infertility	☐	☐
22. Dizziness or headaches	☐	☐
23. Epilepsy or seizure condition	☐	☐
24. Eye, ear, nose or throat condition	☐	☐
25. Gallstone or gall bladder condition	☐	☐
26. Heart or cardiovascular condition	☐	☐
27. Hernia or rupture	☐	☐
28. High blood pressure	☐	☐
If yes, last reading and date _____		
29. High cholesterol	☐	☐
If yes, last reading and date _____		
30. Liver conditions, cirrhosis or hepatitis	☐	☐
If yes, list type _____		

	Yes	No
31. Lung conditions or emphysema	☐	☐
32. Lupus	☐	☐
33. Melanoma	☐	☐
34. Mental or nervous conditions	☐	☐
35. Mental retardation	☐	☐
36. Neurological conditions	☐	☐
37. Phlebitis / Blood clot	☐	☐
38. Polio	☐	☐
39. Sinus conditions	☐	☐
40. Stomach conditions or ulcers	☐	☐
41. Stroke or paralysis	☐	☐
42. Thyroid or pituitary conditions	☐	☐
43. Tuberculosis	☐	☐
44. Tumor, growth, or cyst	☐	☐
45. Ulcerative colitis or Crohn's Disease	☐	☐
46. Varicose Veins	☐	☐
47. Any other condition or treatment in the last 5 years	☐	☐

Other Information

48. Are you a U.S. Citizen?	☐	☐
49. Are you a resident of the state of Idaho?	☐	☐
years _____ months _____		
50. Do you have a family doctor?	☐	☐
Name _____		

If you answered Yes to any question above, please explain below. Use extra paper if necessary.

Item NO.	Patient's Name	Diagnosis/Condition Type of Treatment	Physician's Name and Address	Date of Illness	Date of Last Visit	Was Recovery Complete?

List any medications or drugs taken by all applicants within the past 12 months. Use extra paper if necessary.

Item NO.	Patient's Name	Medication Name	Prescribing Physician and Address	Condition Requiring Medication	Still Taking?

Are you or any of your dependents currently disabled? ..... Yes ☐ No ☐

Name of Disabled Person _____

Physician's Name and Phone Number _____

Date of Disability _____

Physician's Address (street, city, state, and zip code) _____

Nature of Disability _____

Has any person listed on this application used tobacco during the past twelve (12) months? ..... Yes ☐ No ☐

If yes, list applicant's name(s) _____

Has surgery, diagnostic testing, medical treatment or follow up visit been advised (but not yet performed) for any person listed on this application? ..... Yes ☐ No ☐

If Yes, give person's name and details: _____

Has any named person incurred medical expenses or claims exceeding $10,000 in the past 24 months? ..... Yes ☐ No ☐

If Yes, give person's name and details: _____

Are you or any family members listed on this application covered on Medicare or have received Social Security Disability or Workers' Compensation payments or are now eligible to receive such payments? ..... Yes ☐ No ☐

If Yes, give person's name and details: _____

Has any insurance carrier refused, restricted (including waiver or condition), or rated any health coverage for you or any dependents listed on this application? ..... Yes ☐ No ☐

If Yes, please explain (list applicant's name, medical condition and whether refusal, waiver, or restriction) _____

_____

Name of Insurance Carrier _____ Date of refusal, etc. _____
(Please attach a copy of refusal letter, if applicable)

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 pre-existing 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 have at least (in Idaho) 12 months of continuous creditable coverage without any break in coverage greater than 63 days
- Your most recent coverage was under a group health plan, a governmental plan or a church plan (or health insurance offered in connection with such a plan)
- 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 health coverage or continuation coverage ends. Act promptly to protect your rights.

AFFIRMATION

I affirm the answers given 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 this application contains any material misstatements or omissions, the insurance carrier may, within the first 24 months of coverage, deny coverage retroactively and / or take any other legal action available by law. I will promptly inform the insurance carrier in writing if anything happens before my coverage takes effect that makes any answer in this application incomplete or incorrect. I understand that a twelve month waiting period for coverage of pre-existing conditions may apply. I understand and agree no coverage shall be in force until approved by the insurance carrier. If approved, coverage will be in force as of the effective date determined by the carrier.

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, or of my employer 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 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.**
- NOTE: A pre-existing condition is a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the effective date of coverage; a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage; or a pregnancy existing on the effective date of coverage.

I have been advised that if I am declined coverage under the plan I am applying for, that I may be eligible for my choice of the High Risk Basic, Standard, Catastrophic A, Catastrophic B, or HSA plans. I have also been advised that I may be eligible for one of the High Risk Basic, Standard, Catastrophic A, Catastrophic B, or HSA plans, if my insurance carrier refuses to issue a health benefit plan providing coverage substantially similar to coverage offered under an equivalent High Risk Pool plan except at a rate exceeding the rate of the High Risk Pool plan.

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 enrollment form) 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 _____

Signature of Spouse _____ Date _____

AGENT INFORMATION

Agent's Name David Wolfe ID No. BC 1678

Signature of Agent _____ Date _____

INDIVIDUAL UNIVERSAL APPLICATION COVER SHEET

This form must accompany all Idaho Individual (Universal) Applications

Blue Cross of Idaho

You are eligible to apply for individual program coverage unless: (1) part or all of the premium is paid by your employer, either directly or indirectly through wage adjustments or other means of reimbursement; or (2) the health coverage is to be treated as part of a plan or program under Internal Revenue Code Section 106 (contributions by employer to accident and health plans), Section 125 (cafeteria plans) or Section 162 (trade or business expenses, except special rules for health insurance costs of self-employed individuals).

Will any portion of the health coverage premium be paid by an employer, either directly or indirectly through wage adjustments or other means of reimbursement, or is health coverage to be treated as part of a plan or program under Internal Revenue Code Section 106, 125 or 162?

❍ **Yes** ❍ **No** If your answer is Yes, you are not eligible for individual coverage. If your answer is No, you may proceed with this individual application.

Complete every section in ink.

Are you a Federally Eligible Individual as defined on the back of this cover sheet? ❍ **Yes** ❍ **No** If **Yes**, you may apply for any of the preferred programs or the High Risk Pool (HRP) programs. If **No**, please complete and submit the application for a premium quote for one of the preferred programs.

APPLICANT INFORMATION	DISTRICT OFFICE INFORMATION
Applicant's Name (first, initial, last)	**Area Number**
Blue Cross of Idaho Identification Number *(if currently enrolled)*	**Telephone Number** ( )
Applicant's Social Security Number	**Initials**

THE INFORMATION ON THIS COVER SHEET AND THE APPLICATION MUST BE COMPLETED IN FULL. INCOMPLETE INFORMATION WILL DELAY PROCESSING OF THE APPLICATION. YOU MUST ALSO SIGN THE ***STATEMENT OF UNDERSTANDING*** ON THE BACK OF THIS FORM.

PROGRAM INFORMATION

PREFERRED PROGRAMS

*Non-creditable under Medicare Part D**			*No drug coverage; Medicare Part D does not apply*
❍ BlueCare® PPO 1000 ❍ BlueCare® PPO 2000 ❍ BlueCare® PPO 5000 ❍ Supplemental Accident for BlueCare® PPO ❍ Essential Blue℠ **PLUS** PPO 1000** ❍ Essential Blue℠ **PLUS** PPO 2000** ❍ Essential Blue℠ **PLUS** PPO 3000** ❍ Essential Blue℠ **PLUS** PPO 5000**	❍ Simply Blue℠ ($2,500/70%) ❍ Simply Blue℠ ($5,000/70%) ❍ Simply Blue℠ ($7,500/70%) ❍ Simply Blue℠ ($10,000/100%) ❍ Simply Blue℠ with buy-up ($2,500/70%) ❍ Simply Blue℠ with buy-up ($5,000/70%) ❍ Simply Blue℠ with buy-up ($7,500/70%) ❍ Simply Blue℠ with buy-up ($10,000/100%) ❍ Latitude	❍ HSA Blue℠ PPO Single ($2,000/80%) ❍ HSA Blue℠ PPO Single ($3,000/80%) ❍ HSA Blue℠ PPO Single ($2,000/90%) ❍ HSA Blue℠ PPO Single ($3,000/90%) ❍ HSA Blue℠ PPO Single ($5,000/100%) ❍ HSA Blue℠ PPO Family ($4,000/80%) ❍ HSA Blue℠ PPO Family ($6,000/80%) ❍ HSA Blue℠ PPO Family ($4,000/90%) ❍ HSA Blue℠ PPO Family ($6,000/90%) ❍ HSA Blue℠ PPO Family ($10,000/100%)	❍ Essential Blue℠ **BASIC** PPO 1000** ❍ Essential Blue℠ **BASIC** PPO 2000** ❍ Essential Blue℠ **BASIC** PPO 3000** ❍ Essential Blue℠ **BASIC** PPO 5000**

*Non-creditable prescription drug coverage is that which, on average, is not expected to pay out as much as the standard Medicare prescription drug coverage.

****Essential Blue is a Limited Benefit Health Plan. Benefits are not intended to cover all medical expenses.**
The terms "creditable" and "non-creditable" apply to Medicare Part D and are not related to preexisting condition qualifications.

HIGH RISK POOL (HRP) PROGRAMS

You are eligible to apply if:

- you do not qualify for a preferred program because of an existing health condition
- your premium for a preferred program would exceed the premium for an HRP program
- you are a federally qualified individual as defined on page 3 of the Idaho Individual Application

❍ Idaho Basic ❍ Idaho Standard ❍ Idaho HSA ❍ Idaho Catastrophic A ❍ Idaho Catastrophic B

PAYMENT OPTIONS

❍ Automatic monthly bank withdrawal ***(authorization form will be sent to you – $2.00 monthly service fee will apply until authorization is received)***

❍ Monthly – direct ***(payment must include $2.00 service fee)***

OTHER COVERAGE INFORMATION

If other coverage has not terminated, please read the following: Anyone listed on this application who has other coverage presently in effect is not eligible for coverage under any of the programs listed on this application. By signing this application, the applicant hereby certifies that if approved for coverage by Blue Cross of Idaho, the applicant and any listed family members will terminate present health insurance coverage no later than one (1) month after the effective date of coverage being applied for with this application. If such other coverage is not terminated as required, coverage with Blue Cross of Idaho will be rescinded retroactively to the effective date.

If any person listed on this application is covered by Medicare, please complete the following:

NAME	MEDICARE BENEFICIARY NUMBER	REASON FOR MEDICAL ENTITLEMENT *(age, disability or ESRD)*

DATE OF MEDICARE ENTITLEMENT: Part A _____/_____/_____ (mm dd yy) Part B _____/_____/_____ (mm dd yy)

PARENTAL OR GUARDIAN CONSENT TO APPLICATION

I, the undersigned, represent that the person listed as the applicant on this application is under 18 years of age and is making application for Blue Cross of Idaho 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.

SIGNATURE	PRINT NAME	DATE *(mm/dd/yy)*

Office Use Only

Program No.	Enrollee ID	Effective Date	Cr. Days	End Date	Class	Plan
Reason Code	**Risk**	**Smoker**	**Bill Mode**	**Payment Received**	**Receipt ID**	**Auditor**

STATEMENT OF UNDERSTANDING

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

- No Independent Producer, agent or employee of Blue Cross of Idaho may alter any part of this application or waive the requirement that I answer all questions completely and accurately, nor may any such person change the terms of the policy, except by endorsement issued expressly for that purpose over the signature or facsimile signature of the President of Blue Cross of Idaho.
- Blue Cross of Idaho may, at its discretion, request supplemental information from me, any family member listed on this application, or any health care providers before deciding whether to approve or reject the application.
- Blue Cross of Idaho may deny benefits or terminate or rescind my policy retroactive to its effective date for any misrepresentation, omission, or concealment of fact by, concerning, or on behalf of any persons listed on this application that was or would have been material to Blue Cross of Idaho's acceptance of a risk, extension of coverage, provision of benefits, or payment of any claim.
- If this application is not approved for the program(s) applied for upon initial review, any payment submitted with this application will be refunded. Upon the refund of the payment, Blue Cross of Idaho will have no further obligations to me or any family member listed on this application.
- If this application is approved coverage for myself and any eligible family members named on this application will begin on the date assigned by Blue Cross of Idaho.
- If this application is approved, I understand a copy of the application will be attached to my policy. I approve the inclusion of any needed alterations to the application as long as I have been consulted by a duly authorized employee of Blue Cross of Idaho or a licensed and duly appointed Independent Producer representing me, the alterations are duly noted in the "Processing Notations" section of the application, and I have had an opportunity to review the application that will be attached to my policy.
- 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 enrollment 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. For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Blue Cross of Idaho Notice of Privacy Practices that is available at ***www.bcidaho.com***.
- I have been advised that if I am declined coverage under the plan I am applying for, I may be eligible for my choice of the High Risk Basic, Standard, Catastrophic A, Catastrophic B or Idaho HSA plans. I have also been advised that I may be eligible for one of the High Risk Basic, Standard, Catastrophic A, Catastrophic B or Idaho HSA plans if Blue Cross of Idaho refuses to issue a health benefit plan providing coverage substantially similar to coverage offered under an equivalent High Risk Pool plan except at a rate exceeding the rate of the High Risk Pool plan.
- If you have had group or individual coverage or a government health care program for at least 12 months, you are entitled to receive a Certificate of Creditable Coverage from your previous employer or insurance company. This document will state the effective date of prior coverage and the termination date of coverage for you and any covered dependents. Your previous employer or insurance company will furnish you this certificate upon request. If you need assistance in obtaining a certificate, Blue Cross of Idaho can assist you.
- **I affirm that I have reviewed all the answers given on this application and, if an Independent Producer or other person has filled out the answers for me and on my behalf, I verify the answers accurately reflect all the information given by me. I certify that the answers given on the "Health Statement" section are complete and accurate. I understand that this application will become part of any agreement or policy that Blue Cross of Idaho issues.**

IF SELECTING THE ESSENTIAL BLUE POLICY: THE ESSENTIAL BLUE POLICY PROVIDES LIMITED BENEFITS. REVIEW YOUR POLICY CAREFULLY.

X _____ _____
Applicant's Signature (Parent or Guardian's signature if applicant is under age 18) Date

X _____ _____
Spouse's Signature (if listed on application) Date

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:

- You have at least 18 months of continuous creditable coverage without any break in coverage greater than 63 days
- Your most recent coverage was under a group health plan, a governmental plan or a church plan (or health insurance offered in connection with such a plan)
- 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 health coverage or continuation coverage ends. Act promptly to protect your rights.

MEDICARE PART D CREDITABLE / NON-CREDITABLE

Blue Cross of Idaho's individual products are categorized as "creditable" or "non-creditable" for purposes of Medicare Part D. If you are a person nearing age 65 or an individual under 65 who is entitled to Medicare, the creditable/non-creditable information is important to you.

When you become eligible for Medicare, you can enroll in Medicare Part D. If you do not sign up when first eligible, you may generally enroll between November 15 and December 31 of each year.

If you do not sign up when first eligible and/or if you go 63 days or longer without prescription drug coverage that is creditable (at least as good as the standard Medicare prescription drug coverage), you may have to pay a higher monthly premium.

- The higher premium is based on the number of months you did not have creditable coverage.
- The penalty is 1% per month without creditable coverage. For example, if you went 19 months without creditable coverage and then signed up for Medicare Part D, your premium would be 19% higher than the premium rate at the time you sign up.

Creditable prescription drug coverage is that which, on average, is expected to pay out as much as the standard Medicare prescription drug coverage.

Non-creditable prescription drug coverage is that which, on average, is **not** expected to pay out as much as the standard Medicare prescription drug coverage.

Blue Cross of Idaho

NOTICE TO APPLICANT

WILL THE PROGRAM YOU ARE APPLYING FOR REPLACE ANY OTHER ACCIDENT AND SICKNESS INSURANCE PRESENTLY IN FORCE?

❑ No Print Name: _____

Signature: _____

Social Security Number: _____ Date of Birth: _____

❑ Yes If Yes, please read and sign below.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to the application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Blue Cross of Idaho. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits present under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on: _____
Date

_____
Print Name

_____
Signature

Social Security Number: _____

Date of Birth: _____

Blue Cross of Idaho member ID number (if applicable): _____

3000 E. Pine Avenue, Meridian, ID 83642-5995 • P.O. Box 7408, Boise, ID 83707-1408 • **(208) 345-4550** • **www.bcidaho.com**

An Independent Licensee of the Blue Cross and Blue Shield Association