INDIVIDUAL AND
FAMILY PLANS

GroupHealth®

2015 Enrollment application

For coverage effective on or after Jan. 1, 2015

Thank you for considering us for your individual and family coverage. To apply for enrollment:

- Complete this application in black or blue ink only.
- Read the application carefully and answer all applicable sections completely. **All pages must be returned.**
- Confirm that you meet all the eligibility requirements called out throughout this application.
- Send the application and supporting documents to:
  Group Health Individual and Family Sales
  320 Westlake Ave. N., Suite 100
  Seattle, WA 98109-5233

  For application deadlines, see page 6, "Coverage effective date."
- Call us at **1-800-358-8815** or **206-448-4141** if you have any questions about this application or the process.

1 APPLICATION TYPE

Check the boxes below that apply to you. Please note: Coverage usually begins on the first of the month (see "Coverage effective date" on page 6 for details). If you are applying outside of open enrollment, you must have a qualifying event.

☐ **I am/we are new applicants.**

☐ **I am/we are current members and wish to:**

☐ Add dependent(s) ☐ Change plans

☐ Change from dependent to subscriber

(Please complete subscriber information in Section 3 on page 3.)

☐ **I am applying for coverage for a child or children only.** (In Section 3 on page 3, please include parent/guardian information under "applicant/subscriber" and include child information under "dependent child.")

FOR INTERNAL USE ONLY

Date application was received:

Effective date: ____________________

Group Health refers to either Group Health Cooperative or Group Health Options, Inc.

2 QUALIFYING EVENTS

Complete if applying outside open enrollment and submit your documentation along with your application. You must enroll no more than 60 days from the date of the qualifying event.

CHECK ONE	QUALIFYING EVENTS	DOCUMENTATION
☐	Loss of your health coverage, including an employer plan, unless the loss is based on misrepresentation of a material fact affecting coverage or fraud related to the health coverage. Note: terminating other health coverage or being terminated for not paying premiums will not be considered loss of coverage. Losing coverage that is not minimum essential coverage is also not considered loss of coverage.	Copy of the COBRA offer letter or a letter from your employer listing each applicant that experienced a loss in coverage, the reason for the termination, and when the termination occurred.
☐	No longer eligible for Medicaid or a public program providing health benefits.	Copy of the termination letter from Medicaid or other program indicating loss of eligibility and the date of loss.
☐	A permanent move to a new area where the prior plan doesn't provide coverage.	Copy of the termination letter from the prior health plan indicating that you are no longer in the service area and the date coverage was lost.
☐	The birth, adoption, or placement for adoption, of the applicant for whom coverage is sought.	Copy of the official birth certificate, adoption papers, medical support order, or the court order appointing a guardian.
☐	The Health Benefit Exchange discontinues your coverage and the three-month grace period for continuation of coverage has expired.	Letter from the Exchange or health plan indicating coverage was discontinued by the Exchange and the three-month grace period for continuation of coverage has expired.
☐	Your employer doesn't pay your COBRA premiums on time.	Copy of the letter from employer or COBRA administrator indicating loss was due to failure of the employer to remit premium.
☐	Your COBRA coverage has been exhausted or you reach the lifetime limit on your COBRA plan. Note: Voluntary termination of COBRA is not a qualifying event.	Copy of the letter from employer or COBRA administrator indicating loss of COBRA due to exhausting the benefits or exceeding lifetime limit in the plan and no other COBRA coverage is available.
☐	Loss of coverage on a group plan due to age.	Copy of letter from employer of prior health plan indicating loss of coverage due to age.
☐	Marriage or entering into a domestic partnership (dependents also qualify).	Copy of marriage certificate or domestic partnership registration.
☐	Loss of coverage as the result of dissolution of marriage or termination of a domestic partnership.	Copy of divorce decree, annulment papers, or affidavit of termination of domestic partnership, and copy of termination letter from prior health plan.
☐	Discontinuance of Washington State Health Insurance Pool (WSHIP) coverage.	Copy of the termination letter from WSHIP.
☐	Other circumstances where your health plan is no longer available to a subset of people that includes you.	Copy of the termination letter from the prior health plan indicating loss of coverage due to special circumstances.

ALL PAGES MUST BE RETURNED

3 SUBSCRIBER, DEPENDENT, AND ADDRESS INFORMATION

Applicant/subscriber name Last, first, middle initial		Member ID number, if current or former Group Health member	Social Security number (REQUIRED)
Former/other names used		Date of birth	Sex M/F
Preferred language spoken	Preferred language written	If age 21 or older, has individual used tobacco products regularly within the last 6 months?* ☐ Yes ☐ No	

Spouse/domestic partner name Last, first, middle initial	Member ID number, if current or former Group Health member	Social Security number (REQUIRED)
Former/other names used	Date of birth	Sex M/F
If age 21 or older, has individual used tobacco products regularly within the last 6 months?* ☐ Yes ☐ No		

Dependent child name (under age 26) Last, first, middle initial	Member ID number, if current or former Group Health member	Social Security number (REQUIRED)
Former/other names used	Date of birth	Sex M/F
If age 21 or older, has individual used tobacco products regularly within the last 6 months?* ☐ Yes ☐ No		

Dependent child name (under age 26) Last, first, middle initial	Member ID number, if current or former Group Health member	Social Security number (REQUIRED)
Former/other names used	Date of birth	Sex M/F
If age 21 or older, has individual used tobacco products regularly within the last 6 months?* ☐ Yes ☐ No		

Dependent child name (under age 26) Last, first, middle initial	Member ID number, if current or former Group Health member	Social Security number (REQUIRED)
Former/other names used	Date of birth	Sex M/F
If age 21 or older, has individual used tobacco products regularly within the last 6 months?* ☐ Yes ☐ No		

*Regular tobacco use is defined as 4 or more times per week, excluding religious or ceremonial use.

Dependent child name (under age 26) Last, first, middle initial	Member ID number, if current or former Group Health member	Social Security number (REQUIRED)
Former/other names used	Date of birth	Sex M/F
If age 21 or older, has individual used tobacco products regularly within the last 6 months?*		☐ Yes ☐ No

Dependent child name (under age 26) Last, first, middle initial	Member ID number, if current or former Group Health member	Social Security number (REQUIRED)
Former/other names used	Date of birth	Sex M/F
If age 21 or older, has individual used tobacco products regularly within the last 6 months?*		☐ Yes ☐ No

Dependent child name (under age 26) Last, first, middle initial	Member ID number, if current or former Group Health member	Social Security number (REQUIRED)
Former/other names used	Date of birth	Sex M/F
If age 21 or older, has individual used tobacco products regularly within the last 6 months?*		☐ Yes ☐ No

REQUIRED—Residential street address (no P.O. Box)			
City	State	ZIP	County

Mailing address	City	State	ZIP
E-mail address**			Contact phone number

*Regular tobacco use is defined as 4 or more times per week, excluding religious or ceremonial use.

**By providing your e-mail address, you are agreeing to receive e-mail communications from Group Health.

4 BILLING INFORMATION

No payment is required at this time. You will be mailed a bill once you are approved for coverage. Information about paying online or setting up recurring electronic payments will be included with your welcome letter once you are enrolled.

Check one of the following three billing options and fill in the billing information (if applicable).

☐ **1. Send bill to:** subscriber mailing address.

OR

☐ **2. Send bill to:** address other than subscriber mailing address.*	☐ **3. Send bill to:** guarantor at the address below.*
Billing name	Guarantor name
Address	Address
City	City
State/ZIP	State/ZIP
Billing phone number	Guarantor phone number
Billing e-mail	Guarantor e-mail

*The applicant, or the financial guarantor for children under the age of 18 and dependents who are totally incapable of self-sustaining employment, is responsible for premium payments. As permissible by law, if a third party is paying premiums on behalf of the applicant, the third party is required to either set up an account to pay online at ghc.org/premium or, if receiving a paper bill, submit one check per subscriber policy.

5 PLAN CHOICES

Check **one** box to indicate your health plan selection.

Group Health Cooperative Core plans provider network also known as Group Health	**Group Health Options, Inc.** Connect plans provider network also known as Alliant Plus
Group Health Core Plus ☐ Gold ☐ Silver ☐ Bronze	Group Health Connect3 ☐ Gold ☐ Silver
Health Savings Account (HSA) compatible ☐ HealthPays® Core Bronze HSA Group Health has partnered with HealthEquity to administer an HSA that is integrated with your Core Bronze HSA plan. Do you want to choose HealthEquity for your HSA? ☐ Yes ☐ No	Health Savings Account (HSA) compatible ☐ HealthPays® Connect Bronze HSA Group Health has partnered with HealthEquity to administer an HSA that is integrated with your Connect Bronze HSA plan. Do you want to choose HealthEquity for your HSA? ☐ Yes ☐ No

NOTE: Federal law places some limitations on HSA eligibility. Consult your tax advisor or materials available through the U.S. Treasury Dept. for this important information to make sure you're selecting the right HSA plan for your family. Subscribers under the age of 18 can enroll in the health plan but are not eligible for the Health Savings Account.

6 OPTIONAL ADULT DENTAL PLAN

Check the box below if you would like to elect the optional adult dental plan.

☐ I would like the adult dental plan for myself and my eligible dependents age 19 and older.

Check the box below if you are a current member and wish to discontinue your optional adult dental plan.

☐ I would like to discontinue my adult dental plan and the adult dental plan for my enrolled dependents age 19 and older.

Coverage provided by Group Health Options, Inc. Plan is administered by United Concordia Dental. Your plan uses the United Concordia Dental Advantage Plus Network.

7 VOTING OPTION

☐ I and my eligible dependents (age 18 or older) would like to become voting members of Group Health Cooperative.

8 TERMS AND CONDITIONS

1. **Residency eligibility:** You must reside in the Group Health service area, which includes the following counties: Benton, Columbia, Franklin, Island, King, Kitsap, Kittitas, Lewis, Mason, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom, Whitman, or Yakima. A photocopy of a valid Washington State driver's license, identification card, or similar proof of residency acceptable to Group Health may be requested.
2. **Medicare eligibility:** You or your dependent(s) who are applying are not eligible for Medicare; if you are unsure of your Medicare eligibility please visit medicare.gov. If you or your dependent is age 65 or older but not eligible for Medicare, please submit a "Not Eligible for Medicare" document from the Social Security Administration. If it is discovered that you or your dependent(s) were entitled to Medicare prior to enrolling in a Group Health Individual and Family plan, Group Health reserves the right to terminate coverage.
3. **Dependent children:** First 3 children ages 0–20 each will be charged the age 0–20 rate. There's no charge for additional children ages 0–20. Each child older than age 20 will be charged the rate applicable to his or her individual age.
4. **Adults applying as a guarantor (dependent-only coverage):** A guarantor may enroll only dependent children who are under the age of 18 and dependents who are totally incapable of self-sustaining employment. Financial guarantors are required for children under the age of 18. A guarantor will be enrolled as a subscriber without medical benefits. As a guarantor, you hereby agree to accept the financial and contractual responsibilities for the dependent listed on the application.
5. **Coverage effective date:** The effective date of your application is based upon Group Health's receipt of your completed application. All application documents must be received in the Individual and Family Sales Department at Group Health.
   - If you are requesting to enroll during the open enrollment period (Nov. 15, 2014 through Feb. 15, 2015), and wish to enroll for a Jan. 1, 2015 effective date, your application must be received by Dec. 23, 2014. For effective dates of Feb. 1 or March 1, 2015, your application must be received by the 23rd of the month prior to the desired effective date.
   - If you are requesting to enroll outside of the open enrollment period due to a qualifying event:
     - For application documents received on or before the 23rd of the month, coverage will begin on the first day of the following month. (Example: If your application is received on or before June 23, enrollment is effective July 1.)
     - For application documents received on the 24th through the end of the month, coverage will begin on the first of the month following the next full month.
     - For newborns, coverage is effective as of date of birth.
     - For those adopted or placed for adoption, coverage is effective the date of adoption or placement, whichever occurs first.
     - For special enrollment based on marriage or domestic partnership, or loss of minimum essential coverage, coverage will be effective on the first date of the next month.

6. **Premium payments:** Premium payments are due on a calendar-month basis on or before the first day of each month, subject to a grace period of 10 days. Payment can be set up through monthly billing, paid by check or money order, or paid online at ghc.org/premium. Premium amounts are subject to change upon 30 days' written notice, which will be sent to the subscriber's mailing address.
7. **Revoking coverage:** Intentionally providing false or misleading information on your application documents or failing to pay monthly premiums may result in Group Health's refusal to extend coverage, cancellation of coverage, or rescission of coverage for you or your family members.
8. **Applicant's financial liability:** a) Pre-enrollment Services: If any hospital or medical service is rendered to you or your dependent(s) prior to your effective date of coverage, you will be responsible for paying for those services. These non-covered services will be billed to you at full schedule rates. Regardless of whether you or your dependents become a member, you will be responsible for payment of such charges; b) Prior Authorizations: Upon termination from any Group Health Individual and Family plan, all prior authorizations for health care coverage for the terminated individual(s) will no longer be valid, and you will be financially liable for any additional services you receive.

9 PRODUCER INFORMATION (SECTION REQUIRED IF APPLICABLE)

Group Health sales representative or producer name

Group Health producer ID number

Company/house name (if applicable)

Group Health house ID number

Phone number

10 HOW DID YOU HEAR ABOUT GROUP HEALTH'S INDIVIDUAL AND FAMILY HEALTH PLANS?

☐ PRODUCER

☐ REFERRAL: ☐ Current Group Health member ☐ Employer ☐ Friends/family

☐ WEB: ☐ ghc.org/MyGroupHealth ☐ Facebook ☐ Twitter ☐ Other website

☐ ADVERTISEMENT: ☐ TV ☐ Radio ☐ Newspaper/magazine ☐ Online

☐ SEMINAR

(*continued on next page*)

11 ACKNOWLEDGEMENTS AND SIGNATURES

☐ **I acknowledge that:**

- This application becomes part of my Medical Coverage Agreement. If I have elected the optional adult dental plan (Section 6), this application also becomes part of my Dental Certificate of Insurance.
- I have the right to examine and return the Medical Coverage Agreement within 10 days of receipt.
- Regardless of my enrollment date, my plan rate may change at the next plan renewal.
- If my/our physical residential address changes to a different county in the Group Health service area, my premium rates may be subject to change.
- The signatures shown below allow me, my spouse/domestic partner, or my producer (Section 9) to release to Group Health information about any person listed on my Individual and Family plan application documents.
- Under the Health Insurance Portability and Accountability Act (HIPAA), Group Health, without my authorization, may only release limited information about my selection of a plan to my spouse/domestic partner, adult/minor children, producer, or anyone else.
- Group Health may collect, use, or disclose the nonpublic personal information of persons listed on this application as required or permitted by law and to conduct routine business functions such as determining eligibility for enrollment, reviewing prior coverage for waiting periods, paying claims, and, if appropriate, coordinating benefits, and fulfilling other legal obligations specified in my Group Health Medical Coverage Agreement.
- I have read and agree to the Terms and Conditions (Section 8) included with this application.
- I authorize Group Health to disclose information about the selection of a plan to the Producer of Record (Section 9) for the duration of coverage and final reconciliation of the Group Health account. A signed Authorization to Disclose Health Plan Information form is required for all other disclosures to the Producer of Record.

I declare that, to the best of my knowledge, all information I have provided with this application 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 on behalf of myself or any family members, the Medical Coverage Agreement may be cancelled retroactively to its effective date. I further understand that it is a crime to knowingly provide false, incomplete, or misleading information for the purpose of fraudulently obtaining health coverage. Penalties may include imprisonment, fines, and denial of benefits.

Applicant/guarantor signature ______________________ Date ________

Spouse/domestic partner signature ______________________ Date ________

Documentation: I am enclosing all documentation as required, including, if applicable, documentation to enroll due to a special qualifying event. Any missing information may delay processing of my application.

Signature: This application has been signed by me and my spouse/domestic partner, if applicable.