Arizona Individual Enrollment Application

LIFEWISE | HEALTH PLAN OF ARIZONA

Please read all accompanying materials 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 Arizona and not eligible for Medicare to apply.

SECTION 1 – TYPE OF APPLICATION (check one box)

❒ New Enrollment Application: Requested effective date: _____ (month) ❒ 1st ❒ 15th (no more than 60 days after the receipt day)

❒ Plan Change **(from and to a current LifeWise Plan)**: Subscriber ID# _____ (first of the month effective date only)

❒ Adding Spouse: Subscriber ID# _____ Date of Marriage: ____/____/____

❒ Adding Child: Subscriber ID# _____ ❒ Newborn ❒ Adoption Date of birth / placement ____/____/____

❒ Adding Child: Legal Ward/Guardianship/Medical Child Support Order ❒ Date of Order ____/____/____ (attach copy of court order)

SECTION 2 – PRIMARY APPLICANT, SPOUSE & DEPENDENT INFORMATION

Name—Last, First, Middle Initial (as you would like it to appear on your ID card—26 character max.)		**Social Security #**	**Height (Ft. In.)**	**Weight**	**Gender**	**Date of Birth (MM/DD/YYYY)**
Self					☐ Male ☐ Female	/ /
Legal Spouse					☐ Male ☐ Female	/ /
Dependent Child (under 25 only)					☐ Male ☐ Female	/ /
Dependent Child (under 25 only)					☐ Male ☐ Female	/ /
Dependent Child (under 25 only)					☐ Male ☐ Female	/ /

Home Address (not P.O. Box) required	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	Cell Telephone Number ( )
E-mail Address of Primary Applicant			

SECTION 3 – BENEFIT PLAN SELECTION

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

1. Passport 20	Deductible Option:	☐ $500	☐ $1,000	☐ $1,500	☐ $2,500	☐ $5,000
2. Essentials 20	Deductible Option:	☐ $2,500	☐ $5,000			
Health Savings Account (HSA) Qualified Plans						
3. HSA 20 (Individual)	Deductible Options:	☐ $3,000				
4. HSA 20 (Family)	Deductible Options:	☐ $6,000				
5. LifeWise HSA (Individual)	Deductible Options:	☐ $5,000				
6. LifeWise HSA (Family)	Deductible Options:	☐ $10,000				

SECTION 4 – ELIGIBILITY

To be eligible for coverage, applicants:

- Must be a resident of, and have principal residence located within, Arizona State. We may require proof of residency.
- Must not be entitled to Medicare (including entitlement due to disability):
  - ❒ If 65 years of age or older and not eligible for Medicare, attach a "not eligible for Medicare document" from the Social Security Administration.

SECTION 5 – RATE/BILLING INFORMATION

DO NOT SEND PAYMENT with this application.

PAYMENT OPTIONS: **Select One**

❒ Monthly Billing (by mail) ❒ Monthly Automatic Funds Transfer (Complete Section 6.)

SECTION 6 – AUTOMATIC FUNDS TRANSFER AUTHORIZATION

I have selected the Automatic Funds Transfer (AFT), and I hereby authorize LifeWise Health Plan of Arizona (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: 9-digit number at the bottom of check (for checking account) or deposit slip (for savings account)	❒ Checking ❒ Savings

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 if I have chosen an effective date of the 15th of the month, the initial transfer will be for the initial pro-rated month PLUS the first full month's subscription charge. Subsequent transfers will be for single months.
- 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 of Account Holder: **X** _____ Date (MM/DD/YYYY): ____/____/____

SECTION 7 – ELIGIBILITY FOR INDIVIDUAL PORTABILITY COVERAGE

If your employer provided group health coverage or your COBRA continuation coverage terminated within the past 63 days, you may be eligible for Individual Portability Coverage. This coverage does not require medical underwriting and there is no pre-existing condition waiting period. In order to qualify for this coverage, you must meet specific criteria. To determine if you quallify for this coverage, you must also complete the "Eligibility for Individual Portability Coverage Questionnaire."

Are you applying for Portability Coverage? ..... ❒ Yes ❒ No

If you answered "Yes," an "Eligibility for Individual Portabilty Coverage" questionnaire must be completed.

SECTION 8 – PRIOR or CURRENT COVERAGE

Do you have health insurance coverage currently? ..... ❒ Yes ❒ No

If you answered "yes," what is the name of your insurance carrier? _____

What type of coverage is it? ❒ **Group** ❒ **Individual** ❒ **Other (explain)** _____

SECTION 9 – HEALTH QUESTIONNAIRE

In the past 10 years, have you or any family member listed on this application experienced symptoms, been advised of, diagnosed with, received treatment or had treatment recommended for any of the following conditions?

Please check each item either Yes or No		Yes ☐	No ○
1.	**Alcohol or Drug Abuse / Dependence**		
a.	Alcohol / Chemical / Drug / DUI	☐	○
2.	**Autoimmune Disorders**		
b.	Lupus / Scleroderma / Mixed	☐	○
3.	**Bleeding / Blood / Circulatory Disorders**		
a.	Anemia / Bleeding / Hypercoagulation	☐	○
b.	Blood Disorder (TCP, etc.) / Leukemia	☐	○
c.	Aneurysm / Impaired Circulation	☐	○
d.	High Cholesterol, Triglycerides	☐	○
e.	Hypertension (Last: _____/____)	☐	○
f.	Phlebitis / Clots / Raynaud's / PVD	☐	○
4.	**Congenital Conditions**		
a.	Congenital Disorder / Birth Defects	☐	○
5.	**Ear / Nose / Throat / Eye**		
a.	Ear Infections (#____ past yr.) / Tubes	☐	○
b.	Nasal Malformation / Deviated Septum	☐	○
c.	Nasal Polyps / Sinusitis / Tonsillitis	☐	○
d.	Crossed Eyes / Strabismus	☐	○
e.	Retina / Macular: Detach, Degeneration	☐	○
f.	Cataract(s) / Lens Implants / Glaucoma	☐	○
6.	**Gastrointestinal Conditions**		
a.	Swallowing Problems / GERD / Reflux	☐	○
b.	Ulcers / Chronic Abd. Pain / Gallbladder	☐	○
c.	Diverticulitis / Hemorrhoids / IBS	☐	○
d.	Ulcerative Colitis / Crohn's / Colitis	☐	○
e.	Hernia (Specify type) / Polyps	☐	○
f.	Weight gain or loss > 10 lbs. within 1 yr.	☐	○
7.	**Glandular or Hormonal Disorders**		
a.	Diabetes / Elevated Blood Sugar	☐	○
b.	Goiter / Nodule / Thyroid: Hyper / Hypo	☐	○
c.	Adrenal / Pituitary Condition	☐	○
8.	**Heart Conditions**		
a.	Angina / Chest Pain / Heart Attack	☐	○
b.	Arterio-Atherosclerosis / Coronary Artery Disease / Congestive Failure	☐	○
c.	Heart Murmur / Arrhythmia / Pacemaker	☐	○
d.	Valve Disorder (Specify type, cause)	☐	○
9.	**Immune Disorders**		
a.	AIDS / AIDS Related Complex / HIV	☐	○
10.	**Kidney/Bladder Conditions**		
a.	Bladder: Infections / Incontinence	☐	○
b.	Kidney Infections / Kidney Stones	☐	○
c.	Kidney Failure / Nephritis	☐	○
11.	**Liver Conditions**		
a.	Hepatitis A / B / C / Other	☐	○
b.	Cirrhosis / Liver Failure	☐	○

Please check each item either Yes or No		Yes ☐	No ○
12.	**Musculoskeletal Conditions**		
a.	Chronic Back or Neck Pain / Strain	☐	○
b.	Disc Problems / Bone spurs	☐	○
c.	Arthritis / Rheumatoid / Osteoporosis	☐	○
d.	Fibromyalgia / Chronic Fatigue	☐	○
e	Muscular Dystrophy / Polio Residuals	☐	○
f.	Tendon / Joint: Inflammation / Gout / Carpal Tunnel / Replacement (Specify site)	☐	○
g.	Foot Disorder / Bunions / Hammertoe	☐	○
h.	Fractures (Specify site, hardware present)	☐	○
i.	Gait Abnormality / Loss of Limb(s)	☐	○
j.	Chronic Pain / Decreased Motion	☐	○
13.	**Mental Health Disorders**		
a.	Schizophrenia / Bipolar / Psychosis	☐	○
b.	Depression / Anxiety / Suicide Attempt	☐	○
c.	Anorexia / Bulimia	☐	○
d.	Attention Deficit Hyperactivity Disorder	☐	○
14.	**Neurological Conditions**		
a.	Brain Injury / Seizures / Cerebral Palsy	☐	○
b.	Stroke / TIA / Paralysis	☐	○
c.	Headaches (Recurrent or Migraine)	☐	○
d.	MS / Alzheimer's / Huntington's / ALS / Parkinson's	☐	○
e.	Meningitis / Encephalitis	☐	○
f.	Developmental delay (Specify type, cause)	☐	○
15.	**Organ**		
a.	Transplant (Previous or pending)	☐	○
b.	Critical Organ Cyst / Tumor (i.e., brain)	☐	○
c.	Cancer (Specify type, location, extent)	☐	○
16.	**Reproductive System Conditions**		
a.	Menstrual Irregularity / Pregnant	☐	○
b.	Breast Disorder / Fibrocystic / Implant	☐	○
c.	Abnormal Pap Smear / Dysplasia	☐	○
d.	Endometrial / Uterine / Cervix Disorders	☐	○
e.	Ovarian / Testicular: Cyst / Torsion	☐	○
f.	Prostate Problems / Sexual Dysfunction	☐	○
17.	**Respiratory Conditions**		
a.	Allergies / Asthma / Sleep Apnea	☐	○
b.	Chronic Bronchitis / Pneumonia / TB	☐	○
c.	Lung Clot / Collapsed Lung	☐	○
d.	Chronic Obstructive Lung Diseases	☐	○
18.	**Sexually Transmitted Diseases**		
a.	Genital Herpes / HPV / Other	☐	○
19.	**Skin Conditions**		
a.	Burns / Scars / Acne / Ulcers (Specify site)	☐	○
20.	**Specify other condition(s) not listed above:**		
a.		☐	○
b.		☐	○

21. If you have answered "yes" to ANY of the previous questions or have experienced any other health issues, complete this question.
Instructions: Include complete details including site, cause, and extent of condition. Attach additional sheet if needed. You may wish to submit copies of relevant medical records to expedite the process (at your own expense).

#	Name	Dates	Describe Condition	Provider	Current Status	Follow Up
		Start Mo ___ Yr ___	Diagnosis	Practitioner	Condition Present? ☐ No, resolved *OR* ☐ Yes, persists *(Describe):*	Future Care? ☐ No, resolved *OR* ☐ Yes, future surgery or treatment *(Describe type, reason):*
			Treatment	Hospital		
		End Mo ___ Yr ___		______ Days		
		Start Mo ___ Yr ___	Diagnosis	Practitioner	Condition Present? ☐ No, resolved *OR* ☐ Yes, persists *(Describe):*	Future Care? ☐ No, resolved *OR* ☐ Yes, future surgery or treatment *(Describe type, reason):*
			Treatment	Hospital		
		End Mo ___ Yr ___		______ Days		
		Start Mo ___ Yr ___	Diagnosis	Practitioner	Condition Present? ☐ No, resolved *OR* ☐ Yes, persists *(Describe):*	Future Care? ☐ No, resolved *OR* ☐ Yes, future surgery or treatment *(Describe type, reason):*
			Treatment	Hospital		
		End Mo ___ Yr ___		______ Days		
		Start Mo ___ Yr ___	Diagnosis	Practitioner	Condition Present? ☐ No, resolved *OR* ☐ Yes, persists *(Describe):*	Future Care? ☐ No, resolved *OR* ☐ Yes, future surgery or treatment *(Describe type, reason):*
			Treatment	Hospital		
		End Mo ___ Yr ___		______ Days		

22. ☐ **No** ☐ **Yes** **Has anyone listed on this application taken medications within the past year?** If yes:

Name	Medication (name, dose, duration)	Prescriber	Diagnosis

23. ☐ **No** ☐ **Yes** **Has any insurance company refused or restricted any insurance coverage for you or any person listed on this application?** If yes, explain:

____

____

24. ☐ **No** ☐ **Yes** **Has any other future surgery, diagnostic testing or medical treatment been recommended or discussed for any person listed on this application?** If yes, explain:

____

____

25. ☐ **No** ☐ **Yes** **Has anyone listed on this application ever used tobacco products?** If yes:

Name	Tobacco Type	Packs a day/Frequency	# Years	Last Used

26. ☐ **No** ☐ **Yes** **Is any member of the applicant's immediate family currently pregnant? Please include family members not listed on this application.** If yes, explain:

____

____

SECTION 10 – NOTICE OF INFORMATION USE AND DISCLOSURE

Type Of Information To Be Disclosed: I (We) authorize: any physician, health care provider, hospital, insurance or reinsurance company, pharmacy benefits manager or third party benefits administrator to disclose a copy of my (our) personal health information, including any and all diagnostic, procedural, treatment, claim, prescription or other health related information including records concerning alcohol and/or chemical dependency, reproductive health (including abortion), sexually transmitted diseases, HIV, AIDS, psychiatric disorders, mental illness and genetic testing to LifeWise or its representatives as allowed by law.

Purpose Of Disclosure: I (We) understand that personal information will be used for underwriting, evaluating enrollment in the health plan, determining eligibility for benefits and paying claims.

Timeframe Of Release: Unless I revoke it, this release will remain valid for twenty-four (24) months from the date of my signature below.

Revocation Of Release: I understand that I may change my mind and revoke this release at any time. I will do this by letting LifeWise know of my decision. Any change will be effective five (5) business days after LifeWise receives my written notice at the address listed on this form. I understand that some or all of this information may already have been used by LifeWise to make decisions, which will not be affected by its revocation.

Redisclosure: LifeWise Health Plan of Arizona may be required to redisclose this information to another party that is not subject to state and federal privacy rules.

Effect of Not Authorizing: This authorization is a condition of your enrollment in our health plan or your eligibility for benefits. If you decide not to sign this authorization, we may decline to enroll you in our health plan or to give you benefits.

Please Note: You or your authorized representative are entitled to receive a copy of this authorization.

SECTION 11 – 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 TWELVE-MONTH WAITING PERIOD FOR PRE-EXISTING CONDITIONS. NO BENEFITS ARE PROVIDED FOR ANY MEDICAL CONDITION FOR WHICH TREATMENT WAS RECEIVED (OR RECOMMENDED) WITHIN THE TWELVE 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 OR PORTABILITY COVERAGE ISSUED TO A HIPAA-ELIGIBLE INDIVIDUAL.**
   e) The benefits under this Contract will be subject to coordination of benefits with other individual 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 Arizona in order to apply for coverage under this Contract. "Resident" means a person who lives in the state of Arizona 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. 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 a "HIPAA-eligible individual."
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 have substantially higher out-of-pocket costs when treatment is not received from a contracted provider.
7) I understand that this application is not an offer of coverage, and that its submission does not guarantee that I will receive coverage. I also understand that LifeWise may accept this application, but exclude certain conditions by rider. A rider is a form which, when attached to the contract, becomes a part thereof, and lists medical conditions for which coverage is not available under the contract, for the person specified, based on his/her past medical history. If a rider is required for enrollment, I will be notified in writing. All riders will remain for the duration of the coverage, or will be reviewed, upon the subscriber's request, after a period of five years of continuous coverage.
8) I also understand that LifeWise may modify or cancel my contract retroactively to its effective date, deeming some or all entitlements or rights to benefits under the contract void, if on this application I make any misrepresentation, incorrect statement or omit or conceal a fact that:
   - is fraudulent
   - is material to LifeWise's acceptance of the application or to the risk it assumes for the medical conditions I and my family members had at the time of application, or
   - had LifeWise known the facts as required by this application, LifeWise in good faith, would either not have: i) issued the contract; ii) issued the contract at the same premium or iii) provided coverage for the loss hazard.

SECTION 12 – 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 11.
d) I have read the Notice of Information Use and Disclosure in Section 10.
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.
f) I agree to notify LifeWise in writing of any new health condition that occurs prior to my coverage taking effect.

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 (not applicable to HSA plans if this would result in changing family coverage to individual coverage).

☐ Yes ☐ No

Applications postmarked by the 14th of the month will be effective on the 15th of the same month if approved (for new enrollment only). A pro-rated subscription charge will apply for the partial month of coverage. Applications postmarked by the last day of the month will be effective on the first day of the following month if approved.

X _____ / / **X** _____ / /

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

DO NOT SEND PAYMENT WITH THIS APPLICATION.

Completion of this section BY THE GENERAL AGENCY AND/OR 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.

General Agency Information (if applicable):

General Agency Name:	General Agency LifeWise Agent Number & Schedule Code:
General Agency Sales Representative Name (please print):	General Agency Telephone Number:
General Agency Address:	
General Agency E-mail Address:	
General Agency Signature:	Date:

Selling Agency Information:

Selling Agency Name:	
Selling Agent Name (please print):	Selling Agent Number & Schedule Code:
Selling Agent Address:	
Selling Agent Telephone Number:	Selling Agent E-mail Address:
Selling Agent Signature:	Date:

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

LifeWise Health Plan of Arizona
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Seattle, WA 98111-9220