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

Regence BlueShield of Idaho
1602 21st Avenue
PO Box 1106
Lewiston, Idaho 83501

Transfer and Rate Review

Policyholder Name (please print) ______________________________

Producer Name ______________________________ Producer Number ______________

NOTE: All family members currently active on this policy will be included in the policy change.

TYPE OF REQUEST (check one) - Most changes are effective the first of the month following receipt of this form

☐ **Review renewal rate.** Select plan and complete all questions below.

☐ **Move to an individual plan from an active group plan.** If moving to lesser benefits, select plan and complete questions below. If moving to better benefits, discard this form and complete an Idaho Individual Application. **Group Cancel Date** ______________

PLAN SELECTION - Detailed benefit information can be found online at 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
- ☐ $1,500 self-only deductible / 50% coinsurance
- ☐ $1,500 self-only deductible / 80% coinsurance
- ☐ $3,500 self-only deductible / 50% coinsurance
- ☐ $3,500 self-only deductible / 80% coinsurance
- ☐ $3,000 family deductible / 50% coinsurance
- ☐ $3,000 family deductible / 80% coinsurance
- ☐ $7,000 family deductible / 50% coinsurance
- ☐ $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**

1. ☐ Yes ☐ No Are you a resident of the state of Idaho? If Yes: ________ years ________ months
2. ☐ Yes ☐ No Are you or any enrolled family member now pregnant?

   If Yes, list name and relationship to self ______________________ Due Date ________

   Please list complications anticipated ______________________ Multiple Birth? ________
3. ☐ Yes ☐ No Have you or any family member on this policy used tobacco during the last 12 months?

   If Yes, list name(s) ______________________
4. ☐ Yes ☐ No Has future surgery, diagnostic testing or medical treatment been advised for any person listed on this application?

   If Yes, give details ______________________
5. ☐ Yes ☐ No Have you or any enrolled family members consulted with a physician or been hospitalized in the past 90 days?
   If Yes, complete the following:

Patient Name	Doctor and/or Hospital	Reason Seen	Date	Recovery Complete?

6. List all persons covered under your current plan who are eligible for coverage under another plan, including group plan, Medicare, or Medicaid:

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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.

Policyholder's Signature ______________________ Date ______________

Member Identification Number ______________________ Phone Number ( ) ______________

Street Address ______________________ Mailing Address ______________________