Regence

Regence BlueShield is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueShield
1800 Ninth Avenue
Seattle, Washington 98101
Mail form to: PO Box 1106, MS-LB1
Lewiston, ID 83501
OR Fax to: 1-877-369-3410
Please do not include initial payment with application

2015 Washington Individual Enrollment Application

This application is for health care coverage purchased directly from Regence BlueShield (Regence). If you wish to purchase coverage through the exchange, you must apply directly through them.

Please print your answers clearly in black ink so we can process you 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.

SECTION 1 - ELIGIBLE TO APPLY FOR COVERAGE?

You must reside in the plan 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. A photocopy of a valid Washington state driver's license, identification card, or similar proof of residency acceptable to Regence BlueShield (Regence) may be requested.

For more information, please contact your producer or call our Sales department toll-free at 1-888-REGENCE (1-888-734-3623).

SECTION 2 - AM I ELIGIBLE?

You're eligible to apply for a Regence BlueShield 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.
- Are applying during an open enrollment period or when you have a qualifying event as described below.

Eligible dependents that can enroll on your plan include your:

- spouse or domestic partner.
- natural or legally adopted/placed child(ren) under the age of 26.

Open Enrollment Periods: Individuals may apply for enrollment in a Regence plan during an open enrollment period. An open enrollment period is the time frame set by the state of Washington when applicants can enroll. Please refer to **regence.com** or enrollment packet for the dates of an open enrollment period. The completed enrollment application must be received before the end of the open enrollment period.

Qualifying Events: Applicants can apply outside of an enrollment period if they experience certain qualifying events. Refer to Section 3 to determine if your situation qualifies.

SECTION 3 - SPECIAL ENROLLMENT PERIOD: Applications must be received within 60 days of a qualifying event (with evidence of qualifying event).

- ☐ Loss of Medicaid or other public program providing health benefits.
- ☐ A loss of coverage due to a dissolution of marriage or termination of domestic partnership.
- ☐ Permanent change in residence, work, or living situation and existing health plan does not provide coverage in new area.
- ☐ Plan no longer offered to class of similarly situated persons.
- ☐ Exchange terminates person's qualified health plan because of loss of eligibility, non-payment of premiums (and any grace expires), permissible rescission, or qualified health plan termination or decertification.
- ☐ COBRA exhaustion due to employer failure to remit premium.
- ☐ Loss of COBRA due to exhaustion of plan lifetime limit and no other COBRA available.
- ☐ Person discontinues state high-risk pool.
- ☐ Loss of dependent coverage on group plan due to age.
- ☐ Loss for any reason of employer-sponsored insurance coverage due to employer or insurer action, or due to loss of eligibility.
- ☐ Loss of individual or group coverage of another person under whose policy formerly were enrolled (unless due to fraud or material misrepresentation).
  - ☐ Due to fraud or material misrepresentation.
- ☐ Loss of minimum essential coverage (except due to nonpayment of premium or fraud/intentional material misrepresentation
- ☐ Gaining or becoming a dependent through birth, adoption (including placement for adoption), or marriage.
- ☐ Loss of eligibility for group coverage due to termination of employment, reduction of working hours, death of employee, employee's divorce or legal separation, employee's Medicare entitlement, loss of dependent child eligibility, or employer Chapter 11 bankruptcy.
- ☐ New eligibility or new ineligibility for advance premium tax credits, or change in eligibility for cost-sharing reductions.
- ☐ Gain of access to a new qualified health plan due to a permanent move.
- ☐ Adequate demonstration to exchange ("marketplace") of a qualified health plan's substantial violation of a material contract provision.
- ☐ The exchange ("marketplace") evaluates and determines enrollment or nonenrollment in a qualified health plan was unintentional, inadvertent, or erroneous, and was caused by an error, misrepresentation, or inaction of an officer, employee, or agent of exchange ("marketplace") or of U.S. Health and Human Services or its instrumentalities.

Date of Event _____ (mm/dd/yyyy)

SECTION 4 - TYPE OF APPLICATION (check one)

- ☐ **New enrollment** (applying to become a new Regence member)
- ☐ **Addition of a spouse/domestic partner and/or child to my existing policy**
- ☐ **Change to existing individual plan or deductible** (existing Regence member applying to change benefit plans)

Note: Your policy must be paid current in order for a plan change to be made. If your policy cancels due to non-payment, you will need to reapply by submitting a new Individual Application.

SECTION 5 - ENROLLMENT INFORMATION

List all eligible family members to be covered. Eligible family members include a spouse/domestic partner, and/or any child who is under age 26 or who is medically certified as disabled. Copy of certification required. Please use additional paper if needed to complete your dependent's enrollment information.

Last Name	First Name, MI	Relationship to Subscriber	Gender	Birthdate	Social Security Number
		Subscriber	☐F ☐M	(mm/dd/yyyy)	

List your choice of Primary Care Doctor for yourself. Write name and address of your doctor (required for The Everett Clinic, Evergreen Health Partners, MultiCare Health System, and UW Medicine plans) and medical group name (if known), on the line below.

____

Last Name	First Name, MI	Relationship to Subscriber	Gender	Birthdate	Social Security Number
		☐Spouse ☐Certified Domestic Partner ☐Non-Certified Domestic Partner*	☐F ☐M	(mm/dd/yyyy)	

List your choice of Primary Doctor for this dependent. Write name and address of your dependent's doctor (required for The Everett Clinic, Evergreen Health Partners, MultiCare Health System, and UW Medicine plans) and medical group name (if known), on the line below.

____

Last Name	First Name, MI	Relationship to Subscriber	Gender	Birthdate	Social Security Number
			☐F ☐M	(mm/dd/yyyy)	

List your choice of Primary Doctor for this dependent. Write name and address of your dependent's doctor (required for The Everett Clinic, Evergreen Health Partners, MultiCare Health System, and UW Medicine plans) and medical group name (if known), on the line below.

____

Last Name	First Name, MI	Relationship to Subscriber	Gender	Birthdate	Social Security Number
			☐F ☐M	(mm/dd/yyyy)	

List your choice of Primary Doctor for this dependent. Write name and address of your dependent's doctor (required for The Everett Clinic, Evergreen Health Partners, MultiCare Health System, and UW Medicine plans) and medical group name (if known), on the line below.

____

Last Name	First Name, MI	Relationship to Subscriber	Gender	Birthdate	Social Security Number
			☐F ☐M	(mm/dd/yyyy)	

List your choice of Primary Doctor for this dependent. Write name and address of your dependent's doctor (required for The Everett Clinic, Evergreen Health Partners, MultiCare Health System, and UW Medicine plans) and medical group name (if known), on the line below.

____

Last Name	First Name, MI	Relationship to Subscriber	Gender	Birthdate	Social Security Number
			☐F ☐M	(mm/dd/yyyy)	

List your choice of Primary Doctor for this dependent. Write name and address of your dependent's doctor (required for The Everett Clinic, Evergreen Health Partners, MultiCare Health System, and UW Medicine plans) and medical group name (if known), on the line below.

____

*Non-Registered Domestic Partners must submit an Affidavit of Domestic Partnership

SECTION 6 - ADDRESS AND PHONE NUMBER

Residence Street Address		**Mailing** Address (if different than residence street address)	
Residence City, State, ZIP Code	County	**Mailing** City, State, ZIP Code	County

Home Phone Number	Cell Phone Number	Work Phone Number
(xxx) xxx-xxxx	(xxx) xxx-xxxx	(xxx) xxx-xxxx

SECTION 7 - MEMBER CARD (check one)

☐ **Family Level Card** (all members listed on the same card)
☐ **Member Level Card** (each member on a separate card)

SECTION 8 - MEDICAL PLAN CHOICES (Detailed benefit information can be found online at regence.com)

When you visit in-network providers, you receive the highest level of plan benefit. That makes choosing the right plan important. Some plans have a broad provider network while others include specific provider groups that will require the selection of a primary care physician (for example, members choosing a Regence Direct Silver+ The Everett Clinic plan will need to choose a primary care physician with the Everett Clinic, whereas members who choose a Regence Direct Silver+ MultiCare Health System plan will need to choose a primary care physician with the MultiCare Health System). Please note that everyone on the application needs to enroll in the same health plan. Provider network information can be found in the included Network Comparison Guide or online at **regence.com**.

Regence Direct HSA

- ☐ Regence Direct Bronze HSA
- ☐ Regence Direct Bronze HSA+

Regence Direct HSA with Dental, Vision, Individual Assistance Program (IAP)

- ☐ Regence Direct Bronze HSA with Dental, Vision, Individual Assistance Program (IAP)

Regence Direct Silver HSA

- ☐ Regence Direct Silver HSA

Regence Direct

- ☐ Regence Direct Silver
- ☐ Regence Direct Gold

Regence Direct Silver

- ☐ Regence Direct Silver+

Regence Direct with Dental, Vision, Individual Assistance Program (IAP)

- ☐ Regence Direct Silver with Dental, Vision, Individual Assistance Program (IAP)
- ☐ Regence Direct Gold with Dental, Vision, Individual Assistance Program (IAP)

Regence Direct Silver with Dental, Vision, Individual Assistance Program (IAP)

- ☐ Regence Direct Silver+ with Dental, Vision, Individual Assistance Program (IAP)

Regence Direct High

- ☐ Regence Direct Gold+ High
- ☐ Regence Direct Platinum High

Regence Direct High with Dental, Vision, Individual Assistance Program (IAP)

- ☐ Regence Direct Gold+ High with Dental, Vision, Individual Assistance Program (IAP)
- ☐ Regence Direct Platinum High with Dental, Vision, Individual Assistance Program (IAP)

Regence Direct HSA The Everett Clinic

- ☐ Regence Direct Bronze HSA+ The Everett Clinic

Regence Direct Silver HSA The Everett Clinic

- ☐ Regence Direct Silver HSA The Everett Clinic

Regence Direct The Everett Clinic

- ☐ Regence Direct Silver+ The Everett Clinic

Regence Direct The Everett Clinic with Dental, Vision, Individual Assistance Program (IAP)

- ☐ Regence Direct Silver+ The Everett Clinic with Dental, Vision, Individual Assistance Program (IAP)

Regence Direct High The Everett Clinic

- ☐ Regence Direct Gold+ High The Everett Clinic
- ☐ Regence Direct Platinum High The Everett Clinic

Regence Direct High The Everett Clinic with Dental, Vision, Individual Assistance Program (IAP)

- ☐ Regence Direct Gold+ High The Everett Clinic with Dental, Vision, Individual Assistance Program (IAP)
- ☐ Regence Direct Platinum High The Everett Clinic with Dental, Vision, Individual Assistance Program (IAP)

SECTION 8 - MEDICAL PLAN CHOICES (continued)

Regence Direct HSA Evergreen Health Partners
- ☐ Regence Direct Bronze HSA+ Evergreen Health Partners

Regence Direct Silver HSA Evergreen Health Partners
- ☐ Regence Direct Silver HSA Evergreen Health Partners

Regence Direct Evergreen Health Partners
- ☐ Regence Direct Silver+ Evergreen Health Partners

Regence Direct Evergreen Health Partners with Dental, Vision, Individual Assistance Program (IAP)
- ☐ Regence Direct Silver+ Evergreen Health Partners with Dental, Vision, Individual Assistance Program (IAP)

Regence Direct High Evergreen Health Partners
- ☐ Regence Direct Gold+ High Evergreen Health Partners
- ☐ Regence Direct Platinum High Evergreen Health Partners

Regence Direct High Evergreen Health Partners with Dental, Vision, Individual Assistance Program (IAP)
- ☐ Regence Direct Gold+ High Evergreen Health Partners with Dental, Vision, Individual Assistance Program (IAP)
- ☐ Regence Direct Platinum High Evergreen Health Partners with Dental, Vision, Individual Assistance Program (IAP)

Regence Direct HSA MultiCare Health System
- ☐ Regence Direct Bronze HSA+ MultiCare Health System

Regence Direct Silver HSA MultiCare Health System
- ☐ Regence Direct Silver HSA MultiCare Health System

Regence Direct MultiCare Health System
- ☐ Regence Direct Silver+ MultiCare Health System

Regence Direct MultiCare Health System with Dental, Vision, Individual Assistance Program (IAP)
- ☐ Regence Direct Silver+ with Dental, Vision, Individual Assistance Program (IAP) MultiCare Health System

Regence Direct High MultiCare Health System
- ☐ Regence Direct Gold+ High MultiCare Health System
- ☐ Regence Direct Platinum High MultiCare Health System

Regence Direct High MultiCare Health System with Dental, Vision, Individual Assistance Program (IAP)
- ☐ Regence Direct Gold+ High MultiCare Health System with Dental, Vision, Individual Assistance Program (IAP)
- ☐ Regence Direct Platinum High MultiCare Health System with Dental, Vision, Individual Assistance Program (IAP)

Regence Direct HSA UW Medicine
- ☐ Regence Direct Bronze HSA+ UW Medicine

Regence Direct Silver HSA UW Medicine
- ☐ Regence Direct Silver HSA UW Medicine

Regence Direct UW Medicine
- ☐ Regence Direct Silver+ UW Medicine

Regence Direct UW Medicine with Dental, Vision, Individual Assistance Program (IAP)
- ☐ Regence Direct UW Medicine Silver+ with Dental, Vision, Individual Assistance Program (IAP)

Regence Direct High UW Medicine
- ☐ Regence Direct Gold+ High UW Medicine
- ☐ Regence Direct Platinum High UW Medicine

Regence Direct High UW Medicine with Dental, Vision, Individual Assistance Program (IAP)
- ☐ Regence Direct Gold+ High UW Medicine with Dental, Vision, Individual Assistance Program (IAP)
- ☐ Regence Direct Platinum High UW Medicine with Dental, Vision, Individual Assistance Program (IAP)

SECTION 9 - OTHER COVERAGE INFORMATION

Do you have other health care coverage?

☐ Yes (complete the information below) ☐ No (move on to Section 10)

Do you have other health care coverage?

☐ Yes ☐ (Once accepted by Regence, remember to cancel your current health plan, including our corporate affiliates.) If you have other coverage in addition to Regence coverage, we will coordinate benefits between the multiple health plans.

If you answered yes, please sign the statement below:

I wish to terminate my current individual medical coverage from Regence on the effective date of this new individual policy.

Signature ▶ _____ Date _____ (mm/dd/yyyy)

Name (First, Last)	Insurance Company	Policy Number	Dates of Coverage		Type of Coverage
			Date Coverage Began mm/dd/yyyy	Date Coverage Ended (indicate active if you are currently covered) mm/dd/yyyy	◆ Employer Group ◆ Individual ◆ Medicare ◆ COBRA ◆ High Risk Pool ◆ Other (describe)
1.			(mm/dd/yyyy)	(mm/dd/yyyy)	
2.			(mm/dd/yyyy)	(mm/dd/yyyy)	
3.			(mm/dd/yyyy)	(mm/dd/yyyy)	

SECTION 10 – PREMIUM BILLING OPTIONS (if application is approved)

BILLING ADDRESS (Complete only if billing should be sent to an address other than the Residence Street or Mailing Address listed in Section 5 of the application.)

Name (First, Last)

Address	City, State, ZIP Code

PAYMENT OPTIONS (check one):

☐ Monthly Billing ☐ Electronic Funds Transfer (EFT) - premium is automatically deducted from your bank account on the 5th of each month.

If selecting the EFT option:

1. Complete the following **Authorization To My Bank** section.
2. Write 'void' on one of your checks and return your voided check with this application (not a deposit slip). *For savings account, please provide proof of ownership of the account.*

Please do not include initial payment with application.

AUTHORIZATION TO MY BANK

As a convenience and on behalf of the Account Holder identified below, I/we hereby request and authorize you to pay and charge to the account identified below, checks or electronic debits drawn on the account by and payable to the order of Regence BlueShield, Seattle, Washington. I/we agree that your rights to each such check or electronic debit shall be the same as if it were an actual check drawn on you and signed by me/us. This authority is to remain in effect until revoked by me/us in writing, and until you actually receive such notice, I/we agree that you shall be fully protected in honoring any such check. I/we further agree that if any checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. A photocopy of this executed authorization shall be as valid as the original.

Financial Institution or Bank Name	Transit/Routing Numbers	Account Number

Check One: ☐ Checking Account ☐ Savings Account

Account Holder's Name (please print)

▶ (mm/dd/yyyy)

Account Holder's Signature (as it appears on bank records) Date

SECTION 11 - PRODUCER CERTIFICATION

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

FOR PRODUCER USE ONLY

I, (the producer) certify I have explained the eligibility provisions to the applicant. I have not made any statements about benefits, conditions or limitations of the contract except through written material furnished by Regence. I have informed the applicant that the effective date of coverage is assigned only by Regence. **I CERTIFY THAT THE INFORMATION SUPPLIED TO ME BY THE APPLICANT HAS BEEN TRULY AND ACCURATELY RECORDED HERE.**

Producer Name (please print or type)	Regence Producer Number

Producer's Mailing Address	Producer's E-mail Address Email address	Producer's Phone Number (xxx) xxx-xxxx

Producer's Signature (Required) **X**	Date (Required) (mm/dd/yyyy)

SECTION 12 - TOBACCO ABSTINENCE CERTIFICATION STATEMENT

A surcharge is applied to the regular Periodic Rate for an enrolled individual who is a Tobacco User. A Tobacco User is a person who may legally use tobacco and has used tobacco (in any form, but excluding any religious or ceremonial use) on average four or more times per week within the last six months.

By my signature below, I certify that I am NOT a Tobacco User.

PLEASE NOTE: An individual who has signed a tobacco abstinence certification statement and who subsequently becomes a Tobacco User must notify the Company immediately, and the surcharge then will apply to him or her. If false information about tobacco use is submitted or if you fail to notify the Company when changes in your tobacco use would subject you to the tobacco surcharge, the Company reserves the right to take any action available to it, including action to collect unpaid surcharge amounts and/or other damages.

Member Name	Member Name	Member Name
(mm/dd/yyyy) Date	(mm/dd/yyyy) Date	(mm/dd/yyyy) Date
Member Name	Member Name	Member Name
(mm/dd/yyyy) Date	(mm/dd/yyyy) Date	(mm/dd/yyyy) Date

SECTION 13 - CONSENT TO ELECTRONIC DISTRIBUTION

Regence is engaged in efforts to increase the use of technology and curb the use of paper. In support of those efforts, Regence has established a process under which communications to members can be posted to a secured account that a member establishes on myRegence.com, with e-mail notice provided to a member-supplied e-mail account when a new communication is posted.

By my signature and unless I have expressly rejected electronic distribution by marking the checkbox below, I consent, on behalf of myself and any covered dependents, to the electronic distribution of communications related to the coverage applied for and understand that:

- To access electronically distributed communications, I and each of my covered dependents will need to establish myRegence.com accounts for use on a system meeting the outlined requirements and I represent that we each have and will continue to have access to such a system or systems.
- Not all member communications are currently available electronically, but agree that my consent will apply to the following materials available, or as they become available, for electronic distribution, (i) notices of enrollment and/or effective date, (ii) acknowledgements of receipt of claims, requests for additional information related to claims and notices of associated delays in processing, and determinations on submitted claims, (iii) general informational disclosures required by law, including but not limited to notices of rights under the Women's Health and Cancer Rights Act, state patient protection acts, and privacy laws, (iv) communications regarding complaints, grievances, or appeals, including but not limited to acknowledgements of receipt, requests for additional information and notices of associated delays, and notices of determinations, (v) summaries of benefits and coverage and uniform glossary of terms, (vi) notices of benefit changes or policy modifications, (vii) renewal information, (viii) notices of discontinuation, (ix) notices of termination and continuation coverage rights, (x) certificates of creditable coverage, (xi) billing notices and statements.
- Until a type of communication can be distributed electronically, a paper copy will be provided.
- Once available in electronic form, any electronically distributed communications may be printed from the myRegence.com account where they are posted, or a paper copy of any particular communication may be requested at any time using myRegence.com or by contacting Regence Customer Service at the number provided on my ID card.
- I may change the e-mail address for receipt of notice of electronic distributions or withdraw consent (returning to paper distribution) at any time and without charge using myRegence.com or by contacting Regence Customer Service as described in the previous bullet.

The e-mail address for receipt of notice of electronic distributions is Email address

☐ I do not want electronic distribution. Unless my consent is not required for an electronic distribution, I elect to receive communications related to this coverage in a paper format.

SECTION 14 - CERTIFICATION, AUTHORIZATION AND SIGNATURE

Be sure to **sign** and **date** this application. Spouse/Domestic Partner and/or child's (age 18-25) signature is required, if applicable. Signature applies to "Consent to Electronic Distribution", "Certification of Completion and Correctness" and "Authorization for Use and Disclosure of Protected Health Information".

Certification of Completion and Correctness

I affirm that the answers given in this application are complete and correct. I am providing these answers as part of the application procedure required by Regence to enroll in their coverage. I understand that Regence will rely on each answer in making coverage and rating determinations. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. If coverage is rescinded for fraud or intentionally misleading statements, Regence will reimburse premium less any claims paid and will pursue reimbursement for claims paid exceeding any premium. I will promptly inform Regence in writing if anything happens before my coverage takes effect that makes this application incomplete or incorrect. I understand and agree that no coverage shall be in force until approved by Regence. Regence may contact me to clarify answers on this application. As the applicant, I understand I have the right to inspect the information in my file.

Authorization for Use and Disclosure of Protected Health Information

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the application form) from time to time 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 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 authorization may not be used for psychotherapy notes** (notes recorded and separately maintained by a mental health professional documenting or analyzing the contents of a conversation during a counseling session). A separate authorization will be required.

* 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 on our Web site at **regence.com** or by telephone request at **1 (800) 365-3155.**

SIGNATURES

Signature of applicant, parent or legal guardian if applicant is 17 years or under * **X**	Relationship	Date (mm/dd/yyyy)
Signature of applicant's legal spouse or eligible domestic partner * **X**		Date (mm/dd/yyyy)
Signature of child between 18 and 25 years of age * **X**		Date (mm/dd/yyyy)
Signature of child between 18 and 25 years of age * **X**		Date (mm/dd/yyyy)
Signature of child between 18 and 25 years of age * **X**		Date (mm/dd/yyyy)
Signature of child between 18 and 25 years of age * **X**		Date (mm/dd/yyyy)

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

Personal Representative's Name (please print) _____

Relationship to Individual _____ (Attach legal documentation if other than parent of a minor child)