Premera Blue Cross
An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 327
Seattle, WA 98111-0327

Washington Individual Enrollment Application

By using this form you agree to the following conditions: You may not alter or modify this form in any manner. The most recent version of this form supersedes all prior versions. We may modify this form without notice to you and we reserve the right to accept only the current version.

Please read all accompanying material before completing this application. All questions must have complete and accurate answers. Omissions or incomplete answers will result in the return of your application and may cause a delay in the effective date of your coverage. Please **PRINT**, sign and date in ink. You must be a resident of the state of Washington and not eligible for Medicare to apply.

SECTION 1 – TYPE OF APPLICATION

Check one box: ❒ New Enrollment Application ❒ Changing Coverage

❒ Adding Dependents (If adding dependents fill in the following dates, as applicable.)

Spouse with/without Stepchildren: Date of Marriage _____ (MM/DD/YYYY) Adoptive Children: Date of Placement_____ (MM/DD/YYYY)

SECTION 2 - PRIMARY APPLICANT, SPOUSE & DEPENDENT INFORMATION

(Social Security numbers are required for all dependents over 1 year of age.)

Name (Last, First, Middle Initial)	Social Security # (all over age 1)	Sex (M/F)	Date of Birth (MM/DD/YYYY)	Relationship to Subscriber
				SELF
				LEGAL SPOUSE
				DEPENDENT CHILD (under 23)
				DEPENDENT CHILD (under 23)
				DEPENDENT CHILD (under 23)
Home Address (not P.O. Box)			Home Telephone Number ( )	
Mailing Address (if different from Home Address)			Work Telephone Number ( )	

SECTION 3 – ELIGIBILITY

To be eligible for coverage, applicants:

➢Must be a resident of, and have a principal residence located within, Washington State (excluding Clark County). Proof of residency is required with all new applications. I have included **a copy** of one of the following:

- ❒ Valid Washington State drivers license or identification card;
- ❒ Voter registration card; or
- ❒ Current utility bill in your name, including address.

➢Must not be entitled to Medicare:

- ❒ If over 65 years of age and not eligible for Medicare, attach a "not eligible for Medicare document" from social security.

SECTION 4 – PROGRAM SELECTION

Check one box to indicate your family's program selection and deductible option:

1. Personal Prudent Buyer Program Option 1 (PPO)	❒ $500 Deductible	❒ $1,000 Deductible	
2. Personal Prudent Buyer Program Option 2 (PPO)	❒ $500 Deductible	❒ $1,000 Deductible	
3. Personal Prudent Buyer Program Catastrophic Option (PPO)	❒ $2,500 Deductible	❒ $5,000 Deductible	❒ $10,000 Deductible
4. Traditional Program Option 1	❒ $500 Deductible	❒ $1,000 Deductible	
5. Traditional Program Option 2	❒ $500 Deductible	❒ $1,000 Deductible	
6. Traditional Program Catastrophic Option	❒ $2,500 Deductible	❒ $5,000 Deductible	❒ $10,000 Deductible

SECTION 5 – EFFECTIVE DATE

Approved applications postmarked or received, are effective the first of the month, as follows:

- Applications received by the **20th** day of the month will be effective on the first day of the following month.
- Applications received after the **20th** day of the month will be effective on the first day of the second month following receipt.
- To select a later effective date, please indicate here (no more than 60 days after the receipt date): _____/01/ _____

SECTION 6 – RATE/BILLING INFORMATION

PAYMENT OPTIONS: Select One

❒ Bi-Monthly Billing (every two months) ❒ Monthly (Automatic Funds Transfer; see Section 7.)

TOBACCO USE INFORMATION:

If either you or your spouse (if included in this application) has used tobacco products within the 12 months prior to this application, your rate(s) will be the Smoker rate(s).

- I have used tobacco products during the prior 12 months: ❒ Yes ❒ No
- My spouse has used tobacco products during the prior 12 months: ❒ Yes ❒ No

SECTION 7 – AUTOMATIC FUNDS TRANSFER AUTHORIZATION

I have selected the monthly payment option and I hereby authorize Premera Blue Cross to initiate funds transfer from the bank or depository financial institution account indicated below. I authorize my financial institution to honor these transfers.

Financial Institution or Bank Name:	
Account Holder's Name (print):	
City, State:	Account Number:
Bank Routing Number:	❒ Checking ❒ Savings

(Please indicate all dashes, spaces and zeros)

Additional Terms and Conditions:

- Funds are to be transferred on the **1st business day of each month** or as soon thereafter as practical, paying for that month's coverage. (For example: The deduction on December 1st pays for coverage in December.)
- I understand that this Automatic Funds Transfer Authorization will remain in effect until Premera Blue Cross has received a written notice from me that it should be cancelled. To ensure prompt cancellation of my Automatic Funds Transfer, this notice must be submitted at least 20 days prior to my next scheduled transfer. I have the right to stop payment of a specific transfer from my depository financial institution at least 3 days before the next scheduled withdrawal date.

Please enclose a deposit slip or voided check from the account TO BE DEDUCTED.

Signature: X _____ Date (MM/DD/YYYY): _____

SECTION 8 – STANDARD HEALTH QUESTIONNAIRE FOR WASHINGTON STATE

Attach a completed Standard Health Questionnaire for each applicant.

If not attaching the questionnaire(s), please indicate why below (include a copy of the Certificate of Health Coverage from the prior insurer).

Please refer to the Standard Health Questionnaire for specific information on who is exempt from completing the questionnaire.

❒ **Relocation:** Applicant has relocated within Washington, and the prior health plan is not available.
Include a photocopy of a utility bill in your name showing the prior address.

❒ **Provider cancellation:** Applicant's provider has left the prior plan's network and is in this plan's network.
Include a letter of verification from the provider or carrier.

❒ **COBRA:** Applicant has exhausted all COBRA continuation coverage within the past 90 days.
Include a copy of your Certificate of Coverage or other supporting evidence. (Complete section 10.)

❒ **Addition of:** newborn or newly adopted child within 60 days of birth or adoption.

SECTION 9 – PREEXISTING CONDITION WAITING PERIOD DETERMINATION

Premera Blue Cross Individual programs have a nine month waiting period for preexisting conditions. In certain circumstances, we will waive or credit this waiting period based on current or prior coverage. The questions in this section will help us determine whether you are eligible to have the preexisting condition waiting period waived. NOTE: applicants who are "eligible individuals" under federal law will have the preexisting waiting period waived. However, you will lose this right if you do not apply for coverage within 90 days after your group health plan or continuation coverage (such as COBRA) ends. ***Act promptly to protect your rights.***

1. Have you or any dependents applying for coverage had any prior medical coverage within the past 90 days?	❒ Yes ❒ No	If **Yes**, continue to next question. If **No**, go to Section 10.
2. Was your most recent coverage under a group health plan (even if your most recent coverage under a employer sponsored group health plan lasted only 1 day, answer Yes)?	❒ Yes ❒ No	If **Yes**, continue to next question. If **No**, go to Section 10.
3. If you were offered COBRA or state continuation coverage, did you purchase and exhaust the coverage?	❒ Yes ❒ No	If **Yes**, continue to next question. If **No**, go to Section 10.
4. Are you eligible to enroll in another group health plan? If you are eligible to enroll in a health plan offered by your employer, or eligible to enroll as a dependent in your spouse's, parent's, or guardian's health plan, answer Yes.	❒Yes ❒No	If **Yes**, go to Section 10. If **No**, continue to next question.
5. Are you eligible for Medicare or Medicaid?	❒Yes ❒No	If **Yes**, go to Section 10. If **No**, continue to next question.
6. Do you (or did you) have any of the types of coverage listed below (called "creditable coverage") that were in effect for at least 18 months without a break of more than 63 days in a row? Creditable coverage includes: • A group health plan (including COBRA or state continuation coverage) • Health insurance coverage (including individual coverage, college or school insurance, short-term limited duration insurance) • Medicare • Medicaid, other than coverage consisting only of the program for pediatric vaccines • State Children's Health Insurance Program (SCHIP) • Medical and dental care for the Army, Air Force, Marines, Navy, and Coast Guard • A medical care program of the Indian Health Service or a tribal organization • A State health benefits insurance pool • The Federal Employees Health Benefits Program • A public health plan • A Peace Corps health plan	❒Yes ❒No	If **Yes**, continue to next question. If **No**, go to Section 10.
7. Did you buy a conversion policy or a short-term limited duration policy after your group, COBRA, or state continuation coverage ended?	❒Yes ❒No	If **Yes**, go to Section 10. If **No**, continue to next question.
8. Was your most recent health coverage cancelled because: • You did not pay your premiums • You did not pay your premiums on time, or • You committed fraud?	❒Yes ❒No	If **Yes**, go to Section 10. If **No**, go to Section 10.

SECTION 10 – PRIOR or CURRENT COVERAGE

Please provide the following information. ***Provide your Certificate of Coverage,* if applicable.***

Name of carrier (insurance company): _____ Phone #: (_____) _____

Name of subscriber (contract holder) and ID#: _____

Names of all enrollees on prior coverage: _____

Date coverage began: _____ Date coverage ended: _____

Deductible amount: $_____ per individual per year. Deductible amount: $_____ per family per year.

➢ Type of coverage: ❒ Individual ❒ Group ❒ Healthy Options ❒ Basic Health Plan ❒ WSHIP

➢ Other Type of benefits (check all that apply): ❒ Medical ❒ Accident Only ❒ Prescription Drug ❒ Dental ❒ Vision

Do you intend to continue this other coverage if you are accepted by Premera Blue Cross? ❒ Yes ❒ No

Please note: If your current coverage is a Premera Blue Cross Individual Program and you and/or your family members are accepted for enrollment, any prior Individual coverage will be terminated for those accepted.

*Other acceptable evidence may be provided: pay stubs that reflect premium deductions, Explanation of Benefit forms (EOBs), benefit termination notice, verification by a doctor or former health care provider that you had prior health coverage. ***See page 6 for details.***

SECTION 11 – BASIC TERMS OF ENROLLMENT

1) I understand and agree that coverage does not begin until:
   a) This application is received, reviewed, and accepted by Premera Blue Cross and an effective date of coverage is assigned; and
   b) My complete and correct payment is received.

2) I also understand and agree that:
   a) This application becomes a part of my Contract.
   b) This application summarizes certain key terms of the Contract; to the extent that the application is inconsistent with the Contract, the Contract will govern.
   c) Terms and conditions of enrollment are described in the Contract.
   d) **I UNDERSTAND THAT THIS PROGRAM HAS A NINE-MONTH WAITING PERIOD FOR PREEXISTING CONDITIONS. NO BENEFITS ARE PROVIDED FOR ANY MEDICAL CONDITION FOR WHICH TREATMENT WAS RECEIVED (OR RECOMMENDED), OR FOR WHICH A PRUDENT PERSON WOULD HAVE SOUGHT ADVICE OR TREATMENT WITHIN THE SIX MONTHS PRIOR TO THE EFFECTIVE DATE OF THIS PROGRAM. THIS WAITING PERIOD DOES NOT APPLY TO: NEWBORN AND ADOPTIVE CHILDREN ENROLLED AFTER THE SUBSCRIBER'S EFFECTIVE DATE OF COVERAGE AS LONG AS ADDED WITHIN 60 DAYS OF THE BIRTH OR PLACEMENT; FORMULA FOR TREATMENT OF PHENYLKETONURIA; AND PRENATAL CARE (IF THE PLAN PROVIDES BENEFITS FOR THIS). THIS WAITING PERIOD MAY BE CREDITED OR WAIVED BASED ON PRIOR HEALTH CARE COVERAGE.**
   e) **I ALSO UNDERSTAND THAT THIS PROGRAM WILL NOT PROVIDE BENEFITS FOR ORGAN AND BONE MARROW TRANSPLANTS FOR A PERIOD OF 12 MONTHS FROM THE EFFECTIVE DATE OF MY COVERAGE.**
   f) The benefits under this Contract will be subject to coordination of benefits with other plans.

3) I also understand that acceptance for coverage is dependent on the following:
   a) Persons listed on this application must be residents of the state of Washington (excluding Clark County) in order to apply for and maintain coverage under this Contract. "Resident" means a person who lives in the state of Washington, and intends to live in the state permanently or indefinitely. **In no event will coverage be extended to an applicant who resides here for the primary purpose of obtaining health care coverage.** The confinement of a person in a nursing home, hospital, or other medical institution shall not by itself be sufficient to qualify such person as a resident. We may require proof of residency from time to time. Such proof shall include, but not be limited to, the street address of the individual's residence and not a post office box.
   b) No one listed on this application is covered under another Premera Blue Cross or MSC/Premera Blue Cross Individual or Group Contract that would duplicate benefits of this Contract. If you choose to accept this Individual program, you can not keep the other coverage.
   c) No one listed on this application is entitled (enrolled) to Medicare on the date coverage would begin.
   d) No one listed on this application is 65 years of age or older and eligible for Medicare on the date coverage would begin.

4) I also understand that no benefits are available under this Contract for services or supplies related to an inpatient confinement which began prior to the effective date of coverage, unless the applicant is an "eligible individual" as described in Section 9.

5) I also understand and agree that only Premera Blue Cross may:
   a) Make or modify the terms of the application or Contract; or
   b) Waive any of the Premera Blue Cross rights or requirements.

6) I understand that, except for treatment of medical emergencies and accidental injuries (on the date of or within two days following the date of accidental injury), benefits may be limited to contracted providers located in the state of Washington. I also understand that the number of contracted providers varies in different parts of Washington State, and benefits may be provided at different levels based on the contracting status of the provider. In some cases, I may receive benefits which are substantially less than the amount billed by the provider when treatment is not received from a contracted provider.

7) I understand that this application is not an offer of coverage from Premera Blue Cross and that submission of this application does not guarantee I will receive coverage.

SECTION 12 – AUTHORIZATIONS AND RELEASE OF INFORMATION

1) I authorize any health care provider or facility to furnish Premera Blue Cross with any and all medical information concerning anyone who becomes enrolled under this contract necessary for the company to exercise its rights and fulfill its obligations under its contract with me. I authorize Premera Blue Cross to disclose medical information as necessary to conduct its routine health plan functions, or as required or permitted by law. This authorization shall commence immediately and shall remain in effect as long as needed to enable Premera Blue Cross to determine eligibility for benefits, pay claims, coordinate benefits with other insurance carriers, conduct studies, ensure the quality of care and services that enrollees receive, and otherwise conduct routine health plan functions.

2) I authorize Premera Blue Cross to examine any and all personal health information or records maintained by Premera Blue Cross or any of its corporate affiliates pertaining to medical history, services provided, or treatment rendered to anyone who is applying for coverage. This release applies without limitation to all medical records, including records concerning chemical dependency, sexually transmitted diseases, HIV and AIDS, and mental illness.

3) I authorize Premera Blue Cross, at its option, to pay providers directly for services provided.

4) I authorize Premera Blue Cross to obtain from and release to any current or previous employer, provider, insurer or health plan carriers indicated in Section 10, Prior or Current Coverage, any information necessary to establish eligibility for credits on waiting periods.

SECTION 13 – SIGNATURES

I hereby apply for enrollment with Premera Blue Cross for myself and family members listed on this application for coverage under the Individual contract indicated on this form. I understand I will have the right to examine and return the contract within 10 days of its delivery to me. I certify that:

a) I have read this form, and I have supplied all of the required information on this form.
b) I have received and read a product information packet containing a Summary of Benefits and understand that a complete list of exclusions and limitations is detailed in the Contract, and if there is a conflict, the terms of the Contract prevail.
c) I have read and agree to all the Basic Terms of Enrollment listed.
d) I have read and agree to all the authorizations listed in Authorizations and Release of Information listed above.
d) In applying for enrollment as indicated on this application, I declare that to the best of my knowledge, all of the information on all forms necessary for enrollment is true and complete, and that all of the persons for whom I am requesting enrollment are eligible for coverage. I understand that if I have made intentionally false or misleading statements or answers on behalf of myself or any family members, that all entitlements to benefits are void and this Contract may be cancelled or modified retroactively to its effective date.

If one or more family members is not accepted for coverage, I authorize Premera Blue Cross to enroll those who are eligible in the program I have selected. ❒ Yes ❒ No

Signature of Primary Applicant (Parent/Legal Guardian, if minor)

X _____

Date of Signature

(MM/DD/YYYY)_____

Signature of Spouse

X _____

Date of Signature

(MM/DD/YYYY)_____

DO NOT SEND PAYMENT WITH THIS APPLICATION.

Completion of this section **BY THE AGENT** is required if the agent wishes to be considered as agent of record for applicant. All agent information must be provided below to ensure credit/commission for the application.

Agency Name (If applicable): _____

Agent Name (Please Print): _____

Agent Signature: _____

Agent Address: _____

Agent Telephone Number: _____ Premera Blue Cross Agent Number: _____
(5 digits)

Please Note: Agents who do not have a current appointment with Premera Blue Cross are not authorized to offer Premera Blue Cross Products.

APPLICATION CHECKLIST

To ensure timely processing of your application, please review this checklist. All questions must be complete and accurate. Incomplete answers or missing documentation will result in the return of your application and may cause a delay in your effective date.

✓ Please check each box when complete.

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- ❒ Have you checked a box in Section 1 – Type of Coverage?
- ❒ Section 3 – Eligibility, proof of residency is required with all applications. Did you include a photocopy?
- ❒ Did you check a box in Section 4 – Program Selection?

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- ❒ Have you reviewed Section 5 – Effective Date?
- ❒ In Section 6 – Rate/Billing Information, did you select a payment plan?
- ❒ Did you complete Tobacco Use Information in Section 6?
- ❒ If Automatic Funds Transfer Authorization is selected in Section 7, sign and include a photocopy of a deposit slip or voided check.
- ❒ Have you completed the Standard Health Questionnaire for each applicant, if required?
- ❒ In Section 8 – Standard Health Questionnaire, if you or your dependents do not have to complete the questionnaire, did you include a photocopy of the required proof?

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- ❒ Did you complete Section 9 – Preexisting Condition Waiting Period Determination, to protect your rights?
- ❒ Did you complete Section 10 – Prior or Current Coverage. Include a photocopy of your Certificate of Coverage (a form or letter you received from your prior insurance company that states the beginning and ending dates of coverage), if applicable. If the Certificate of Coverage is not included, your substitute documentation must include:
  - ➢ Effective date of prior coverage (or proof coverage was effective for a least nine months or the actual number of months if less than nine)
  - ➢ Termination date of prior coverage
  - ➢ Adequate benefit plan information to indicate a group or individual plan with equal or greater benefits to our Individual programs

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- ❒ Have you read all of Section 11 – Basic Terms of Enrollment?

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- ❒ Did you read all of Section 12 – Authorizations and Release of Information?
- ❒ Is Section 13 – Signatures complete, signed and dated, including the blue boxes?
- ❒ Is the Agent portion of Section 13 completed, if an agent is to be considered agent of record for this application?

IMPORTANT: Please do not send in a payment with your application. You will receive a statement from us upon acceptance of your application. Do not send original supporting documentation – photocopies only, please.

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