

Individual Application Cover Sheet

(To Be Used With Idaho Individual Application)



An Independent Licensee of the Blue Cross and Blue Shield Association

Applicant's Name (please print) _____

Social Security Number _____ Idaho Driver's License Number _____

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

Plan Selection		
Regence Select for Individuals		Regence Individual Health Savings Accounts
Choose One Plan	Choose One Network	
RegenceClassic <input type="checkbox"/> \$1,000 Deductible <input type="checkbox"/> \$2,000 Deductible RegencePreferred <input type="checkbox"/> \$3,000 Deductible <input type="checkbox"/> \$5,000 Deductible RegenceEssential <input type="checkbox"/> \$5,500 Deductible <input type="checkbox"/> \$7,500 Deductible	<input type="checkbox"/> TraditionalCare <input type="checkbox"/> AccessCare <input type="checkbox"/> RegionalCare <input type="checkbox"/> ValueCare <i>Detailed information regarding the providers belonging to these networks is available on our Web site www.id.regence.com or by contacting your agent.</i>	<input type="checkbox"/> \$1,500 Deductible (Individuals Only) <input type="checkbox"/> \$2,500 Deductible (Individuals Only) <input type="checkbox"/> \$3,500 Deductible (Individuals Only) <input type="checkbox"/> \$3,000 Family Deductible (Families Only) <input type="checkbox"/> \$5,000 Family Deductible (Families Only) <input type="checkbox"/> \$7,000 Family Deductible (Families Only)

For further benefit information about all plan options, please see sales literature.

I have been advised that if I am declined coverage under the plan I am applying for, the insurance carrier must offer me my choice of the High Risk Basic, Standard, Catastrophic A or Catastrophic B plans. I have also been advised that I may be eligible for one of the High Risk Basic, Standard, Catastrophic A or Catastrophic B 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.

Method of Payment
<input type="checkbox"/> Monthly automatic bank deduction (Authorization form will be sent to you) <input type="checkbox"/> Monthly billing

Effective Date
Choose One: <input type="checkbox"/> 1. First of the month following the date the complete application is received and approved in our office. <input type="checkbox"/> 2. Day after the date the complete application is received and approved in our office. Premium will be prorated for that month. Note: This option is only available the first seven days of each month.
If no option is selected, the effective date will be option number 1. Option number 2 must be indicated at the time of application. Retroactive requests for option number 2 will not be honored.

Parent or Guardian Consent	
<i>(Complete only if applicant is under age 18 and will be the only insured.)</i>	
Notice is hereby given that _____ SSN _____ who is under the age of eighteen years is making application for Regence BlueShield of Idaho 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: _____
Print Name: _____	Relationship to Child: _____
Phone #: _____	Address: _____

Definition of Dependent:

Dependent means: (1) The legal spouse of the Policyholder; and/or (2) the unmarried child of a Policyholder or Policyholder’s spouse, up to the age of nineteen (19); (3) an unmarried child who is a full-time student under the age of twenty-three (23) and who is financially dependent upon the Policyholder or Policyholder’s spouse; or (4) an unmarried child of any age who is medically certified as disabled and dependent upon the Policyholder or Policyholder’s spouse. The term “children” includes natural children, stepchildren, adopted children, or children in the process of adoption from the time placed with the Policyholder. The term “children” also includes children legally dependent upon the Policyholder or Policyholder’s spouse for support where a normal parent-child relationship exists with the expectation that the Policyholder will continue to rear that child to adulthood. However, if one or both of that child’s natural parents live in the same household with the Policyholder, a parent-child relationship shall not be deemed to exist, even though the Policyholder or the Policyholder’s spouse provides support.

Medicare:

If you or any listed dependents have Medicare, please list family member’s name and the Medicare Health Insurance Claim (HIC) number shown on his/her red, white and blue Medicare card:

ACKNOWLEDGEMENT

By signing the attached Idaho Individual Application, you understand and agree to the terms and conditions set forth on this coversheet as well as the terms and conditions set forth on the attached application.

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 www.id.regence.com or by calling 1-800-632-2022.

-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 YY

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

APPLICATION INFORMATION

Applicant / Insured Name		Occupation		<input type="checkbox"/> Single <input type="checkbox"/> Married
				<input type="checkbox"/> 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 19; or who is under age 23, 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			<input type="checkbox"/> Yes <input type="checkbox"/> No			
Spouse				<input type="checkbox"/> Yes <input type="checkbox"/> No			
Child				<input type="checkbox"/> Yes <input type="checkbox"/> No			
Child				<input type="checkbox"/> Yes <input type="checkbox"/> No			
Child				<input type="checkbox"/> Yes <input type="checkbox"/> 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) 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		Will continue any current coverage?	Type of Coverage	
		FROM	TO			
Applicant / Insured		MM / DD / YY	MM / DD / YY	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> High Risk Pool	<input type="checkbox"/> Individual <input type="checkbox"/> Cobra
Spouse				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> High Risk Pool	<input type="checkbox"/> Individual <input type="checkbox"/> Cobra
Child				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> High Risk Pool	<input type="checkbox"/> Individual <input type="checkbox"/> Cobra
Child				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> High Risk Pool	<input type="checkbox"/> Individual <input type="checkbox"/> Cobra
Child				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> High Risk Pool	<input type="checkbox"/> Individual <input type="checkbox"/> Cobra

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

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		Yes	No		Yes	No
1. Are you, your spouse, any eligible dependent child, or mate, whether or not listed on this application, now pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	14. Bodily deformity or congenital disease/defect	<input type="checkbox"/>	<input type="checkbox"/>	31. Lung conditions or emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Due Date _____			15. Breast condition or fibrocystic breast disease	<input type="checkbox"/>	<input type="checkbox"/>	32. Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Complications anticipated?	<input type="checkbox"/>	<input type="checkbox"/>	16. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	33. Melanoma	<input type="checkbox"/>	<input type="checkbox"/>
Prior or anticipated multiple births?	<input type="checkbox"/>	<input type="checkbox"/>	17. Colon / Bowel / Rectal condition	<input type="checkbox"/>	<input type="checkbox"/>	34. Mental or nervous conditions	<input type="checkbox"/>	<input type="checkbox"/>
2. Used any medication or drug within the past 12 months? (list below)	<input type="checkbox"/>	<input type="checkbox"/>	18. Depression	<input type="checkbox"/>	<input type="checkbox"/>	35. Mental retardation	<input type="checkbox"/>	<input type="checkbox"/>
3. Positive test for HIV (Human Immunodeficiency Virus) infection	<input type="checkbox"/>	<input type="checkbox"/>	19. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	36. Neurological conditions	<input type="checkbox"/>	<input type="checkbox"/>
4. Acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC)	<input type="checkbox"/>	<input type="checkbox"/>	20. Disorders of the female reproductive organs/infertility	<input type="checkbox"/>	<input type="checkbox"/>	37. Phlebitis / Blood clot	<input type="checkbox"/>	<input type="checkbox"/>
5. Alcoholism, drinking problem, drug abuse, or convicted of DUI/DWI	<input type="checkbox"/>	<input type="checkbox"/>	21. Disorders of the male reproductive organs including the prostate/infertility	<input type="checkbox"/>	<input type="checkbox"/>	38. Polio	<input type="checkbox"/>	<input type="checkbox"/>
6. Allergies or Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	22. Dizziness or headaches	<input type="checkbox"/>	<input type="checkbox"/>	39. Sinus conditions	<input type="checkbox"/>	<input type="checkbox"/>
7. Anemia or blood condition	<input type="checkbox"/>	<input type="checkbox"/>	23. Epilepsy or seizure condition	<input type="checkbox"/>	<input type="checkbox"/>	40. Stomach conditions or ulcers	<input type="checkbox"/>	<input type="checkbox"/>
8. Arthritis or rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	24. Eye, ear, nose or throat condition	<input type="checkbox"/>	<input type="checkbox"/>	41. Stroke or paralysis	<input type="checkbox"/>	<input type="checkbox"/>
If yes, list type			25. Gallstone or gall bladder condition	<input type="checkbox"/>	<input type="checkbox"/>	42. Thyroid or pituitary conditions	<input type="checkbox"/>	<input type="checkbox"/>
9. Asthma or chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	26. Heart or cardiovascular condition	<input type="checkbox"/>	<input type="checkbox"/>	43. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
10. Attempted suicide	<input type="checkbox"/>	<input type="checkbox"/>	27. Hernia or rupture	<input type="checkbox"/>	<input type="checkbox"/>	44. Tumor, growth, or cyst	<input type="checkbox"/>	<input type="checkbox"/>
11. Back or joint condition	<input type="checkbox"/>	<input type="checkbox"/>	28. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	45. Ulcerative colitis or Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>
If yes, pins in place?			If yes, last reading and date			46. Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>
12. Bladder or kidney condition	<input type="checkbox"/>	<input type="checkbox"/>	29. High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	47. Any other condition or treatment in the last 5 years	<input type="checkbox"/>	<input type="checkbox"/>
13. Bone infection	<input type="checkbox"/>	<input type="checkbox"/>	If yes, last reading and date			Other Information		
			30. Liver conditions, cirrhosis or hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	48. Are you a U.S. Citizen?	<input type="checkbox"/>	<input type="checkbox"/>
			If yes, list type			49. Are you a resident of the state of Idaho?	<input type="checkbox"/>	<input type="checkbox"/>
						years _____ months _____		
						50. Do you have a family doctor?	<input type="checkbox"/>	<input type="checkbox"/>
						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.

- 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 were not offered COBRA, Temporary Continuation of Coverage (TCC), or State continuation coverage, or if you were offered such continuation coverage and you purchased and exhausted the coverage

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 or Catastrophic B plans. I have also been advised that I may be eligible for one of the High Risk Basic, Standard, Catastrophic A or Catastrophic B 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 _____ ID No. _____

Signature of Agent _____ Date _____