Regence

Regence BlueShield serves select counties in the state of Washington and 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-LC1NW
Lewiston, ID 83501-1106
OR Fax to: 1-877-369-3410
Please do not include initial payment with application
IndElig@Regence.com

2017 Washington Individual Enrollment Application

This application is for health care coverage purchased directly through Regence BlueShield (Regence). Washington law (RCW 48.43.510) requires an offer of certain health plan information before purchase or selection of a health plan. You can review that information at Regence.com or request it from our Customer Service Department by calling (888) 344-6347. Available information concerns benefits, required preauthorization, premiums and cost-sharing, in-network providers, appeals and grievances, accreditation, and confidentiality. If you wish to purchase coverage through the Health Benefit Exchange, you must apply directly through them.

Please print your answers clearly in black 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.

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

SECTION 1 - ELIGIBILITY

Is any person applying incarcerated or jailed due to a conviction? ☐ Yes ☐ No

If yes, please provide name(s): _____

You are eligible if you are:

- A resident of and have a primary residence in the state of Washington. 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.
- 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. Any individual eligible or enrolled in Medicare (or who will be on the requested effective date) is ineligible to apply for private individual or family health coverage and should not be included in the application.
- 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 2 to determine if your situation qualifies.

You are not eligible if:

- You are currently eligible and/or enrolled on Medicaid or Medicare Part A, B, or D. Participation in a government program does not allow enrollment on an individual product.
- You have a third-party payer paying for any portion of this policy.

SECTION 2 - SPECIAL ENROLLMENT QUALIFYING EVENTS

Complete this section only if applying outside of open enrollment. During special enrollment, you can apply for insurance or make changes to your existing insurance only if you have a major life change such as the loss of a job or the birth of a child. You have 60 days from the date of the event to apply. Check the box(es) to indicate which event(s) have occurred and type in the date of the event.

Date of Event _____ (mm/dd/yyyy)

Qualifying Events:	Submit the following documentation:
☐ Birth of a child.	Copy of birth certificate.
☐ Adoption or placement of a child.	Copy of adoption or placement papers.
☐ Gaining or becoming a dependent through marriage or domestic partnership.	Marriage Certification or Domestic Partnership Certification.
☐ Loss of coverage due to a dissolution of marriage or termination of domestic partnership.	◆ Divorce decree or a signed/dated statement indicating date the domestic partnership terminated. ◆ Employer letter on company letterhead, Certificate of Coverage or evidence of other creditable coverage.
☐ Loss of group coverage due to the death of the employee, voluntary or involuntary termination of employee's job, reduction in employee's working hours, divorce or legal separation, Medicare entitlement of employee, loss of dependent status, Chapter 11 bankruptcy of employer sponsor or due to employer or insurer action.	◆ Employer letter on company letterhead, Certificate of Coverage or evidence of other creditable coverage. ◆ Letter from employer on company letterhead indicating your Qualifying Event and Qualifying Event Date.
☐ Loss of minimum essential coverage as defined in federal law, including but not limited to most government-sponsored programs (e.g., Medicare, Medicaid, CHIP), employer-sponsored plans, and individual market plans in the state (except due to nonpayment of premium or fraud/intentional material misrepresentation).	◆ Employer letter on company letterhead, Certificate of Coverage or evidence of other creditable coverage. ◆ Coverage termination reason. If this reason is due to dissolution of marriage, please provide a divorce decree.
☐ COBRA exhaustion due to employer failure to remit premium or reaching plan lifetime limits (and no other COBRA is available). NOTE: Voluntary termination of COBRA is not a qualifying event. If you terminate or stop paying your COBRA, you must wait for the next Open Enrollment Period.	◆ A letter from the COBRA administrator or prior insurance company verifying that you have exhausted your Federal COBRA benefits.
☐ Enrollment or non-enrollment in Qualified Health Plan that is unintentional, inadvertent, or erroneous and caused by error, misrepresentation, or inaction of Health Benefit Exchange officer, employee, or agent or Health and Human Services (or its instrumentalist) as evaluated and determined by the Health Benefit Exchange.	◆ Documentation from the Health Benefit Exchange.
☐ Adequate demonstration to the Health Benefit Exchange of a Qualified Health Plan's substantial violation of a material contract provision.	◆ A copy of the Qualified Health Plan contract. ◆ A statement of the provision that is claimed violated. ◆ Proof of the violation.
☐ New eligibility or ineligibility for advance payment of premium tax credit, or change in eligibility for cost-sharing reductions.	◆ Letter from Health and Human Services or Internal Revenue Services or the Health Benefit Exchange.
☐ You discontinue a health plan offered by the Washington State Insurance Pool (WSHIP).	◆ Evidence of discontinuation from WSHIP.

SECTION 2 - SPECIAL ENROLLMENT QUALIFYING EVENTS (continued)

Qualifying Events:	Submit the following documentation:
☐ Gain of access to a new Qualified Health Plan due to permanent move or a permanent change in residence, work or living situation and existing health plan does not provide coverage in new area.	◆ A copy of a utility bill in your name from your prior address dated within the last 60 days. **AND** 1) A valid picture I.D. enlarged 125% indicating physical residential address ◆ Washington driver's license ◆ Washington state-issued identification card ◆ tribal identification card ◆ military identification card 2) An additional document that shows the physical residential address ◆ Current full month of service (bill date not older than 60 days) utility bill for utility services (needs to include both service and mailing addresses) ◆ Signed rental agreement for current residence (signed by all parties-tenant/landlord) ◆ Copy of voter's registration card that has your residential address on it ◆ Current bank checking account statement or copy of a voided check ◆ Current student enrollment or letter from college/university registrar noting residence
☐ Plan no longer offered to class of similarly situated persons.	◆ Proof of change of offer.
☐ Loss of individual or group coverage of another person under whose policy formerly were enrolled (unless due to fraud or material misrepresentation).	◆ Employer letter on company letterhead, Certificate of Coverage or evidence of other creditable coverage. ◆ Letter from employer on company letterhead indicating your Qualifying Event and Qualifying Event Date.
☐ Health Benefit 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.	◆ Certificate of Coverage or evidence of other creditable coverage.

SECTION 3 - 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. To make a change to your existing Individual policy, we recommend submitting our Plan Change Request form.

SECTION 4 - MEMBER CARD (check one)

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

SECTION 5 - EFFECTIVE DATE

I request a start date of _____ (mm/dd/yyyy) with the understanding my qualifying event may allow a different date as determined by Regence.

SECTION 6 - 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 EvergreenHealth Partners-Virginia Mason, The Everett Clinic, MultiCare Connected Care, and UW Medicine plans) and medical group name (if known), on the line below.

____

		☐Spouse ☐Registered Domestic Partner ☐Non-Registered 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 EvergreenHealth Partners-Virginia Mason, The Everett Clinic, MultiCare Connected Care, and UW Medicine plans) and medical group name (if known), on the line below.

____

			☐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 EvergreenHealth Partners-Virginia Mason, The Everett Clinic, MultiCare Connected Care, and UW Medicine plans) and medical group name (if known), on the line below.

____

			☐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 EvergreenHealth Partners-Virginia Mason, The Everett Clinic, MultiCare Connected Care, and UW Medicine plans) and medical group name (if known), on the line below.

____

			☐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 EvergreenHealth Partners-Virginia Mason, The Everett Clinic, MultiCare Connected Care, and UW Medicine plans) and medical group name (if known), on the line below.

____

			☐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 EvergreenHealth Partners-Virginia Mason, The Everett Clinic, MultiCare Connected Care, 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 7 - TOBACCO USAGE

Is anyone listed on this application a Tobacco User? ☐Yes ☐No

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.

If you answered No, but your answer changes to "Yes" any time after you submit this application, you must notify the Company immediately, and a surcharge will be applied.

If you answered Yes, provide the name(s) of the Tobacco User(s) listed on this application below:

SECTION 7 - TOBACCO USAGE (continued)

If you answered Yes, provide the name(s) of the Tobacco User(s) listed on this application below:

Name	Name
Name	Name
Name	Name

PLEASE NOTE: A surcharge is applied to the regular Periodic Rate for an enrolled individual who is a Tobacco User. The Company reserves the right to take any action available to it, including collection of unpaid surcharges, if false information about tobacco use is submitted or if you fail to notify the Company of a change in an enrolled individual's tobacco usage.

SECTION 8 - 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 (xxx) xxx-xxxx	Cell Phone Number (xxx) xxx-xxxx	Work Phone Number (xxx) xxx-xxxx	

Does any listed proposed insured live, reside, work or attend school outside the state of Washington at any time during the year? ☐ Yes ☐ No

If yes, name the proposed insured and percent of time out of the state _____

Please indicate the reason:

☐ Reside ☐ Work ☐ School - Provide student enrollment documentation ☐ Other _____

SECTION 9 - MEMBER PREFERENCES

Spoken Language Preference if other than English (optional) _____

Preferred communication method for application processing:

☐ United States Postal Mail ☐ Secure Email

Go paperless! Regence can send secure communications about your insurance claims and benefits to a Regence.com account! Once registered, an email or text (your choice) will notify you when a new communication is posted.

Yes, please set up an account for me and email me a link to access and personalize it.
My email address: Email address _____

SECTION 10 - MEDICAL PLAN CHOICES (Detailed benefit information can be found online at www.regence.com)

When you visit in-network providers, you receive the highest level of plan benefit. That makes choosing the right network important. Please verify your physicians are in the network of your choice.

Some plans have a broad provider network (Preferred) while others include specific provider groups that will require the selection of a primary care physician (for example, members who choose a Gold Connect 1500 The Everett Clinic plan will need to choose a primary care physician with The Everett Clinic; whereas, members who choose a Gold Connect 1500 MultiCare Connected Care plan will need to choose a primary care physician with MultiCare Connected Care). Some networks are limited based on where you reside. The Everett Clinic is only available to those who reside in Snohomish County. UW Medicine is only available to those who reside in King County. EvergreenHealth Partners-Virginia Mason is available to those who reside in King County and certain areas of Snohomish County. MultiCare Connected Care is available to those who reside in Pierce County and certain areas of King County. Provider network information can be found online at **regence.com**. Please note that everyone on the application needs to enroll in the same health plan.

☐ Gold Connect 1500 EvergreenHealth Partners-Virginia Mason
☐ Gold Connect 1500 The Everett Clinic
☐ Gold Connect 1500 MultiCare Connected Care
☐ Gold Connect 1500 UW Medicine

SECTION 10 - MEDICAL PLAN CHOICES (continued)

- ☐ Gold 1000 Preferred
- ☐ Silver 3000 Preferred
- ☐ Silver HSA 2500 Preferred**
- ☐ Silver Connect 4000 EvergreenHealth Partners-Virginia Mason
- ☐ Silver Connect 4000 The Everett Clinic
- ☐ Silver Connect 4000 MultiCare Connected Care
- ☐ Silver Connect 4000 UW Medicine
- ☐ Bronze HSA 5000 Preferred**
- ☐ Bronze Essential 7150 EPO Preferred*

*If you buy an EPO product, you **must** use the doctors and hospitals within your network because there is no coverage for care outside of your network (except in emergencies). If you go to a doctor or hospital that is not in your network, you'll pay all costs. Visit regence.com to learn which doctors and hospitals are in each network.

Optional Benefits (only available in addition to the selection of a medical plan)

☐ Dental and Vision (you must select both Dental and Vision products)

Note: In order to be eligible for the adult dental and vision benefits of this plan, you and/or any covered dependents must be age 19 or older.

If you selected an HSA plan, please answer the following:

☐ **Yes, I authorize Regence to share my eligibility information and my claims information with HealthEquity for the purposes of establishing and administering my HealthEquity Health Savings Account (Social Security Number must be provided in Section 6).

For additional disclosures and information, view the HealthEquity terms and conditions at http://healthequity.com/legal.aspx. Terms and conditions of the Health Savings Account will be mailed with your HealthEquity HSA Visa Card.

☐ **No, do not share my information with HealthEquity; I have/will open my own HSA bank account.

Please Note: To take advantage of pre-tax savings of your HSA fund from day one, you must have your account open for your effective date.

SECTION 11 - MY OTHER COVERAGE

Will anyone listed on this application have other medical and/or dental insurance, including Medicare, while covered on this plan?

☐ Yes (complete the information below) ☐ No (move on to Section 12)

Are you currently enrolled in a Regence Individual medical plan and wish to cancel that coverage?

☐ Yes (Once accepted by Regence, remember to cancel your current health plan offered by Us or one of 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 12 – 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 8 of the application.)

Name (First, Last)	
Address	City, State, ZIP Code

THIRD PARTY CONTRIBUTION

1. Is any third-party payer including employers, providers, not-for-profit agencies paying for any portion of this policy?
   ☐ Yes ☐ No

We do not accept any third-party payments, except as required by law.

2. Are you Self-Employed? ☐ Yes ☐ No

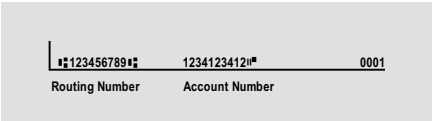
If yes, please provide the name of your business _____

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.*
3. Sign and date the Account Holder lines at the bottom of this section.



If more than one month's premium is due upon first draft, do you authorize Regence to pull all amounts? ☐ Yes ☐ No

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 13 - 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
Fred Green		0102736-0001
Producer's Mailing Address	**Producer's E-mail Address**	**Producer's Phone Number**
11930 Slater Ave. NE, Suite 100 Kirkland, WA 98034	fred@greenfinancial.com	(425) 821-1111
Producer's Signature (Required)		**Date (Required)**
X		(mm/dd/yyyy)

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.**

SECTION 14 - CERTIFICATION, AUTHORIZATION AND SIGNATURE (continued)		
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)