-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 Steve Marsh ID No. _____

Signature of Agent _____ Date _____

BRIGHTIDEA APPLICATION COVER SHEET

PacificSource HEALTH PLANS

PO Box 9555
Boise, ID 83707
(888) 492-2875 ● (208) 342-3709
Fax (208) 342-4508
individual@pacificsource.com

Please type or print neatly in ink.

Applicant's Name: _____ Social Security Number: _____

Requested effective date: _____ *Note: Policies are only issued on the first day of the month. If this field is left blank, or if an invalid date is requested, the first day of the following month will be assigned as the effective date.*

CHOOSE A PLAN AND A DEDUCTIBLE:

BrightIdea Preferred	BrightIdea Value	BrightIdea HSA
☐ $2,500 deductible ☐ $5,000 deductible	☐ $ 2,500 deductible	☐ $1,500 deductible ☐ $3,000 deductible
☐ $7,500 deductible	☐ $ 5,000 deductible	☐ $5,000 deductible
	☐ $ 7,500 deductible	
	☐ $10,000 deductible	

METHOD OF PAYMENT

☐ Monthly automatic bank deduction (complete authorization form) ☐ Monthly billing

Will your employer pay any portion of your premium? ☐ **Yes** ☐ **No** *PacificSource individual policies may not be used for an employer-based plan for employers of 2-50 employees if the employer pays or reimburses any part of the premium or if the health plan is treated as part of a plan or program for the purposes of section 106 or 162 of the Internal Revenue Code of 1986. PacificSource does not accept premium payment from employers for individual policies.*

PARENT OR GUARDIAN CONSENT

(Complete only if applicant is under the age 18 and will be the only insured)

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

Signature: _____ Date: _____

Print name: _____ Relationship to Child: _____

Phone #: _____ Address: _____

_____

_____

If I am declined for the coverage I applied for, the carrier must offer High Risk Basic, Standard, Catastrophic A or Catastrophic B Plans, and Health Savings Account High Risk Plans.

Definition of Dependent:
Dependent means a spouse, or an unmarried child under the age of 25 and who receives more than one-half (1/2) of his or her financial support from the parent, and an unmarried child of any age who is medically certified as disabled and dependent upon the parent. A dependent child also includes an unmarried brother, sister, niece, nephew or grandchild under the age of 21, if the subscriber is designated by a court as legal guardian with the expectation that the child will live in the subscriber's household for at least one year.

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 cover sheet 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 PacificSource Health Plans Privacy notice. A copy is available on our Web site at www.pacificsource.com or by calling (800) 624-6052.

OTHER INFORMATION

How did you hear about PacificSource? ☐ Producer ☐ Mailing ☐ TV ☐ Web site ☐ other _____

FOR OFFICE USE ONLY: