Washington Individual Enrollment Application

Effective January 1, 2015

PREMERA | BLUE CROSS

This application is for health care coverage purchased directly from Premera Blue Cross (Premera). If you wish to purchase coverage through the Washington Healthplanfinder, you must make application directly through them. Contact them at 855.923.4633 (TTY/TTD 855-627-9604) or www.wahbexchange.org or our Premera Sales Department at 888.304.4755.

Please print your answers clearly in ink so we can process your application quickly. Be sure to return **all** pages to us. Omissions or incomplete answers will result in the return of your application and may cause a delay in the effective date of your coverage.

1 My Enrollment Information

☐ I am a new applicant

☐ I am a current member. My subscriber ID# is _____ (see your ID card) I want to →

☐ add my spouse or domestic partner _____ (marriage date/date of partnership)

☐ add my newborn or newly-adopted/placed for adoption child(ren): _____ (placement date)

☐ add my dependent child(ren)

☐ add my legal ward/guardianship/medical support order/foster child(ren)

☐ change my plan

2 Am I Eligible?

You're eligible to apply for a Premera Blue Cross plan if you are:

- A resident of and have a principal residence in the state of Washington.
- Not entitled to Medicare. If you are 65 or older but not eligible for Medicare, please submit a "Not Eligible for Medicare" document from the Social Security Administration.
- Applying during an open enrollment period or when you have a qualifying event as described below and on the next page.

Eligible dependents that can enroll on your plan include your:

- spouse or domestic partner
- natural or legally adopted/placed child(ren), legal ward or foster child(ren) under the age of 26
  (Newborns or newly adopted/legally placed children under age 26 can apply as a subscriber or dependent outside an open enrollment period within the first 60 days of birth or placement.)

Open Enrollment Periods

Individuals may apply for enrollment in a Premera plan during an open enrollment period. An open enrollment period is the timeframe set by the state of Washington when applicants can enroll. Please refer to **premera.com** for the dates of the open enrollment period. The completed enrollment application must be postmarked or received electronically before the end of the open enrollment period. If you are applying outside an open enrollment period, see below.

Special Enrollment

Individuals can apply for enrollment outside of an open enrollment period if they qualify for a special enrollment period. To qualify for a special enrollment period, you must experience a qualifying event. See the table on the next page to determine if you qualify for special enrollment. Please check the box for the qualifying event that applies to you and include your supporting documentation.

2 Am I Eligible? (continued)

Qualifying Events (Application must be received within 60 days of the qualifying event)	Submit a Copy of the Following Document(s). Supporting documents must be received within 60 days of the qualifying event.
☐ The birth, placement for adoption or adoption of the applicant for whom coverage is sought; for Qualified Health Plans (QHPs), also applies to children placed in foster care, legal wards, guardianship or medical support orders.	Copy of birth certificate Copy of adoption papers Copy of foster care papers Copy of medical support order Copy of the court order appointing a guardian
☐ The loss of eligibility for Medicaid or a public program providing health benefits	Letter from Medicaid or other program indicating loss of eligibility.
☐ A permanent change in residence, work, or living situation, where the prior health plan does not provide coverage in that person's new service area	Utility bills from your prior address and new address within the last 90 days and a verification letter from your prior health plan.
☐ The loss of coverage as the result of dissolution of marriage or termination of a domestic partnership	Copy of divorce decree or annulment papers, a statement (including the date) the Domestic Partnership ended or a letter from the prior health plan.
☐ Marriage or entering into a domestic partnership, including eligibility as a dependent	Copy of marriage certificate; state registration or Copy of marriage certificate; state registration or a Declaration of Domestic Partnership. (a Declaration of Domestic Partnership form can be found on our web site at premera.com)
☐ Loss of minimum essential benefits, including loss of employer sponsored insurance coverage; except for voluntary termination of health coverage, misrepresentation or fraud	Your COBRA offer letter or a letter from your employer listing each applicant that experienced a loss of coverage and reason for termination.
☐ Loss of coverage purchased on the Exchange, due to an error by the Exchange, the health plan, or Health and Human Services (HHS).	Letter from the Exchange, health plan or HHS indicating coverage was lost due to an error
☐ If coverage is discontinued in a qualified health plan by the health benefit exchange pursuant to 45 C.F.R. 155.430 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
☐ Loss of COBRA coverage due to failure of the employer to remit premium	Letter from employer or COBRA administrator indicating loss was due to failure of the employer to remit premium
☐ The COBRA coverage period ends (usually after 18 months) or the individual has exceeded the lifetime limit in the plan and no other COBRA coverage is available ***Note:*** Voluntary termination of COBRA is not a qualifying event. If you terminate or stop paying for your COBRA, you must wait for the next Open Enrollment Period to apply.	Letter from employer or COBRA administrator indicating loss of COBRA coverage due to individual exhausting the COBRA period or exceeding the lifetime limit in the plan and that no other COBRA coverage is available
☐ A situation in which a plan no longer offers benefits to the class of similarly situated individuals that includes the applicant	Letter from the prior health plan indicating loss of coverage due to not being in a class of similarly situated individuals
☐ Loss of coverage as a dependent on a group plan due to age	Letter from employer or insurance health plan indicating loss of coverage due to age
☐ If the person discontinues coverage under the Washington State Health Insurance Pool (WSHIP)	Letter from WSHIP indicating coverage has been discontinued

3 I Want to Enroll My…

Self* (Last, First, Middle Initial)	Social Security Number		Gender: ☐ M ☐ F
	Date of Birth / /	**I used tobacco in the last 6 months**:**	☐ Y ☐ N
Legal Spouse or Domestic Partner* (Last, First, Middle Initial)	Social Security Number		Gender: ☐ M ☐ F
	Date of Birth / /	**I used tobacco in the last 6 months**:**	☐ Y ☐ N
Dependent Child—under 26 only* (Last, First, Middle Initial)	Social Security Number		Gender: ☐ M ☐ F
	Date of Birth / /	**I used tobacco in the last 6 months**:**	☐ Y ☐ N
Dependent Child—under 26 only* (Last, First, Middle Initial)	Social Security Number		Gender: ☐ M ☐ F
	Date of Birth / /	**I used tobacco in the last 6 months**:**	☐ Y ☐ N
Dependent Child—under 26 only* (Last, First, Middle Initial)	Social Security Number		Gender: ☐ M ☐ F
	Date of Birth / /	**I used tobacco in the last 6 months**:**	☐ Y ☐ N
Dependent Child—under 26 only* (Last, First, Middle Initial)	Social Security Number		Gender: ☐ M ☐ F
	Date of Birth / /	**I used tobacco in the last 6 months**:**	☐ Y ☐ N

Home Address (not P.O. Box) **required**	City / State / ZIP	County	Home Telephone Number ( )
Mailing Address (if different from Home Address)	City / State / ZIP	County	Work Telephone Number ( )
Billing Address (if different from Mailing Address)	City / State / ZIP	County	Cell Telephone Number ( )
E-mail Address of Primary Applicant			
Primary language(s), **if other than English (Primary Applicant)**:			

* Only the first 26 characters will be displayed on the ID card(s)

** "Tobacco use" means use of any tobacco product on average four or more times per week within the past 6 months. Tobacco use does not include religious or ceremonial use.

4 Selecting My Plan

I want this plan to begin on the ☐ 1st **or** ☐ 15th of ____________ (enter month) (no more than 60 days after the application is signed)

Effective dates for plan changes are on the first of each month.

Health Plan

I want to enroll in the following Premera Blue Cross Preferred health plan (check only one option):

PPO Plans

- ☐ Preferred Gold 1000
- ☐ Preferred Gold 1500
- ☐ Preferred Silver 2000
- ☐ Preferred Silver 3000
- ☐ Preferred Bronze 5500
- ☐ Preferred Bronze 6350

HSA Plans

- ☐ Preferred Silver HSA 2500/5000
- ☐ Preferred Bronze HSA 5250/10,500

4 Selecting My Plan (continued)

If you selected an HSA plan, please provide an option below.

☐ Yes, establish UMB Health Savings Account (Social Security Number must be provided in section 3)

For additional disclosures and information, view the UMB terms and conditions at https://hsa.umb.com/stellent/groups/public/documents/web_content/006538.pdf . UMB is a member of the FDIC and one of the largest independent banks in the U.S. since 1913. Terms and conditions of the Personal Funding Account will be mailed with your HSA Healthcare Payment Visa Card. With enrolling in an HSA, I authorize the sharing of my information to establish a bank account.

☐ No, I will use my own bank

Individual Select Dental Plan for Adults

Check the box of the plan you want to enroll in:

☐ Select Dental Plan for Adults ($50 Deductible) ☐ Select Dental Plan for Adults ($75 Deductible)

Individual Pediatric Dental Plan

☐ Individual Pediatric Dental Plan ☐ I do not want this coverage. (see below)

Pediatric Dental Certification

☐ I am over 18 years of age and will not be enrolling anyone under 19 years of age on this plan or;

You must certify that you have enrolled in a separate pediatric dental plan if you choose one of our medical plans but do not purchase a pediatric dental plan from us. **By checking the boxes below and your signature on this application you are attesting to this separate coverage**.

☐ I have selected a health plan and certify that I have enrolled myself, or will enroll myself and all dependents in a separate pediatric dental plan.

☐ I understand that I must submit proof of coverage from the stand-alone pediatric dental plan from the other carrier. (The stand-alone dental plan issuer has the responsibility for providing proof of coverage upon request)

5 Paying for My Health Plan (select one) **Don't send payment**

We do not accept subscription payments from third party payers including employers, providers and not-for-profit agencies except as required or allowed by law.

☐ Monthly paper bill by mail (move on to Section 6)

☐ Automatic monthly withdrawal from my bank account. Here's my account information:

I have selected automatic monthly withdrawal and I hereby authorize Premera to initiate funds transfer from the bank or financial institution account indicated below. I authorize my financial institution to honor these transfers.

Account Holder's Name (print)	Financial Institution or Bank Name
Financial Institution/Bank City, State, ZIP	☐ Checking ☐ Savings
Bank Routing Number (see picture below, number cannot begin with a "5")	Account Number (see picture below)

Bank Routing Number Account Number

Attach your **voided** check HERE

(Continued)

5 Paying for My Health Plan (continued) **Don't send payment**

Additional Terms and Conditions:

- Funds are transferred on the 1st business day of each month to pay for that month's coverage. (For example, the deduction on February 1st pays for coverage in February.)
- I understand that if I choose the 15th of the month as my effective date, my first transfer amount will cover 15 days of the current month PLUS the next full month. Subsequent transfers will be for a full month of coverage.
- It may take as long as 45 days to set up the funds transfer. I may receive a paper bill to cover the initial month(s) while the transfer is being set up.
- I understand that my monthly subscription charges will be automatically withdrawn from my bank account each month until I notify Premera that it should be cancelled. To ensure prompt cancellation, I must notify Premera no later than the 20th of the month to be effective for the following month's automatic withdrawal. I have the right to stop payment of a specific bank transfer at least 3 days prior to the next scheduled withdrawal date.

I affirm that my subscription charges are not paid or sponsored by my employer, a not-for-profit agency, provider or any other third party except as required or allowed by law.

Account Holder Signature X _____ **Date of Signature** ___/___/___

6 My Other Health Coverage

Do you have other health care coverage?

☐ Yes (complete the information below) ☐ No (move on to Section 7)

Do you intend to continue this current coverage if you are accepted by Premera?

☐ Yes If you have other coverage in addition to Premera coverage, we will coordinate benefits between the multiple health plans.

☐ No Once accepted by Premera, remember to cancel your current health plan.

Prior Coverage?

Remember to attach your documents that verifies your prior coverage beginning and end dates. You can get it from your previous employer or health plan carrier.

Name of Your Previous or Current Health Plan Carrier ☐ Premera ☐ Premera Blue Cross Blue Shield of Alaska ☐ Other (list below)	
Name of Other Carrier	Other Carrier Telephone Number ( )
Name of Subscriber (contract holder)	Subscriber ID # (include 3 letter prefix if applicable)
Names of All Members on Prior Coverage	
Date Coverage Began ___/___/___	Date Coverage Ended ___/___/___

7 Health Information (Optional)

To assist you in managing your health, Premera provides a range of support programs. In an effort to identify programs appropriate for you or your dependents, please provide the following information. This information is not used to make a decision on your eligibility for coverage. If you need to, please attach an additional piece of paper for information on additional dependents.

Please write names of all those you are enrolling >> and answer the questions below for each person.	Your Name: _____	Dependent: _____	Dependent: _____	Dependent: _____	Dependent: _____
How would you describe your overall health? (Please indicate an "E" for Excellent, "G" for Good, "F" for Fair or "P" for Poor for each applicant and all listed dependents)					
Please answer the following questions with a "Y" for Yes or a "N" for No for each the applicant and any listed dependents					
Have you thought about doing any of the following to improve your health: stop smoking, lose weight, or getting more exercise?					
If Yes, would you like help with any of these?					
Do you or any of your dependents applying for coverage have diabetes, asthma, heart failure, coronary artery disease, chronic obstructive lung disease (COPD) or any other condition that is treated with medicine, or limits activities?					
If Yes, do you or your dependents see a doctor regularly about the condition?					
Is there anything that stops you or your dependents from taking care of your health as well as you would like?					
In the last three months, have you or your dependents gone to the hospital or emergency room for a condition other than an accident?					

If you answered "Yes," to any questions in Section 7, please provide details below:

Name (first, last)	Describe the condition

8 Basic Terms of Enrollment

1) I understand and agree that this application is not an offer of coverage, and coverage does not begin until: a) This application is received, reviewed, and accepted by Premera and an effective date of coverage is assigned; and b) My complete and correct payment is received. Submission of this application does not guarantee I will receive coverage.
2) I understand and agree that this application becomes a part of my contract and to the extent that the application is inconsistent with the plan, the plan will govern.
3) I understand that no benefits are available under this plan for services or supplies related to an inpatient confinement that began prior to the effective date of coverage, unless the applicant is an "eligible individual" as defined by Federal law.
4) I understand that acceptance for coverage is dependent on: a) Persons listed on this application must be residents of the state of Washington in order to apply for and maintain coverage under this plan; and b) No one listed on this application is eligible for Medicare (Persons eligible for Medicare may apply for a Medicare Supplement or Medicare Advantage contract offered by Premera). "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 healthcare 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. Premera 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.
5) I understand and agree that only Premera may: a) Make or modify the terms of the application or contract; or b) Waive any of the Premera rights or requirements. I understand that I may receive benefits which are less than the amount billed by my provider when treatment is not received from a contracted provider.
6) I understand and agree that this coverage is issued as individual health coverage, is not sold or issued for use as a government, or third party sponsored health plan, and is not partially or fully paid for by an employer, a not-for-profit agency, provider or any other third party payer, either directly or indirectly, except as required or allowed by law.
7) For the Individual Pediatric Dental Plan only: I understand that pediatric dental is a required part of the medical plan and a separate individual pediatric dental plan must be purchased for all persons enrolling on an individual medical plan.
8) I understand that dental coverage has a waiting period for major services of 12 months from the effective date of coverage. This waiting period may be reduced or waived based on prior group dental coverage with Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Oregon or LifeWise Health Plan of Washington.

   I understand that I must maintain current enrollment on a Premera individual medical plan in order to enroll in a Premera dental plan. If I cancel my Premera individual medical plan or lose coverage for any reason, my dental coverage will also end at the same time.

9 Notice of Information Use and Disclosure

Type of Information to be Disclosed: I (We) authorize: any physician, health care provider, hospital, insurance or reinsurance company, pharmacy benefits manager or third party benefits administrator to disclose a copy of my (our) personal health information, including any and all diagnostic, procedural, treatment, claim, prescription or other health related information including records concerning alcohol and/or chemical dependency, reproductive health (including abortion), sexually transmitted diseases, HIV, AIDS, psychiatric disorders, mental illness to Premera or its representatives as allowed by law.

Purpose of Disclosure: I (We) understand that personal information will be used for evaluating enrollment in the health plan, determining eligibility for benefits and paying claims.

Timeframe of Release: Unless I revoke it, this release will remain valid for twenty-four (24) months from the date of my signature below.

Revocation of Release: I understand that I may change my mind and revoke this release at any time. I will do this by letting Premera know of my decision. Any change will be effective five (5) business days after Premera receives my written notice at the address listed on this form. I understand that some or all of this information may already have been used by Premera to make decisions, which will not be affected by its revocation.

Redisclosure: Premera Blue Cross may be required to redisclose this information to another party that is not subject to state and federal privacy rules.

Effect of Not Authorizing: This authorization is a condition of your enrollment in our health plan or your eligibility for benefits. If you decide not to sign this authorization, we may decline to enroll you in our health plan or to give you benefits.

Please Note: You or your authorized representative will receive a copy of this authorization.

10 My Final Checklist:

Omissions or incomplete answers will result in the return of your application and may cause a delay in the effective date of your coverage.

Did I remember to:

- ☐ Provide documentation for my qualifying event in as indicated in Section 2? (If applying outside Open Enrollment)
- ☐ Indicate in Section 3 whether my spouse/domestic partner, dependents or I use tobacco? This will ensure I pay the correct rate.
- ☐ Choose an effective date in Section 4?
- ☐ Select only one medical plan option in Section 4?
- ☐ Attach a voided check and sign at the bottom of Section 5 if you want to pay your bill with automatic bank withdrawal?
- ☐ Provide information about my other coverage (if applicable) in Section 6?

Remember to have all applicants age 18 or older sign this application in Section 11.

11 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, agree to its terms and I have supplied all of the required information on this form.

b) I understand that a complete list of exclusions and limitations is detailed in the contract available online at premera.com. If there is a conflict, the terms of the contract prevail.

c) 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 false, incomplete, or misleading statements or answers on behalf of myself or any family members, 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.

Approved applications postmarked or received by the 14th day of the month will be effective on the 15th of that month. A prorated subscription charge will apply for the partial month of coverage. Approved applications postmarked or received by the last day of the month will be effective on the first day of the following month. This does not apply to applicants enrolling during open enrollment.

Important! Signatures are required for all applicants age 18 or older.

Signature of Primary Applicant (Parent/Legal Guardian) *Subscriber must sign if adding spouse/domestic partner or child.*	Date of Signature
X	/ /
Signature of Spouse/Domestic Partner	Date of Signature
X	/ /
Signature of Dependent Child age **18 or older**	Date of Signature
X	/ /
Signature of Dependent Child age **18 or older**	Date of Signature
X	/ /
Signature of Dependent Child age **18 or older**	Date of Signature
X	/ /
Signature of Dependent Child age **18 or older**	Date of Signature
X	/ /

If not the primary applicant, I am the: ☐ Parent ☐ Holder of Power of Attorney ☐ Legal Guardian
(If you are the legal guardian or holder of a power of attorney for the applicant, attach legal documentation.)

PREMERA BLUE CROSS

Marketing Authorization

Premera Blue Cross continuously strives to provide products and services to meet the needs of its members. Please sign this form to allow Premera to use your contact information to send you information about products and services offered by us and other companies that could provide you with additional financial protection such as critical illness, accident and life insurance.

I understand that:

1. I may change my mind and cancel this authorization at any time by sending written notice to Premera. After Premera receives my notice, they will cancel this Authorization within ten (10) business days. My notice will not have an effect on any actions taken prior to Premera receiving my revocation.
2. If information is shared with third parties, it may no longer be protected by HIPAA and other privacy rules.
3. I understand that this release is voluntary. It does not affect my enrollment in a health plan, eligibility for benefits or payment of claims.
4. Unless revoked by me, this release will remain valid for 1 year after my coverage with Premera terminates.

Name of subscriber: _____ Date of birth: ___/___/___

Signature of subscriber: _____ Date signed: ___/___/___

Please return this page.

The following information is collected for statistical purposes only, and is not used to determine your eligibility for coverage.

Total Number Of Individuals In Household (includes those not applying for coverage): _____

Household Income (check one):

☐ $0 to $19,999 ☐ $20,000 to $39,999 ☐ $40,000 to $59,999
☐ $60,000 to $74,999 ☐ $75,000 to $99,000 ☐ $100,000 or more

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

Agency Name	
Producer Name	Premera Blue Cross Producer Number
Producer Address	
Producer Telephone Number ( )	Producer E-mail Address
Producer Signature **X**	Date / /

Please Note: Producers who do not have a current appointment with Premera are not authorized to offer Premera products.

Mail completed application to:

Premera Blue Cross
PO Box 91120, MS 295
Seattle, WA 98111-9220

Fax: 425.918.5278
premera.com

If you are applying for the first time and have questions, please contact Individual Plan Sales at **888.304.4755**.
If you are an established member with Premera, please contact Customer Service at **800.722.1471**.