



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

Regence BlueShield of Idaho  
1602 21st Avenue  
Lewiston, Idaho 83501  
Mail form to: PO Box 1106  
Lewiston, ID 83501

### Individual Application Cover Sheet (to be used with the Idaho Individual Application)

#### SECTION 1 - GENERAL INFORMATION

Applicant's Name (please print) \_\_\_\_\_

Social Security Number \_\_\_\_\_ Idaho Driver's License Number \_\_\_\_\_

(Note: If applying for underage child only, please list parent/legal guardian's Idaho Driver's License Number)

EFFECTIVE DATE: Complete applications received in our office by 5:00 PM Pacific Time on the last business day of the month will be eligible for an effective date of the first of the following month, unless otherwise indicated. Incomplete applications may receive a later effective date. Requested Effective Date \_\_\_\_\_

Yes  No I want to do my part for the environment and reduce waste. Please send my Explanation of Benefits (and when possible, other communications) electronically.

What type of member card would you like to receive?  Family Level Card (all members listed on the same card)  
 Member Level Card (each member on a separate card)

#### SECTION 2 - PLAN SELECTION (Detailed benefit information can be found online at [www.regence.com](http://www.regence.com))

##### BASE PLANS (select ONE medical plan)

###### Evolve Core

- \$2,500 deductible per member (maximum of 2 deductibles per family)
- \$5,000 deductible per member (maximum of 2 deductibles per family)
- \$7,500 deductible per member (maximum of 2 deductibles per family)
- \$10,000 deductible per member (maximum of 2 deductibles per family)

###### Evolve Plus

- \$2,500 deductible per member (maximum of 2 deductibles per family)
- \$5,000 deductible per member (maximum of 2 deductibles per family)
- \$7,500 deductible per member (maximum of 2 deductibles per family)
- \$10,000 deductible per member (maximum of 2 deductibles per family)

###### Evolve HSA

- |                                                                         |                                                                      |
|-------------------------------------------------------------------------|----------------------------------------------------------------------|
| <input type="checkbox"/> \$1,500 self-only deductible / 50% coinsurance | <input type="checkbox"/> \$3,000 family deductible / 50% coinsurance |
| <input type="checkbox"/> \$1,500 self-only deductible / 80% coinsurance | <input type="checkbox"/> \$3,000 family deductible / 80% coinsurance |
| <input type="checkbox"/> \$3,500 self-only deductible / 50% coinsurance | <input type="checkbox"/> \$7,000 family deductible / 50% coinsurance |
| <input type="checkbox"/> \$3,500 self-only deductible / 80% coinsurance | <input type="checkbox"/> \$7,000 family deductible / 80% coinsurance |

###### Evolve HSA 100

- \$5,000 self-only deductible
- \$10,000 family deductible

##### DENTAL OPTIONS (select ONE of the following dental options)

- Dental Option 1** - 100/80/50; \$750 annual maximum benefit that may increase over time to \$1,500
- Dental Option 2** - 100% of first \$200 and 50% of next \$1,100 (\$750 annual maximum benefit)
- No Dental**



**SECTION 3 - PARENT OR GUARDIAN CONSENT**  
**(Complete only if applicant is under age 18 and will be the only insured)**

Notice is hereby given that \_\_\_\_\_ Social Security Number \_\_\_\_\_ who is under the age of eighteen years is making application for individual health care coverage, with my full knowledge and consent. I request that you consider the child for such health care coverage. I accept full responsibility for the payment of monthly premium and the contents of the application attached hereto.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_

Address \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

**SECTION 4 - DEFINITION OF DEPENDENT**

Dependent means: (1) The legal spouse or domestic partner of the Policyholder; and/or (2) the child of a Policyholder or Policyholder's spouse or domestic partner, up to the age of twenty-six (26); or (3) a child of any age who is medically certified as disabled. The term "children" includes natural, step, or adopted children, or children in the process of adoption from the time placed with the Policyholder.



**SECTION 5 – PREMIUM BILLING OPTIONS (if application is approved)**

Yes  No Is your employer reimbursing or paying for any portion of this policy's premium? Individual benefit plans are not intended for sale as an employer-sponsored health benefit plan for employees.

**Please indicate which billing option you want to use. (If billing option is left blank, your policy will automatically default to Monthly Billing).**

- Monthly Billing     Quarterly Billing  
 Surepay (premium is automatically deducted from your bank account on the 5th of each month).

**Note: If selecting Surepay, please fill out the information below.**

SUREPAY is a simple and convenient way to keep your health coverage in force. If you select the SUREPAY option of paying for your Regence BlueShield of Idaho health insurance the payment will be deducted automatically on the 5th of each month. This will provide several advantages to you:

- ◆ Your payment will always be made on time (if funds are available in your account).
- ◆ You won't have to worry about your coverage accidentally lapsing due to overlooked payments.
- ◆ Your monthly bank statement will show a withdrawal notation. This will serve as receipt of payment.
- ◆ Claims will be paid promptly due to your policy always being paid current.

**GETTING STARTED IS EASY:**

1. **Complete**, date and sign the Surepay Authorization information below.
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.*

Initially you will receive an invoice and need to make your payment by check, accompanied by the invoice stub. Surepay will be activated approximately 90 days from the approval of your application. You will be notified by phone or letter prior to the first withdrawal from your bank account. Your account must be paid current prior to activating Surepay, therefore it is important to pay your invoice promptly.

**AUTHORIZATION TO MY BANK**

- Checking Account**  
 **Savings Account**

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 of Idaho, Lewiston, ID. 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	Transit/Routing Numbers	Account Number

Account Holder's Name (please print)

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

Date



**SECTION 6 - MEDICARE**

If you or any listed dependents have Medicare, please list family member's name and the Medicare Health Insurance Claim (HIC) number shown on his/her Medicare card:

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**SECTION 7 - ACKNOWLEDGEMENT**

By signing the attached Individual Application, you understand and agree to the terms and conditions set forth on this cover sheet as well as the terms and conditions set forth on the attached application. If you are declined the coverage you applied for, the carrier must offer the High Risk Pool (HRP) Plans.

I certify that all statements contained herein are true to the best of my knowledge. I understand that any misrepresentation, omission, or inaccurate information required herein shall prevent recovery under the policy if such answer is fraudulent or materially affects the risk assumed by Regence BlueShield of Idaho. I understand this request will be underwritten to determine the extent of my eligibility, and that Regence BlueShield of Idaho will consider all medical information currently on file. I hereby expressly authorize any physician or hospital, or any other health care provider, to disclose to Regence BlueShield of Idaho any information obtained by having attended me or hereafter attending or examining me, and I understand that Regence BlueShield of Idaho will not disclose any information so obtained.

**SECTION 8 - YOUR PRIVACY**

For information about the use and disclosure of health information, including uses and disclosures required by law, please refer to the Regence Consumer Privacy Notice. A copy is available on our Web site at [www.regence.com](http://www.regence.com).

**Federally Eligible Individual Information**

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), guaranteed availability of individual coverage means that if you are HIPAA eligible, you cannot be denied the right to buy individual coverage. In addition, a pre-existing condition exclusion cannot be applied to your coverage.

You are HIPAA eligible, also called an "eligible individual," if ALL of the following are true at the time you apply for individual coverage.

- ◆ You have at least 12 months of continuous creditable coverage without any break in coverage greater than 63 days.
- ◆ Your most recent coverage was under a group health plan, a governmental plan, or a church plan (or health insurance offered in connection with such a plan).
- ◆ You are not covered under another group health plan.
- ◆ Your most recent coverage was not cancelled because you did not pay your premiums or because you committed fraud.
- ◆ You are not currently eligible for Medicare or Medicaid.

If you are HIPAA eligible, you will lose your right to get individual coverage without an exclusion unless you submit an application for individual coverage within 63 days after the day your group health coverage or continuation coverage ends. Act promptly to protect your rights.

