

# Application for the Addition of Family Members to an Individual Plan

P.O. Box 91120  
M.S. 295  
Seattle, WA 98111-9220



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. Upon approval, dependents will be enrolled on the subscriber's current individual plan.

## SECTION 1 – EFFECTIVE DATE

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

- Applications received by the **20<sup>th</sup>** day of the month will be effective on the first day of the following month.
- Applications received after the **20<sup>th</sup>** 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 2 – SUBSCRIBER INFORMATION

Last Name (of current subscriber)	First	Middle Initial	Subscriber Number (See your ID Card)	
Home Address (not P.O. Box) <i>(required)</i>	City / State / ZIP		County	Home Telephone Number (    )
Mailing Address <i>(if different from Home Address)</i>	City / State / ZIP		County	Work Telephone Number (    )
Billing Address <i>(if different from Mailing Address)</i>	City / State / ZIP		County	Cell Telephone Number (    )

## SECTION 3 – LEGAL SPOUSE AND DEPENDENTS TO BE ADDED

Name (26 character max) (Last, First, Middle Initial)	Social Security #	Gender (M/F)	Date of Birth (MM/DD/YYYY)	Date of Marriage Placement/Custody	Relationship to Subscriber*
	- -		/ /	/ /	
	- -		/ /	/ /	
	- -		/ /	/ /	
	- -		/ /	/ /	

\* Please indicate the relationship of these dependents. (Application must be received within 60 days of the event, to be effective the date of the event.)

## SECTION 4 – ELIGIBILITY

To be eligible for coverage, applicants:

- Must be a resident of, and have a principal residence located within, Washington state. We may require proof of residency.
- Must not be entitled to Medicare (including entitlement due to disability):
  - If over 65 years of age and not eligible for Medicare, attach a "not eligible for Medicare document" from the Social Security Administration.

## SECTION 5 – STANDARD HEALTH QUESTIONNAIRE FOR WASHINGTON STATE

Attach a completed Standard Health Questionnaire for each applicant. Please refer to the Standard Health Questionnaire for specific information on who is exempt from completing the questionnaire. If not attaching the questionnaire(s), please indicate the reason below:

- 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 (dated no more than 90 days prior to the date of this application).**
- Provider cancellation:** Applicant's health-care provider has left the prior plan's network within the last 90 days of this application and is in this plan's network. Prior plan must have been an **Individual plan**, not group. **Include a letter of verification from the provider or carrier.**
- COBRA:** Applicant has exhausted all COBRA continuation coverage within 90 days of the date of this application.\*
- Non-COBRA Continuation:** Applicant is applying for coverage within 90 days of termination of a group health plan (including church plans) that is exempt from offering COBRA coverage that was in effect for at least 24 months.\*\*
- Washington State Basic Health Plan:** Applicant is applying for coverage within 90 days of termination of the Washington State Basic Health Plan that was in effect for at least 24 months.
- Addition of:** newborn or newly adopted child to an existing LifeWise plan, within 60 days of birth or adoption.

\* Include a copy of your Certificate of Coverage or other supporting evidence. (Complete Section 7.)

\*\* Include a letter from the small group employer indicating the type and length of prior coverage.

## SECTION 6 – TOBACCO USE INFORMATION FOR ADDING SPOUSE

If the spouse who is being added has used tobacco products within the 12 months prior to this application, his/her rate will be the smoker rate. Not checking a box will result in paying the higher rate.

➤ My spouse has used tobacco products during the prior 12 months:  Yes  No

## SECTION 7 – PRIOR or CURRENT COVERAGE (USE FOR ADDING DEPENDENTS ONLY)

If you have prior creditable coverage, we will waive or credit the nine-month waiting period. To help us determine if you qualify for shortening the pre-existing condition waiting period, please complete the following. Application must be received within 63 days of prior coverage ending for consideration of waiting period credit.

**Attach your Certificate of Coverage from your current or prior carrier.**

If you do not have a Certificate of Coverage, you may provide other documentation which demonstrates prior coverage beginning and ending dates.

**This documentation may be sent in separate from the application, but should be provided within 60 days of the effective date.**

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

➤ Type of benefits (check all that apply):  Medical  Hospital Only  Accident Only  Prescription Drug  Dental  Vision

Do you intend to continue this other coverage if you are accepted by LifeWise?  Yes  No (If no, remember to contact your insurance company to cancel, including our corporate affiliates.)

## SECTION 8 – SIGNATURES

I hereby apply for enrollment with LifeWise for the family members listed on this application for coverage under my Individual Contract. I certify that:

- I have read this form, and I have supplied all of the required information on this form.
- The persons listed qualify for dependent enrollment as stated in my subscriber contract.
- Benefits may be subject to pre-existing condition or benefit-specific waiting periods as stated in my subscriber contract.
- 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. I further understand that it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
- Eligibility and benefits under this program are subject to all terms, conditions and limitations stated in my original enrollment application and subscriber contract.

If one or more family members is not accepted for coverage, I authorize LifeWise to enroll those who are eligible in the plan I have selected (not applicable to HSA plans if this would result in changing family coverage to individual coverage).

Yes  No

X

/ /

X

/ /

Signature of Primary Applicant (Parent/Legal Guardian)

Date of Signature

Signature of Spouse

Date of Signature

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