

**Washington Individual Enrollment Application**

MS 295  
P.O. Box 91120  
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, excluding Clark County, 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 Premera Blue Cross Plan): Subscriber ID# \_\_\_\_\_
- Adding Spouse: Subscriber ID# \_\_\_\_\_ Date of Marriage: \_\_\_\_/\_\_\_\_/\_\_\_\_
- Adding Child: Subscriber ID# \_\_\_\_\_  Newborn  Adoption - Date of birth / placement \_\_\_\_/\_\_\_\_/\_\_\_\_

**Office Use Only**  
 Interplan trans.  
 Direct trans.

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

Name (26 character max) (Last, First, Middle Initial)	Social Security #	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) 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 ( )

**SECTION 3 – BENEFIT PLAN SELECTION**

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

1. Heritage Preferred Plus™ 20	Deductible Options:	<input type="checkbox"/> \$1,000		
2. Heritage Preferred Plus™ 30	Deductible Options:	<input type="checkbox"/> \$1,000		
3. Heritage Value Plus™ 30*	Deductible Options:	<input type="checkbox"/> \$2,500	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$10,000
4. Heritage Protector Plus™ 20*	Deductible Options:	<input type="checkbox"/> \$500	<input type="checkbox"/> \$1,000	

\* Catastrophic plan: Catastrophic plan coverage may not provide portability of benefits if you later enroll in other individual coverage.

## SECTION 4 – ELIGIBILITY

To be eligible for coverage, applicants:

➤ Must be a resident of, and have a principal residence located within, Washington state (excluding Clark County). 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 (Subscription charges for this policy can not be paid or sponsored by an employer.)

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- Monthly Automatic Funds Transfer withdrawn 1st of the month (Complete Section 6.)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

### 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 Premera Blue Cross 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:

Checking  Savings

9-digit number at bottom of check (for checking account) or deposit slip (for savings account)

### Additional Terms and Conditions:

- Funds are to be transferred on the **1<sup>st</sup> business day of each month** 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 **prorated month PLUS 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 Premera 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).

**Please enclose a voided check (for checking account) or deposit slip (for savings account) from the account TO BE DEDUCTED.**

Signature of Account Holder: **X** \_\_\_\_\_ 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 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 Premera Blue Cross 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 Premera Blue Cross 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 PROGRAM. 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 (excluding Clark County) 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 covered under another Premera Blue Cross Individual or Group Contract that would duplicate benefits of this Contract. If you choose to accept this Individual program, you cannot keep the other coverage.
  - c) No one listed on this application is entitled (enrolled) to 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 Premera Blue Cross may:
  - a) Make or modify the terms of the application or Contract; or
  - b) Waive any of the Premera Blue Cross 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 Premera Blue Cross and that submission of this application does not guarantee I will receive coverage.
- 8) I understand this coverage is issued as individual health coverage, and is not sold or issued for use as an employer-sponsored group health plan.

**SECTION 10 – PRIOR OR CURRENT COVERAGE**

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 Premera?  Yes  No (If no, remember to contact your insurance company to cancel, including our corporate affiliates.)

**SECTION 11 – SIGNATURES**

I hereby apply for enrollment with Premera 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, and I have supplied all of the required information on this form.
- b) I have received and read a product information packet containing plan summaries and understand that a complete list of exclusions and limitations is detailed in the Contract. If there is a conflict, the terms of the Contract prevail.
- c) I have read and agree to all the Basic Terms of Enrollment listed in Section 9.
- d) I have read the Notice of Information Use and Disclosure.
- e) 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.

**If one or more family members is not accepted for coverage, I authorize Premera to enroll those who are eligible in the plan I have selected.  Yes  No**

<b>X</b>	/ /	<b>X</b>	/ /
Signature of Primary Applicant (Parent/Legal Guardian)	Date of Signature	Signature of Spouse	Date of Signature

**Approved applications postmarked or received by the 5<sup>th</sup> day of the month will be effective on the 15<sup>th</sup> of that month. A prorated subscription charge will apply for the partial month of coverage. Approved applications postmarked or received by the 20<sup>th</sup> day of the month will be effective on the first day of the following month.**

**To select a later effective date, please indicate here (no more than 60 days after the receipt day, and must be the 1<sup>st</sup> or 15<sup>th</sup> of the month): \_\_\_\_\_.**

**DO NOT SEND PAYMENT WITH THIS APPLICATION.**

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

Agency Name (If applicable): \_\_\_\_\_

Agent Name (Please Print): \_\_\_\_\_

Agent Address: \_\_\_\_\_

Agent Telephone Number: \_\_\_\_\_ Agent e-mail Address: \_\_\_\_\_

Agent Signature: \_\_\_\_\_ Premera Agent Number: \_\_\_\_\_

**Please Note:** Agents who do not have a current appointment with Premera Blue Cross are not authorized to offer Premera Blue Cross products.