Blue Cross of Idaho®

IDAHO INDIVIDUAL APPLICATION COVER SHEET
FOR ENROLLMENT OUTSIDE OF THE IDAHO EXCHANGE

Welcome to Blue Cross of Idaho

*To apply for **medical** and/or **dental** coverage for 2016, complete this cover sheet and the Idaho Individual Universal Application. Plan information is available at **shoppers.bcidaho.com.***

Instructions: Please complete pages 1 and 2 of the cover sheet and return it with the completed Idaho Individual Application to Blue Cross of Idaho. This completed application must be received by Blue Cross of Idaho no later than the 15th to become effective the 1st of the following month. The first month's premium payment must be received by the end of the month prior to the effective date. Incomplete information will delay processing of the application.

Please keep a copy for your records.

SECTION 1 ENROLLMENT INFORMATION

1a. Are you: ❑ A new applicant (adult) ❑ Responsible party (if you are not applying for coverage for yourself but are enrolling dependent children for coverage, you are considered the responsible party and not the applicant.)
Name of responsible party: _____

1b. Do you have a current Idaho's driver's license or Idaho identification card? ❑ Yes ❑ No

Idaho driver's license or identification card number _____ Expiration date _____

If you are unable to provide an Idaho driver's license or identification card number, to establish residency you must provide copies of two other forms of documentation that contain your name and residential address with this completed application.

Examples include home mortgage statement; lease or loan agreement; homeowner's, renter's, or car insurance policy; or current bank statements (within the last 60 days). These documents must contain the applicant's name and residential address.

1c. Please list each family member enrolling in medical coverage and indicate if they are also enrolling in dental coverage. You may exclude yourself or other applicants from the dental plan. The applicant may be a child if no adults are applying for coverage.

Member's Name *(first, middle initial, last)*	**For each plan the dependent enrolls, the Applicant must enroll.**		****For Managed Care Plans Only** (See Section 2 b on reverse-Connect Plans)	
	Enrolling in Medical?	***Enrolling in Dental?**	Name of Primary Care Physician (PCP) or PCP ID Number (For the highest benefit level you must select a PCP)	Existing Patient of PCP?
Applicant	❑ Yes ❑ No	❑ Yes ❑ No		
Dependent 1	❑ Yes ❑ No	❑ Yes ❑ No		
Dependent 2	❑ Yes ❑ No	❑ Yes ❑ No		
Dependent 3	❑ Yes ❑ No	❑ Yes ❑ No		
Dependent 4	❑ Yes ❑ No	❑ Yes ❑ No		
Dependent 5	❑ Yes ❑ No	❑ Yes ❑ No		
Dependent 6	❑ Yes ❑ No	❑ Yes ❑ No		

***ESSENTIAL HEALTH BENEFITS DISCLAIMER:**
The medical policy you are applying for does not include coverage for pediatric dental care, which is considered an essential health benefit under the Affordable Care Act. You have access to pediatric dental plans, including those offered by Blue Cross of Idaho, as a separate policy. Please contact us, your insurance agent, or Your Health Idaho if you want to learn more about the stand-alone pediatric dental insurance plans available in the market.

P.O. Box 7408 Boise, ID 83707-0938 Sales: 1-800-365-2345 Fax: 208-331-7582

SECTION 2 SELECT A MEDICAL PLAN *(Choose one medical plan from 2.a or 2.b below.)*

2.a PREFERRED PROVIDER ORGANIZATION PLANS (QHP)

- ❑ Bronze Choice
- ❑ Bronze Saver
- ❑ Covered Choice (Catastrophic)
- ❑ Gold Choice
- ❑ Silver Choice – $500 Deductible
- ❑ Silver Choice – $2,000 Deductible
- ❑ Silver Choice – $3,000 Deductible
- ❑ Silver Choice – $4,000 Deductible
- ❑ Silver Saver

2.b COORDINATED CARE ORGANIZATION PLANS (QHP)** These plans have a specific network of providers. Please check the network before choosing a Coordinated Care plan. If you choose a Coordinated Care plan, please indicate the region of Idaho you live in:

❑ Southwestern ❑ Eastern

- ❑ Bronze Connect
- ❑ Covered Connect *(Catastrophic)*
- ❑ Silver CarePoint - $4,000 Deductible *(Southwest and Central Idaho Only)*
- ❑ Gold Connect
- ❑ Silver Connect – $500 Deductible
- ❑ Silver Connect – $2,000 Deductible
- ❑ Silver Connect – $3,000 Deductible
- ❑ Silver Connect – $4,000 Deductible

To view and print a Summary of Benefits and Coverage (SBC) for our standard individual health insurance plans and the uniform glossary, visit our website at ***bcidaho.com/SBC*** or contact your local district office at 800-365-2345.

****FOR MANAGED CARE PLANS ONLY:**

If you are enrolling in a managed care plan (Coordinated Care), you must select a Primary Care Provider (PCP) for yourself and each covered family member. Each member of your family may choose a different PCP or you may all share the same one. Please indicate each family member's PCP in Section 1b.

To help you choose a PCP, you may contact Customer Service at 800-627-1188 or you can view the provider directory for the plan you are enrolling in on our website:

For Connect Southwest plans, visit ***www.bcidaho.com/SaintAlphonsus***. For Connect East plans, visit ***www.bcidaho.com/Portneuf.*** For CarePoint plans, visit ***www.bcidaho.com/StLukes.***

SECTION 3 SELECT A DENTAL PLAN *Please choose the dental plan you wish to enroll in:*

- ❑ Dental Choice
- ❑ Dental Choice Plus
- ❑ No Dental*

Pediatric dental coverage is available for those 18 and under. Additional limitations and waiting periods apply for those ages 19 and older.

SECTION 4 TERMINATION OF OTHER COVERAGE

If you have existing coverage that will be replaced by your Blue Cross of Idaho plans, be sure to terminate the policy prior to this one becoming effective. Are you currently enrolled in other Blue Cross of Idaho medical or dental coverage?

❑ **No** If No, please sign and date below. ❑ **Yes** If Yes, do you wish to terminate this coverage?

Medical ❑ Yes ❑ No **Dental** ❑ Yes ❑ No

Blue Cross of Idaho Identification Number(s) _____

SECTION 5 REPLACEMENT OF EXISTING COVERAGE

Will this policy replace any other accident and sickness insurance presently in force? ❑ Yes ❑ No

If YES, please read, sign and date the following notice.

Notice to Applicant Regarding Replacement of Accident and Sickness Insurance

According to this application, you intend to allow to lapse or otherwise terminate existing accident and sickness insurance and replace it with a program to be issued by Blue Cross of Idaho. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the health care coverage available to you under the new program.

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new program or the new program may also require a waiting period for certain specified conditions. This could result in denial or delay of a claim for benefits under the new program, whereas a similar claim might have been payable under your present program.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present program. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present program and replace it with new coverage, please be certain to completely and accurately answer all questions on this application. Failure to include all information on an application may provide a basis for the company to deny any future claims and to refund your premiums as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

I confirm that a copy of "Notice to Applicant Regarding Replacement of Accident and Sickness Insurance" was furnished to me.

SIGNATURES

Signature _____ Date _____

Applicant or Responsible Party

Signature _____ Date _____

Spouse, if applying for coverage

IDAHO INDIVIDUAL APPLICATION
FOR ENROLLMENT OUTSIDE OF THE IDAHO EXCHANGE

Please type or print legibly in black ink and complete all applicable sections.

SECTION 1 ENROLLMENT INFORMATION (check all that apply)

1. Are you: ☐ A new applicant ☐ Adding dependents ☐ Enrolling during the annual open enrollment
2. If you are enrolling ***outside*** of the annual open enrollment or adding dependents, what is the reason

   (documentation may be required)? ☐ Marriage ☐ Divorce ☐ Birth ☐ Adoption

   ☐ Involuntary loss of ***employer*** coverage ☐ Involuntary loss of ***individual*** coverage ☐ Involuntary loss of Medicaid

   ☐ Court order *(copy of court order required)* ☐ Other _____

   Date of event *(mm/dd/yyyy)* _____
3. The primary applicant and any spouse must be residents of the state of Idaho at the time of application and during the term of this policy to be eligible for coverage. Coverage under this policy will be terminated and this policy may be rescinded if residency within the state of Idaho is not maintained.

   Are you a resident of the state of Idaho? ☐ Yes ☐ No If yes:_____years _____months
4. Requested effective date *(Subject to approval): (mm/dd/yyyy)* _____

SECTION 2 APPLICANT INFORMATION

1. **Legal** First Name, Middle Name, Last Name *(and suffix, if applicable)*			
2. Street Address			
3. City	4. State	5. Zip Code	6. County
7. Mailing Address *(Street, Route, P.O. Box) (if different than street address)*			
8. City	9. State	10. Zip Code	11. County
12. Billing Address *(if different than mailing address)*			
13. City	14. State	15. Zip Code	16. County
17. Preferred **Daytime** Phone Number ( )	18. Alternate Phone Number ( )		19. Date of Birth *(mm/dd/yyyy)*
20. Gender ☐ Male ☐ Female	21. Social Security Number **(required)**	22. Marital Status ☐ Single ☐ Married ☐ Other _____	
23. Email Address			

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SECTION 3

DEPENDENT INFORMATION **(List all eligible dependents you wish to enroll, including any child who is under the age of 26; or who is medically certified as disabled and dependent on parent for support (copy of certification required). If you have more dependents to include, make a copy of this page and attach.)**

Dependent 1

1. Legal First Name, Middle Name, Last Name *(and suffix, if applicable)*		2. Relationship ☐ **Legal** spouse ☐ Child ☐ Step-child ☐ Other _____
3. Gender ☐ Male ☐ Female	4. Date of Birth *(mm/dd/yyyy)*	5. Social Security Number **(required)**
6. Does dependent 1 live at the same address as you? ☐ Yes ☐ No		

Dependent 2

1. Legal First Name, Middle Name, Last Name *(and suffix, if applicable)*		2. Relationship ☐ **Legal** spouse ☐ Child ☐ Step-child ☐ Other _____
3. Gender ☐ Male ☐ Female	4. Date of Birth *(mm/dd/yyyy)*	5. Social Security Number **(required)**
6. Does dependent 2 live at the same address as you? ☐ Yes ☐ No		

Dependent 3

1. Legal First Name, Middle Name, Last Name *(and suffix, if applicable)*		2. Relationship ☐ **Legal** spouse ☐ Child ☐ Step-child ☐ Other _____
3. Gender ☐ Male ☐ Female	4. Date of Birth *(mm/dd/yyyy)*	5. Social Security Number **(required)**
6. Does dependent 3 live at the same address as you? ☐ Yes ☐ No		

Dependent 4

1. Legal First Name, Middle Name, Last Name *(and suffix, if applicable)*		2. Relationship ☐ **Legal** spouse ☐ Child ☐ Step-child ☐ Other _____
3. Gender ☐ Male ☐ Female	4. Date of Birth *(mm/dd/yyyy)*	5. Social Security Number **(required)**
6. Does dependent 4 live at the same address as you? ☐ Yes ☐ No		

SECTION 4

OTHER INFORMATION

1. Are you or any dependent listed on this application receiving Worker's Compensation payments or are now eligible to receive such payments? ☐ **YES** ☐ **NO**
   If yes, give person's name, specific type and details: _____
   _____
2. Has any person listed on this application used a tobacco product on average four or more times a week within no longer than the past six months (anyone age 18 or older)? ☐ **NO** ☐ **YES** **If yes**, list names below:
   1. _____ 3. _____
   2. _____ 4. _____

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SECTION 5 OTHER COVERAGE INFORMATION *(Please complete the section below if you have other coverage that will remain in effect. If you have more policies to include, make a copy of this page and attach.)*

If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation that shows who is responsible for the dependent(s)' health care insurance so that the insurance carrier can determine whose coverage is primary.

Policy 1

1. Other Insurance Carrier Information: Insurance Carrier Name, Policy Number, Phone Number

2. Policy Holder Name

3. Names of Covered Members

4. Types of Coverage *(check all that apply)*
☐ Group ☐ COBRA
☐ Individual ☐ HRP
☐ Medicare ☐ Medicaid
☐ Other _____

5. Coverage Start Date *mm/dd/yyyy*

6. Is this coverage terminating?
☐ Yes (complete #7)
☐ No

7. Coverage End Date *mm/dd/yyyy*

Policy 2

1. Other Insurance Carrier Information: Insurance Carrier Name, Policy Number, Phone Number

2. Policy Holder Name

3. Names of Covered Members

4. Types of Coverage *(check all that apply)*
☐ Group ☐ COBRA
☐ Individual ☐ HRP
☐ Medicare ☐ Medicaid
☐ Other _____

5. Coverage Start Date *mm/dd/yyyy*

6. Is this coverage terminating?
☐ Yes (complete #7)
☐ No

7. Coverage End Date *mm/dd/yyyy*

SECTION 6 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 preexisting 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 in Idaho.

- You are not covered under another group health plan
- Your most recent coverage was not canceled 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 coverage or continuation coverage ends. Act promptly to protect your rights.

SECTION 7 AFFIRMATION

I affirm the answers in this "Idaho Individual Application" are complete and correct. I am providing these answers as part of the application procedure required by this insurance carrier to enroll in its insurance coverage. I understand that the insurance carrier will rely on each answer in making its determination to extend coverage and to determine the type of coverage offered. I understand if I have made any misstatement or omission in this application, the insurance carrier may take any action available by law, including but not limited to, retroactive adjustment of premiums or claims. Further, I understand that any fraud or intentional misrepresentation of material fact in my completion of this applicationn is cause for retroactive termination of coverage by the insurance carrier and/or other action available by law. I will promptly inform the insurance carrier in writing if anything happens before my coverage takes effect that makes an answer on this application incomplete or incorrect. Following receipt of a fully-executed application, coverage will be in force as of the effective date determined by the insurance carrier under applicable law.

SECTION 8 STATEMENT OF UNDERSTANDING

By signing this application, I represent that all my answers are complete and accurate to the best of my knowledge and belief and that I understand and agree to the following conditions:

- No independent producer, agent or employee of the insurance carrier can change any part of this application or waive the requirement that I answer all questions completely and accurately.
- The insurance carrier may terminate or rescind an insured's coverage for any intentional misrepresentation, omission of fact by, concerning, or on behalf of any insured that was or would have been material to the insurance carrier's acceptance of a risk, extension of coverage, provision of benefits or payment of any claim.
- If this application is approved, coverage for me and any eligible persons named on this application will begin on the effective date assigned by the insurance carrier.
- I understand that this application will become part of the contract between the insurance carrier and me.
- I affirm that I have reviewed all answers given on this application and, regardless of whether an independent producer or other person has filled out the answers for me, I verify that the answers are true and complete.

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SECTION 9 PREEXISTING CONDITION WAITING PERIOD (OVER 19 YEARS OF AGE)

NOTICE OF PREEXISTING CONDITION LANGUAGE: I understand that until the first plan year beginning January 1, 2014 or later, a waiting period for preexisting conditions may apply. This mean if you have a medical condition before coming to our plan, you might have to wait a specified period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a six-month period. Generally, the six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period began. This preexisting condition exclusion does not apply to pregnancy nor to individuals under the age of 19 years beginning upon the policy renewal on or after September 23, 2010, as provided in the Patient Protection and Affordable Care Act (PPACA).

This exclusion may last up to 12 months from your first day of coverage, or if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is considered creditable coverage and can be used to reduce the preexisting condition exclusion if you have experienced a break in coverage of at least 63 days. To reduce the 12-month exclusion period by your creditable coverage, you should give us a copy of any certificated of creditable coverage you have. If you do not have a certificate, buy you do have prior health coverage, we will help you obtain one from your prior issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

SECTION 10 PARENTAL OR GUARDIAN CONSENT TO APPLICATION

By completing this section and signing this application, I represent that the person listed as the applicant on this application is under 18 years of age and is making application for health coverage with my full knowledge and consent. I hereby accept full responsibility for the payment of premiums and the answers and information provided in this application.

Print Name	Date *(mm/dd/yyyy)*

Address *(if different than Dependent)*

SECTION 11 ACKNOWLEDGMENT

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 acknowledgment does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

Signature of Applicant _____ Date *(mm/dd/yyyy)* _____

Signature of Spouse _____ Date *(mm/dd/yyyy)* _____
(if applying for coverage)

SECTION 12 INDEPENDENT PRODUCER (AGENT) INFORMATION

Agent's Name _____ ID No. _____

Signature of Agent _____ Date *(mm/dd/yyyy)* _____

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