APPLICATION FOR INDIVIDUAL COVERAGE

PO Box 91053
1800 Ninth Avenue
Seattle, WA 98111-9153

MAIL APPLICATION TO:
PO Box 1107
1602 21st Ave.
Lewiston, ID 83501

All answers must be complete and accurate. Omissions or incomplete answers will result in the return of your application and may cause delays. In most cases, approved applications postmarked or delivered to Regence BlueShield by the 20th of the month are eligible for an effective date of the first of the following month.

SECTION 1. TYPE OF APPLICATION (Check all that apply.)

❒ New Application ❒ Transferring from Regence BlueShield Group or COBRA Coverage ❒ Transferring from another carrier
❒ Changing Coverage Type ❒ Transferring from another County or State Blue Shield Plan
❒ Adding Dependent(s). (Dependent(s) may be added only to your current plan/deductible option. **Skip to Section 4.**)

SECTION 2. TYPE OF COVERAGE (SELECT ONLY ONE PLAN .)

PREFERRED PLANS — Deductible Options: PCP is not required on the Preferred Plans.			SELECTIONS® PLANS — Deductible Options: Please choose a PCP from the Individual Selections Provider Directory.	
Regence Breakthru 50 ❒ $2,500 ❒ $5,000 **Regence Breakthru 70** ❒ $1,000 ❒ $3,000 **Regence Breakthru 80** ❒ $500 ❒ $1,500	**PPO Comprehensive** ❒ $750 **PPO Catastrophic** ❒ $1,500	**Catastrophic (HSA-Qualified)** ❒ $2,500 Member/ $5,000 Family	**Comprehensive** ❒ $500 ❒ $1,000	**Catastrophic** ❒ $1,500

SECTION 3. PAYMENT TYPE (Select one of the following payment options.)

❒ Monthly ❒ Quarterly ❒ Semiannually ❒ Annually ❒ Automatic Bank Withdrawal
Complete the enclosed Subscriber Agreement for Preauthorized Bill Payment (monthly only).

SECTION 4. MEMBER INFORMATION

To be eligible to apply for our individual plans, you must reside in our service area for at least 30 days prior to submitting your application and continue to live in our service area for six months out of the year. Eligible dependents include your spouse and/or children under the age of 23. Proof of residence within the Regence BlueShield service area may be required. (See the Application Checklist on page 4 for acceptable forms of proof.) Please list subscriber, spouse, and eligible dependent children for whom you are requesting coverage. Please provide Social Security numbers for yourself and all dependents over one year of age. **PLEASE PRINT.** (Persons who are eligible for Medicare coverage are not eligible for coverage under individual contracts.)

Name			Social Security Number	Sex	Birth Date	Relationship to Subscriber	Personal Care Provider (PCP) (Selections only)	PCP Number (See Provider Directory) (Please check the box if you are a current patient of this PCP)
First	MI	Last						
					/ /	SUBSCRIBER		❒
					/ /			❒
					/ /			❒
					/ /			❒
					/ /			❒

Street Address	City	State	ZIP	County
Mailing Address	City	State	ZIP	Home Telephone Number
Billing Address (if different)	City	State	ZIP	E-mail address (optional)

Name and Health Insurance Claim Number of anyone listed on this form that is covered by Medicare.

REGENCE BLUESHIELD USE ONLY				
Date Application Substantially Complete	COB	Effective Date	Package Number	Agent Number

SECTION 5. EXCEPTIONS FOR THE STANDARD HEALTH QUESTIONNAIRE

Please read the full explanation of the exceptions listed on the Standard Health Questionnaire (SHQ). Do your circumstances match any of the exceptions described in the SHQ? If so, please complete this section.

Name of person(s) not required to complete the Standard Health Questionnaire: ______________________________

Reason for exception (check one):

- ❒ **Relocation:** Change of your prior coverage service area in Washington State. *Include a copy of a utility bill in your name from the prior address and a letter of verification from your prior carrier verifying that because you have moved, you no longer reside in their service area and they cannot provide health insurance at your new location.*
- ❒ **Provider Cancellation:** Health provider left network. *Include a letter of verification from the provider or carrier.*
- ❒ **COBRA Exhaustion:** Exhaustion of COBRA continuation. *Include a letter from the COBRA Administrator verifying that you have exhausted your COBRA benefits.*
- ❒ **COBRA Termination:** Former employer has gone out of business while member was on COBRA coverage. *Include a letter of verification from the employer or carrier.*
- ❒ **Employer Not Required to Offer COBRA:** Employer normally employs fewer than 20 employees and is not required to offer COBRA coverage and you had at least 24 months of continuous group coverage before a qualifying event. *Include a letter of verification from the employer, including the nature and date of the qualifying event.*

In addition to the exceptions listed above, the Standard Health Questionnaire is not required for the **subscriber's** natural newborn or newly adopted child if the Company receives the application for coverage within 60 days of birth or placement of adoption (to be effective from date of birth or placement of adoption if the subscriber has active coverage on the date of birth or placement of adoption). Are you adding a newborn or newly adopted child with this application?

❒ Yes (For adopted child, include documentation indicating date of placement.)

SECTION 6. OTHER COVERAGE INFORMATION

Are you or any dependents who are applying for coverage currently covered on any group, individual, or self-insured plan?

❒ Yes ❒ No

If Yes, do you intend to replace your current plan with this contract? ❒ Yes ❒ No

Regence BlueShield Individual Plans contain a nine-month preexisting condition waiting period. In certain circumstances, we will waive or credit this waiting period based on current or prior coverage. To help us determine if you qualify for crediting the preexisting condition waiting period, please provide the following information, and attach a copy of your Certificate of Coverage from your current or prior carrier or a similar document showing the beginning and ending dates of your current coverage, if applicable. Please note: If your prior coverage was with a Regence BlueShield group plan, it is not necessary to include a copy of your Certificate of Coverage. SEE THE APPLICATION CHECKLIST ON PAGE 4 FOR MORE INFORMATION.

Carrier Name: ______________________________

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

Out-of-pocket (stoploss) amount: $ ____________ per individual per year Out-of-pocket (stoploss) amount: $____________ per family per year

Was your most recent coverage with a group plan? ❒ Yes ❒ No

SECTION 7. NON-SMOKER CERTIFICATION STATEMENT

Complete this section only if you or your spouse is applying for a non-smokers' discount.

I certify that I have not smoked cigarettes, cigars, pipes, or used chewing tobacco, smokeless tobacco or any other form of tobacco or illegal drug substance within the past 12 months. PLEASE NOTE: The Company reserves the right to cancel coverage and collect claims payments or other damages if false information is submitted or if you fail to notify us you are no longer eligible for the non-smoker discount.

____________________	__________	____________________	__________
Applicant's Signature	Date	Spouse's Signature (If applying)	Date

SECTION 8. RELEASE OF INFORMATION

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are eligible for benefits coverage and are listed on the application) for the purpose of facilitating health-care treatment, payment or for the purpose of business operations necessary to administer health-care benefits; or as required by law.*

Health information requested or disclosed may be related to treatment or services performed by:

- A physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- A clinic, hospital, long term care or other medical facility;
- Any other institution providing care, treatment, consultation, pharmaceuticals or supplies; or
- An insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

This acknowledgement does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

*For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Regence Consumer Privacy Notice. A copy is available from our Web site (www.wa.regence.com) or by phone at 1-800-458-3523 or 1-206-464-3663.

SECTION 9. APPLICATION AGREEMENT

I hereby apply for myself and/or for any spouse/dependent(s) listed on this application for coverage under the individual contract indicated on this form or currently in effect if adding dependent(s). Contracts are offered through Regence BlueShield (the Company), an independent licensee of the Blue Cross and Blue Shield Association. I understand I will have the right to examine and return the contract (if new) within 10 days of its delivery to me. I certify that my listed dependents and I meet the eligibility requirements set forth in **Section 4. Member Information**.

I agree to pay in advance the appropriate rates for myself and listed dependents and authorize rate increases as the Company deems necessary.

I have read and understand the waiting period provisions of the plan for which I am applying. I understand that under certain circumstances the Company may impose a **nine-month waiting period** for preexisting conditions as defined in the contract.

I understand that occupational injuries and illnesses are not covered under Selections Comprehensive, Selections Catastrophic, PPO Comprehensive, PPO Catastrophic, and Catastrophic (HSA-Qualified) plans.

I understand that this application is not an offer of coverage from Regence BlueShield and that submission of this application does not guarantee I will receive coverage.

I understand that any false or misrepresented information or statements may result in retroactive termination of coverage. The Company will be entitled to repayment after I have been notified thereof. Please sign and date **Section 10. Signature and Date**.

SECTION 10. SIGNATURE AND DATE

All statements and answers on this form and the Standard Health Questionnaire (if applicable) are complete and true, and all rights to service are void if found false or incomplete.

APPLICATION SIGNATURE:* ______________________________ **DATE:** ________________

*If signature by a personal representative of the member/enrollee, please complete the following:

Personal Representative's Name: ________________________________

Relationship to Individual: ❒ Parent ❒ Legal Guardian† ❒ Holder of Power of Attorney†

(†Attach legal documentation if legal guardian or Holder of Power of Attorney)

APPLICANT SPOUSE SIGNATURE: ______________________________ **DATE:** ________________

(If applying)

Dependent Signature: ______________________________ **Dependent Signature:** ______________________________

(If age 18 or over) (If age 18 or over)

In most cases, approved applications postmarked or delivered to Regence BlueShield by the 20th day of the month will be considered effective on the first day of the following month.

To select a later effective date, please indicate here: _____ / 01 /_____ (no more than two months from date of application).

HOW DID YOU HEAR ABOUT REGENCE BLUESHIELD?

Please check the box that best describes how you heard about Regence BlueShield.

❒ Regence Group Plan ❒ Web site ❒ Seminar ❒ Agent ❒ Radio

❒ Television ❒ Newspaper ❒ Direct mail ❒ Word of mouth

❒ Other: ______________________________

APPLICATION CHECKLIST

To ensure timely processing of your application, please review this checklist.

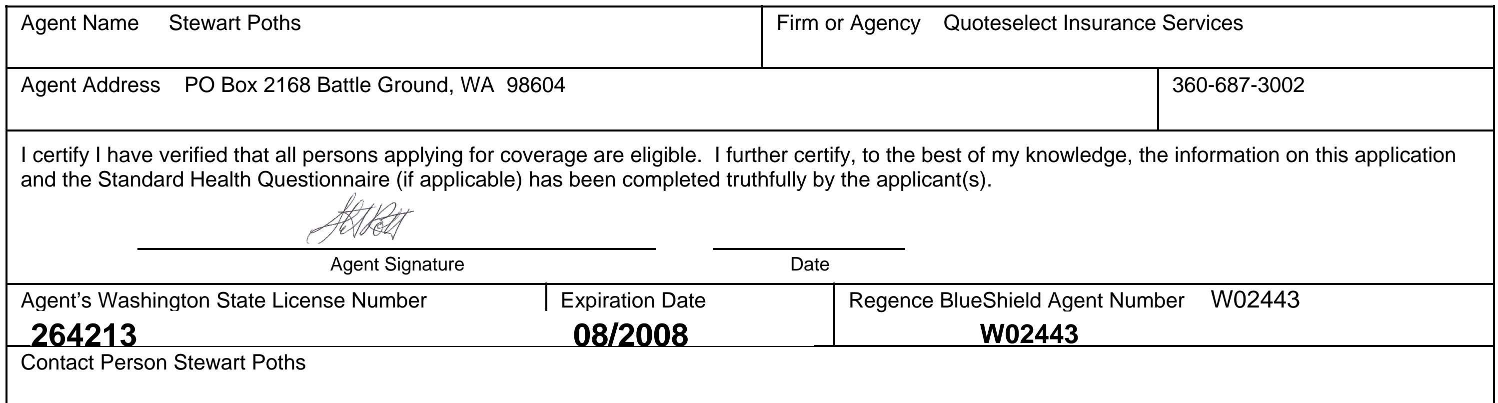
- ✓ Proof of residency may be required with all new applications. A photocopy of one of the following may be requested as proof of residency:
  - A. Valid Washington State driver's license or identification card.
  - B. Current utility bill with name and address.
- ✓ Did you indicate the type of coverage you are selecting in **Section 2. Type of Coverage**? (Not required when adding dependent(s) to current coverage.)
- ✓ If you chose automatic bank withdrawal in **Section 3. Payment Type**, did you complete the **Subscriber Agreement for Preauthorized Bill Payment** form enclosed? Please pay your paper billing until you are notified that your electronic funds transfer has been initiated. Processing can take up to 60 days. Our notification to you will appear as a message on your billing statement. (Not required when adding dependent(s) to current coverage.)
- ✓ Have you completed the **Standard Health Questionnaire** for yourself and each dependent you want to cover, if required?
- ✓ If you or your dependents do not have to complete the Standard Health Questionnaire, did you include the required proof (see **Section 5. Exceptions for the Standard Health Questionnaire**)?
- ✓ Did you complete **Section 6. Other Coverage Information**? Please provide us with documentation of current or prior coverage showing beginning and ending dates of coverage for you and/or your dependent(s) unless the current or prior coverage was with Regence BlueShield. Examples of documentation of coverage could include a copy of your Certificate of Coverage from your current or prior carrier. If you do not have a Certificate of Coverage, you may provide other documentation in accordance with federal law.
- ✓ If you and/or your dependent spouse are non-smokers, did you read **Section 7. Non-Smoker Certification Statement** and sign, if applicable?
- ✓ Please read **Section 8. Release of Information** and **Section 9. Application Agreement**.
- ✓ Did you sign and date this application (including all family members age 18 and over) in **Section 10. Signature and Date**?
- ✓ If an agent is helping you complete these forms, he or she must complete the **Agent Information** section.

Do not send a rate payment with your application. You will receive a statement from us upon acceptance of your application.

AGENT INFORMATION

IF APPLICATION IS BEING MADE THROUGH AN AGENT, HE/SHE MUST PROVIDE THE INFORMATION BELOW.

NOTE: Agents who do not have a current appointment with Regence BlueShield are not authorized to enroll members.



Agent Name Stewart Poths		Firm or Agency Quoteselect Insurance Services
Agent Address PO Box 2168 Battle Ground, WA 98604		360-687-3002

I certify I have verified that all persons applying for coverage are eligible. I further certify, to the best of my knowledge, the information on this application and the Standard Health Questionnaire (if applicable) has been completed truthfully by the applicant(s).

Agent Signature　　　　Date

Agent's Washington State License Number	Expiration Date	Regence BlueShield Agent Number W02443
264213	08/2008	W02443

Contact Person Stewart Poths

If you have an agent, that agent may receive bonuses, commissions, administrative service fees, or other compensation, including non-cash compensation, from Regence BlueShield. Incentives may be based on any of several factors, including the products you buy, your agent's volume of business with Regence, and the other services your agent provides to you. These incentives may have an indirect impact on your rates. For more information, please contact your agent.