Washington Individual Enrollment Application

P.O. Box 91120
M.S. 295
Seattle, WA 98111-9220

LIFEWISE | HEALTH PLAN OF WASHINGTON

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, and not eligible for Medicare to apply.

SECTION 1 – TYPE OF APPLICATION

Check one box: ❒ New Enrollment Application ❒ Changing Coverage (from and to a plan listed in Section 3)

❒ Adding Dependents to Existing Contract (If adding dependents fill in the following dates, as applicable.)

Spouse with/without Stepchildren: Date of Marriage _____ (MM/DD/YYYY) Adoptive Children: Date of Placement _____ (MM/DD/YYYY)

SECTION 2 - PRIMARY APPLICANT, SPOUSE & DEPENDENT INFORMATION

(Social Security numbers are required for all dependents over 1 year of age.)

Name (Last, First, Middle Initial)	Social Security # (if over age 1)	Sex (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)	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	Work Telephone Number ( )

SECTION 3 – BENEFIT PLAN SELECTION

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

1. Preferred80	❒ $500 Deductible	❒ $1,000 Deductible	
2. Choice80	❒ $500 Deductible	❒ $1,000 Deductible	
3. Preferred70	❒ $500 Deductible	❒ $1,000 Deductible	
4. Choice70	❒ $500 Deductible	❒ $1,000 Deductible	
5. Share Preferred	❒ $2,500 Deductible	❒ $5,000 Deductible	❒ $10,000 Deductible
6. Share Traditional	❒ $2,500 Deductible	❒ $5,000 Deductible	❒ $10,000 Deductible
The following are Medical Savings Account (MSA) Eligible Plans			
7. Share MSA (Individual)	❒ $1,700 Deductible	❒ $2,500 Deductible	
8. Share MSA (Individual Plus One or More)	❒ $3,400 Deductible	❒ $5,000 Deductible	

SECTION 4 – ELIGIBILITY

To be eligible for coverage, applicants:

➢Must be a resident of, and have a principal residence located within, Washington State. 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

❒ Monthly Billing ❒ Monthly Automatic Funds Transfer withdrawn 1st of the month (Complete Section 6.)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

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 LifeWise Health Plan of Washington (LifeWise) 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 **1st business day of each month** or as soon thereafter as practical, paying for that month's coverage. (For example: The deduction on January 1st pays for coverage in January.)
- ➢ I understand that this Automatic Funds Transfer Authorization will remain in effect until LifeWise 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: **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 (include a copy of the Certificate of Coverage from the prior insurer).

- ❒ **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.
  Include a copy of your Certificate of Coverage or other supporting evidence. (Complete Section 10.)
- ❒ **Addition of:** newborn or newly adopted child to an existing LifeWise plan, within 60 days of birth or adoption.

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 management, utilization review, and quality studies;
- 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 LifeWise 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 PREEXISTING 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 PLAN. 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 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 65 years of age or older and eligible for 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 LifeWise may:
   a) Make or modify the terms of the application or Contract; or
   b) Waive any of the LifeWise 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 LifeWise and that submission of this application does not guarantee I will receive coverage.

SECTION 10 – PRIOR or CURRENT COVERAGE

LifeWise Individual plans have a nine-month waiting period for preexisting conditions. In certain circumstances, we will waive or credit this waiting period based on current or prior coverage. To help us determine if you qualify for shortening the preexisting condition waiting period, please complete the following.

Please provide the following information, ***and attach your Certificate of Coverage from your current or prior carrier.****

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

*If you do not have a Certificate of Coverage, you may provide other documentation which demonstrates prior coverage beginning and ending dates

SECTION 11 – SIGNATURES

I hereby apply for enrollment with LifeWise 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 an Overview of Coverage 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.

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

X	/ /	X	/ /
Signature of Primary Applicant (Parent/Legal Guardian)	**Date of Signature**	**Signature of Spouse**	**Date of Signature**

Approved applications postmarked or received by the 20th day of the month will be effective on the first day of the following month. To select a later effective date, please indicate date here (no more than 60 days after the receipt date): _____/01/____

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): **Coordinated Benefit Plans**

Agent Name (Please Print): **Patrick J. Conroy**

Agent Address: **600 Stewart St. #602, Seattle, WA 98101**

Agent Telephone Number: **(206) 441-1363** LifeWise Agent Number: **5 6 1 2 2** (5 digits)

Agent Signature: _____

Please Note: Agents who do not have a current appointment with LifeWise are not authorized to offer LifeWise products.