

**APPLICATION FOR INDIVIDUAL COVERAGE**



PO Box 91053  
1800 Ninth Avenue  
Seattle, WA 98111-9153

All answers must be complete and accurate. Omissions or incomplete answers will result in the return of your application and may cause delays. In most cases, approved applications postmarked or delivered to Regence BlueShield by the 20<sup>th</sup> of the month are eligible for an effective date of the first of the following month.

**SECTION 1. TYPE OF APPLICATION** (Check all that apply.)

<input type="checkbox"/> New Application	<input type="checkbox"/> Transferring from Regence BlueShield Group or COBRA Coverage	<input type="checkbox"/> Transferring from another carrier
<input type="checkbox"/> Changing Coverage Type	<input type="checkbox"/> Transferring from another County or State Blue Shield Plan	

**SECTION 2. TYPE OF COVERAGE** (Select one; you must also select a deductible option.)

<b>SELECTIONS<sup>®</sup> PLANS</b> — Deductible Options: Comprehensive                      Catastrophic <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$1,000 Please choose a PCP from the Individual Selections Provider Directory.	<b>PREFERRED PLANS</b> — Deductible Options: Comprehensive                      Catastrophic <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,500 PCP is not required on the Preferred Plans.
---	---

**SECTION 3. PAYMENT TYPE** (Select one of the following payment options.)

<input type="checkbox"/> Monthly	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Semi-annually	<input type="checkbox"/> Annually	<input type="checkbox"/> Automatic Bank Withdrawal Complete the enclosed Subscriber Agreement for Preauthorized Bill Payment (monthly only).
----------------------------------	------------------------------------	--	-----------------------------------	---

**SECTION 4. MEMBER INFORMATION** (Please list subscriber, spouse, and dependent children for whom you are requesting coverage. Social Security numbers are required for all dependents over one year of age.) **PLEASE PRINT.** Proof of residence within the Regence BlueShield service area is required. See application checklist on page 4 for acceptable forms of proof.

Name (Last, First, Middle Initial)	Social Security Number	Sex	Birth Date	Relationship to Subscriber	Personal Care Provider (PCP) (Selections only)	PCP Number (See Provider Directory) <small>(Please check the box if you are a current patient of this PCP)</small>
			/ /	<b>SUBSCRIBER</b>		<input type="checkbox"/>
			/ /			<input type="checkbox"/>
			/ /			<input type="checkbox"/>
			/ /			<input type="checkbox"/>
			/ /			<input type="checkbox"/>
			/ /			<input type="checkbox"/>
Home Address (including full street address, city, state, and ZIP)				P.O. Box (if applicable)	County	
Billing Address (if different than home or mailing address)						
Home Telephone Number		Current Length of Washington State Residency		Email Address (optional)		
Name and Health Insurance Claim Number of anyone listed on this form that is covered by Medicare.						

REGENCE BLUESHIELD USE ONLY			
Date Application Substantially Complete	Effective Date	Package Number	Agent Number

**SECTION 5. EXCEPTIONS FOR THE HEALTH QUESTIONNAIRE**

Do your circumstances match any of the exceptions described in the Standard Health Questionnaire for Washington State? If so, please complete this Section.

Name of person(s) not required to complete the Health Questionnaire: \_\_\_\_\_

Reason for exemption (check one):

- Exception 1. Change of your prior coverage service area in Washington State. *Include a copy of a utility bill in your name from the prior address and a letter of verification from your prior carrier.*
- Exception 2. Health provider left network. *Include a letter of verification from the provider or carrier.*
- Exception 3. Exhaustion of COBRA continuation. *Include a letter verifying that you have exhausted your COBRA benefits.*

In addition to Exceptions listed above, no Health Questionnaire is required for the Subscriber's natural newborn or newly adopted child if the Company receives the application for coverage within 60 days of birth or placement (to be effective from date of birth or placement). Are you adding a newborn or newly adopted child with this application?

- Yes (For adopted child, include documentation indicating date of placement.)

**SECTION 6. OTHER COVERAGE INFORMATION**

Regence BlueShield Individual Plans contain a nine-month preexisting condition waiting period. In certain circumstances, we will waive or credit this waiting period based on current or prior coverage. ATTACH A COPY OF YOUR CERTIFICATE OF COVERAGE FROM YOUR CURRENT OR PRIOR CARRIER or a similar document showing the beginning and ending dates of your current coverage, if applicable. Please note: If your prior coverage was with a Regence BlueShield group plan, it is not necessary to include a copy of your Certificate of Coverage. SEE ATTACHED APPLICATION CHECKLIST FOR MORE INFORMATION.

- 1. Are you or any dependents applying for coverage eligible for, or currently covered on any group, individual, or self-insured plan?  
 Yes  No

If yes, please indicate the plan and the member's name:

\_\_\_\_\_

- 2. Have you or any dependent applying for coverage had any prior medical coverage within the past 63 days?  Yes  No

If yes, you must provide the following information in order for us to determine if the preexisting condition waiting period can be credited:

Carrier Name: \_\_\_\_\_

Date coverage began: \_\_\_\_\_ Date coverage ended: \_\_\_\_\_

Deductible amount: \$ \_\_\_\_\_ per individual per year Deductible amount: \$ \_\_\_\_\_ per family per year

Out-of-pocket (stoploss) amount: \$ \_\_\_\_\_ per individual per year Out-of-pocket (stoploss) amount: \$ \_\_\_\_\_ per family per year

- 3. Have you or any dependents applying for coverage had 18 continuous months of medical coverage, the most recent coverage being on a group plan?  Yes  No

**SECTION 7. NON-SMOKER CERTIFICATION STATEMENT**

Complete this section only if you are applying for a Non-smokers' plan.

I certify that I have not smoked cigarettes, cigars, pipes, or used chewing tobacco, smokeless tobacco or any other form of tobacco or illegal drug substance within the past 12 months. PLEASE NOTE: The company reserves the right to cancel coverage and collect claims payments or other damages if false information is submitted or if you fail to notify us you are no longer eligible for the non-smoker discount.

\_\_\_\_\_  
Applicant's Signature Date Spouse's Signature (If applying) Date

**SECTION 8. RELEASE OF INFORMATION**

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are eligible for benefits coverage and are listed on the application) 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 group 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 acknowledgement does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

\* 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 from our web site (www.wa.regence.com) or by phone at 1-800-458-3523 or 1-206-464-3663.

**SECTION 9. APPLICATION AGREEMENT**

I hereby apply for myself and for any spouse and/or dependents listed on this application for coverage under the individual contract indicated on this form, offered through Regence BlueShield (the company), an independent licensee of the Blue Cross and Blue Shield Association. I understand I will have the right to examine and return the contract within 10 days of its delivery to me. I certify that my listed dependents and I meet the eligibility requirements set forth in the overview of benefits.

I agree to pay in advance the appropriate rates for myself and listed dependents and authorize rate increases as the company deems necessary.

I have read and understand the waiting period provisions of the plan for which I am applying. I understand that under certain circumstances the company may impose a nine-month benefit-waiting period for preexisting conditions as defined in the contract.

I understand that this application is not an offer of coverage from Regence BlueShield and that submission of this application does not guarantee I will receive coverage.

I understand that any false or misrepresented information or statements may result in retroactive termination of coverage. The company will be entitled to repayment after I have been notified thereof. *Please sign and date Section 10. Signature and Date.*

**SECTION 10. SIGNATURE AND DATE**

*All statements and answers on this form and Health Questionnaire (if applicable) are complete and true, and all rights to service are void if found false or incomplete.*

**APPLICANT SIGNATURE:\*** \_\_\_\_\_ **DATE:** \_\_\_\_\_

\*If signature by a personal representative of the member/enrollee, please complete the following:  
 Personal Representative's Name: \_\_\_\_\_  
 Relationship to Individual:  Parent  Legal Guardian†  Holder of Power of Attorney†  
 ( †Attach legal documentation if legal guardian or Holder of Power of Attorney)

**APPLICANT SPOUSE SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
 (If applying)

**Dependent Signature:** \_\_\_\_\_ **Dependent Signature:** \_\_\_\_\_  
 (If age 18 or over) (If age 18 or over)

In most cases, approved applications postmarked or delivered to Regence BlueShield by the 20<sup>th</sup> day of the month will be considered effective on the first day of the following month.

To select a later effective date, please indicate here: \_\_\_\_ / 01 / \_\_\_\_ (no more than two months from date of application).

**HOW DID YOU HEAR ABOUT REGENCE BLUESHIELD?**

Please check the box that best describes how you heard about Regence BlueShield.

- Employer  Agent  Direct Mailing  Web Site  Other: \_\_\_\_\_

**AGENT INFORMATION**

IF APPLICATION IS BEING MADE THROUGH AN AGENT, HE/SHE MUST PROVIDE THE INFORMATION BELOW.

*NOTE: Agents who do not have a current appointment with Regence BlueShield are not authorized to enroll members.*

Agent Name <b>Patrick J. Conroy</b>	Firm or Agency <b>Coordinated Benefit Plans</b>
Agent Address <b>600 Stewart St., Suite 602 Seattle, WA 98101</b>	Agent Telephone Number <b>(206) 441-1363</b>
I certify I have verified that all persons applying for coverage are eligible. I further certify, to the best of my knowledge, the information on this application and Health Questionnaire (if applicable) has been completed truthfully by the applicant(s).	
_____ Agent Signature	_____ Date
Agent's Washington State License Number <b>CONROPJ409R1</b>	Expiration Date <b>12/21/2005</b>
Regence BlueShield Agent Number <b>C22512</b>	
Contact Person <b>Patrick J. Conroy</b>	

**APPLICATION CHECKLIST**

To ensure timely processing of your application, please review this checklist

- ✓ Proof of residency is required with all new applications. Please include a photocopy of one of the following:
  - A. Valid Washington State driver's license or identification card.
  - B. Current utility bill with name and address.
- ✓ Did you indicate the type of coverage you are selecting in **Section 2. Type of Coverage?**
- ✓ If you chose automatic bank withdrawal in **Section 3. Payment Type**, did you complete the **Subscriber Agreement for Preauthorized Bill Payment** form enclosed? Please pay your paper billing until you are notified that your electronic funds transfer has been initiated. Processing can take up to 60 days. Our notification to you will appear as a message on your billing statement.
- ✓ Have you completed a **Health Questionnaire** for yourself and each dependent you want to cover, if required?
- ✓ If you or your dependents do not have to complete a health questionnaire, did you include the required proof (see **Section 5. Exceptions for the Health Questionnaire**)?
- ✓ Did you complete **Section 6. Other Coverage Information?** Please provide us with documentation of prior coverage showing your beginning and ending date of coverage unless your prior coverage was with Regence BlueShield. Examples of documentation of prior coverage could include a copy of your Certificate of Prior Coverage or a letter from your prior carrier providing beginning and ending dates of your coverage with them. Copies of ID cards or bills for rate payments are not acceptable proof of prior coverage because they do not provide beginning and ending dates of coverage.
- ✓ If you are a non-smoker, did you read **Section 7. Non-smoker Certification Statement** and sign, if applicable?
- ✓ Please read **Section 8. Release of Information** and **Section 9. Application Agreement**.
- ✓ Did you sign and date this application in **Section 10. Signature and Date?**
- ✓ If an agent is helping you complete these forms, he or she must complete the **Agent Information** section.

*Do not send a rate payment with your application. You will receive a statement from us upon acceptance of your application.*