

**Washington Individual Enrollment Application**

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.

**SECTION 1 - TYPE OF APPLICATION (check one box)**

- New Enrollment Application: Requested effective date: \_\_\_\_\_ (month)  1st  15th
- Plan Change (from and to a current LifeWise Plan): Subscriber ID# \_\_\_\_\_
- Adding Spouse: Subscriber ID# \_\_\_\_\_ Date of Marriage: \_\_\_\_/\_\_\_\_/\_\_\_\_
- Adding Child: Subscriber ID# \_\_\_\_\_  Newborn  Adoption - Date of birth / placement \_\_\_\_/\_\_\_\_/\_\_\_\_

**SECTION 2 - PRIMARY APPLICANT, SPOUSE & DEPENDENT INFORMATION**

Name (26 character max) (Last, First, Middle Initial)	Gender (M/F)	Date of Birth (MM/DD/YYYY)	Relationship to Subscriber
		/ /	SELF
		/ /	LEGAL SPOUSE
		/ /	DEPENDENT CHILD (under 23 only)
		/ /	DEPENDENT CHILD (under 23 only)
		/ /	DEPENDENT CHILD (under 23 only)
Home Address (not P.O. Box) <i>required</i>	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 ( )

**SECTION 3 - BENEFIT PLAN SELECTION**

Check one box to indicate your family's plan selection and deductible option:

1. Preferred 80	<input type="checkbox"/> \$500 Deductible	<input type="checkbox"/> \$1,000 Deductible	
2. Choice 80	<input type="checkbox"/> \$500 Deductible	<input type="checkbox"/> \$1,000 Deductible	
3. Preferred 70	<input type="checkbox"/> \$500 Deductible	<input type="checkbox"/> \$1,000 Deductible	
4. Choice 70	<input type="checkbox"/> \$500 Deductible	<input type="checkbox"/> \$1,000 Deductible	
5. Share Preferred	<input type="checkbox"/> \$2,500 Deductible	<input type="checkbox"/> \$5,000 Deductible	<input type="checkbox"/> \$10,000 Deductible
6. Share Traditional	<input type="checkbox"/> \$2,500 Deductible	<input type="checkbox"/> \$5,000 Deductible	<input type="checkbox"/> \$10,000 Deductible
7. Essentials 25	<input type="checkbox"/> \$1,500 Deductible	<input type="checkbox"/> \$2,500 Deductible	
8. Essentials 50	<input type="checkbox"/> \$500 Deductible	<input type="checkbox"/> \$1,000 Deductible	<input type="checkbox"/> \$1,500 Deductible <input type="checkbox"/> \$2,000 Deductible
<b>The following are Health Savings Account (HSA) Eligible Plans</b>			
9. Share HSA Plus (Individual)	<input type="checkbox"/> \$1,250 Deductible		
10. Share HSA Plus (Family)	<input type="checkbox"/> \$2,500 Deductible		
11. Share HSA (Individual)	<input type="checkbox"/> \$1,700 Deductible	<input type="checkbox"/> \$2,500 Deductible	
12. Share HSA (Family)	<input type="checkbox"/> \$3,400 Deductible	<input type="checkbox"/> \$5,000 Deductible	

## SECTION 4 – ELIGIBILITY

### To be eligible for coverage, applicants:

- Must be a resident of, and have a principal residence located within, Washington State. Proof of residency is required with all new applications. I have included a **copy** of one of the following (proof must match home address provided in Section 2):
  - Valid Washington State drivers license or identification card;
  - Voter registration card; or
  - Current utility bill in your name, including address.
- 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 – RATE/BILLING INFORMATION

### PAYMENT OPTIONS: **Select One**

- Monthly Billing
- Monthly Automatic Funds Transfer withdrawn 1st of the month (Complete Section 6.)  
(include: checking account-voided check or savings account-deposit slip)

### TOBACCO USE INFORMATION:

The smoker rate will apply if either you or your spouse (if included on this application) has used tobacco products within the 12 months prior to this application. That person/s rate(s) will be the Smoker rate(s). **Not checking a box will result in paying the higher rate.**

- I have used tobacco products during the prior 12 months:  Yes  No
- My spouse has used tobacco products during the prior 12 months:  Yes  No

## SECTION 6 – AUTOMATIC FUNDS TRANSFER AUTHORIZATION

I have selected the Automatic Funds Transfer (AFT), and I hereby authorize LifeWise Health Plan of Washington (LifeWise) to initiate funds transfer from the bank or depository financial institution account indicated below. I authorize my financial institution to honor these transfers.

Financial Institution or Bank Name:	
Account Holder's Name (print):	
City, State, ZIP:	Account Number:
Bank Routing Number:	<input type="checkbox"/> Checking <input type="checkbox"/> Savings <input type="checkbox"/> Money Market
9-digit number at bottom of check (for checking account) or deposit slip (for savings account)	
<b>Additional Terms and Conditions:</b>	
➤ Funds are to be transferred on the <b>1<sup>st</sup> business day of each month</b> or as soon thereafter as practical, paying for that month's coverage. (For example: The deduction on January 1 <sup>st</sup> pays for coverage in January.)	
➤ I understand that if I have chosen an effective date of the 15 <sup>th</sup> of the month, the initial transfer will be for the initial <b>pro-rated month PLUS</b> the first full month's subscription charge. Subsequent transfers will be for single months.	
➤ I understand that this Automatic Funds Transfer Authorization will remain in effect until LifeWise has received notice from me that it should be cancelled. To ensure prompt cancellation of my Automatic Funds Transfer, this notice must be submitted at least 20 days prior to my next scheduled transfer. I have the right to stop payment of a specific transfer from my depository financial institution at least 3 days before the next scheduled withdrawal date.	
➤ It may take as long as 45 days to set up an AFT. You may receive an invoice to cover initial month(s).	
<b>Please enclose a voided check (for checking account) or deposit slip (for savings account) from the account TO BE DEDUCTED.</b>	
Signature of Account Holder: <b>X</b> _____	Date (MM/DD/YYYY): ____/____/____

## SECTION 7 – 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 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 group coverage through an employer too small for COBRA that was in effect for at least 24 months.\*
- Conversion:** Applicant is applying for individual coverage within 90 days of termination of conversion coverage.\*
- 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 10.)

## SECTION 8 – NOTICE OF INFORMATION USE AND DISCLOSURE

When you apply for or are enrolled on this health plan, we may collect, use, share or disclose Protected Personal Information (PPI). PPI includes information about your health, including medical records, information on prior or current health-care coverage; and personal information such as your address, telephone number, and Social Security Number. This information may come from health-care providers, insurance companies (including members of our corporate family) or other sources.

We may collect, use, or disclose your PPI to conduct routine business functions, such as:

- Determining your eligibility for enrollment, credit for waiting periods, benefits;
- Paying claims and coordinating benefits with other insurers;
- Conducting case and care management, and quality reviews;
- Fulfilling other legal obligations specified in our contract with you; and,
- We may also collect or disclose PPI as required or permitted by law.

If a disclosure of PPI is not related to a routine business function, we remove anything that can be used to easily identify you, or we obtain your prior signed authorization. This authorization will describe the PPI to be released, who it is released to, reasons for the release, and the time period in which the authorization is valid. You may revoke this authorization.

## SECTION 9 – BASIC TERMS of ENROLLMENT

- 1) I understand and agree that coverage does not begin until:
  - a) This application is received, reviewed, and accepted by LifeWise and an effective date of coverage is assigned; and
  - b) My complete and correct payment is received.
- 2) I also understand and agree that:
  - a) This application becomes a part of my Contract.
  - b) This application summarizes certain key terms of the Contract; to the extent that the application is inconsistent with the Contract, the Contract will govern.
  - c) Terms and conditions of enrollment are described in the Contract.
  - d) **I UNDERSTAND THAT THIS PLAN HAS A NINE-MONTH WAITING PERIOD FOR PRE-EXISTING CONDITIONS. NO BENEFITS ARE PROVIDED FOR ANY MEDICAL CONDITION FOR WHICH TREATMENT WAS RECEIVED (OR RECOMMENDED), OR FOR WHICH A PRUDENT PERSON WOULD HAVE SOUGHT ADVICE OR TREATMENT WITHIN THE SIX MONTHS PRIOR TO THE EFFECTIVE DATE OF THIS PLAN. THIS WAITING PERIOD DOES NOT APPLY TO: NEWBORN AND ADOPTIVE CHILDREN ENROLLED AFTER THE SUBSCRIBER'S EFFECTIVE DATE OF COVERAGE AS LONG AS ADDED WITHIN 60 DAYS OF THE BIRTH OR PLACEMENT; FORMULA FOR TREATMENT OF PHENYLKETONURIA; AND PRENATAL CARE (IF THE PLAN PROVIDES BENEFITS FOR THIS). THIS WAITING PERIOD MAY BE CREDITED OR WAIVED BASED ON PRIOR HEALTH CARE COVERAGE.**
  - e) **I ALSO UNDERSTAND THAT THIS PLAN WILL NOT PROVIDE BENEFITS FOR ORGAN AND BONE MARROW TRANSPLANTS FOR A PERIOD OF 12 MONTHS FROM THE EFFECTIVE DATE OF MY COVERAGE.**
  - f) The benefits under this Contract will be subject to coordination of benefits with other plans.
- 3) I also understand that acceptance for coverage is dependent on the following:
  - a) Persons listed on this application must be residents of the state of Washington in order to apply for and maintain coverage under this Contract. "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 health care 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. We 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.
  - b) No one listed on this application is 65 years of age or older and eligible for Medicare on the date coverage would begin.
- 4) I also understand that no benefits are available under this Contract 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.
- 5) I also understand and agree that only LifeWise may:
  - a) Make or modify the terms of the application or Contract; or
  - b) Waive any of the LifeWise rights or requirements.
- 6) I understand that the benefits under this plan may vary based on the contracting status of the provider, and that the number of contracted providers varies in different geographic locations. In some cases, I may receive benefits that are substantially less than the amount billed by the provider when treatment is not received from a contracted provider.
- 7) I understand that this application is not an offer of coverage from LifeWise and that submission of this application does not guarantee I will receive coverage.

