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, MS-LB1
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)

If you are currently eligible for Medicare, or will be on the requested effective date of coverage for which you are applying, you are not eligible for private individual or family health coverage and should not fill out this application cover sheet or the Individual Application.

Note: If you are requesting a change to your existing plan or deductible, your policy must be paid current in order for the change to be made.

SECTION 2 - EFFECTIVE DATE

Your application is subject to review and approval by Regence BlueShield of Idaho. 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________________

SECTION 3 - MEMBER CARD (check one)

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

SECTION 4 - PLAN SELECTION (Detailed benefit information can be found online at regence.com)

MEDICAL PLANS (check one):

Evolve Core

Deductibles are per member (2 individual deductibles satisfy the family deductible)

☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000

Evolve HSA

Self-Only Deductibles	Family Deductibles
☐ $1,500 with 50% coinsurance	☐ $3,000 with 50% coinsurance
☐ $1,500 with 80% coinsurance	☐ $3,000 with 80% coinsurance
☐ $3,500 with 50% coinsurance	☐ $7,000 with 50% coinsurance
☐ $3,500 with 80% coinsurance	☐ $7,000 with 80% coinsurance

Evolve HSA 100

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

DENTAL OPTIONS (check one)

☐ **No Dental**
☐ **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)

SECTION 5 - 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 6 - 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 7 - 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 8 - 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 9 - 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 **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.

SECTION 10 – PREMIUM BILLING OPTIONS

BILLING ADDRESS (Complete only if billing should be sent to an address other than the Mailing Address listed on the application.)

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

EMPLOYER CONTRIBUTION

☐ 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.

PAYMENT OPTIONS (check one):

If no payment option is checked, your policy will automatically default to Monthly Billing.

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

It may take 45 - 90 days from the approval of your application to set up Surepay. To cover initial month(s) you will receive an invoice and need to make your payment by check in order to keep your account paid current.

If selecting the **Surepay** 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.*

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 of Idaho, Lewiston, Idaho. 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)

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

Date