Individual and Family Plan Application

For coverage effective on or after July 1, 2012

Thank you for considering us for your individual and family coverage.

To be considered for enrollment:

- Complete this application in black or blue ink only.
- Read the application carefully and answer all applicable sections completely. **All pages must be returned.**
- Confirm that you meet all the eligibility requirements called out throughout this application by checking the appropriate boxes. Not checking appropriate boxes will delay the processing of your application.
- Send the completed application and supporting documents to be received at our offices by the 20th of the month, or the first business day following the 20th if it's a weekend or holiday, for coverage to begin the first of the following month.
- Send the application and supporting documents to:
  Group Health individual and family sales
  320 Westlake Ave N, Suite 100
  Seattle, WA 98109-5233
- Call us at **1-800-358-8815** or **206-448-4141** if you have any questions about this application or the process.

FOR INTERNAL USE ONLY
Date application was received:

Group Health refers to either Group Health Cooperative or Group Health Options, Inc.

SECTION 1. APPLICATION TYPE

Pick **one** of these two options:

☐ **I/we are new applicants.**

I/we wish coverage to begin on the first day of _____.
(month/year)

OR

☐ **I'm a current Group Health individual and family plan member and my member ID is _____, and I am (please check the box below that applies):**

I/we wish coverage to begin on the first day of _____
(month/year)

Note: Separate applications are required if dependents are being added **and** a plan change is also being requested.

☐ **Adding eligible dependents**:

- ☐ Adding a spouse/domestic partner.
- ☐ Adding a dependent child.
- ☐ Adding a newborn. Date of birth (coverage effective as of date of birth): _____
  (month/day/year)
- ☐ Adding a newly adopted child. Date of event (coverage effective as of date of placement): _____
  (month/day/year)

☐ **Requesting changes:**

- ☐ Changing plans.*
- ☐ Changing from dependent to subscriber.

NOTE: If you are terminating a dependent, please call Customer Service at **1-888-901-4636** for assistance.

NOTE:
If you are making a change, your account must be current and paid in full.

*Changing plans between Group Health Cooperative and Group Health Options, Inc. will require completion of a new Standard Health Questionnaire. You can find this online at **ghc.org.** If you are changing from a higher deductible plan to a lower one within the same group, you **may** be required to complete a new Standard Health Questionnaire. Call Customer Service at **1-888-901-4636** for more information.

SECTION 2. SUBSCRIBER & ADDRESS INFORMATION

Name: Last, first, middle initial	Member number	Sex M/F	Date of birth	Social Security number (REQUIRED)
Applicant/subscriber*				
Spouse/domestic partner*				
Dependent child (under 26)*				
Dependent child (under 26)*				
Dependent child (under 26)*				
Dependent child (under 26)*				
Dependent child (under 26)*				
Dependent child (under 26)*				
Dependent child (under 26)*				

REQUIRED:

Street address (no P.O. Box)		
City State ZIP		County
Mailing address	City	State ZIP
E-mail address		Contact phone number

*Applicants under 19 years of age are subject to special guidelines for enrollment. See the instruction sheet affecting applicants under age 19.

REQUIRED:

Have tobacco or nicotine products been used during the last 12 months?

Applicant/subscriber ☐ Yes ☐ No Spouse/domestic partner ☐ Yes ☐ No

SECTION 3. BILLING INFORMATION

No payment is required at this time. You will be mailed a bill once you are approved for coverage. Information about automatic funds transfer from a checking or savings account will be included with your welcome letter once you are enrolled.

Check one of the following three billing options and fill in the billing information (if applicable).

☐ **1 – Send bill to:** subscriber address.

OR

☐ **2 – Send bill to:** different address below.*	☐ **3 – Send bill to:** guarantor at the address below.* (This option is only available if the applicant is under age 18.)
Billing name	Guarantor billing name
Address	Address
City	City
State/ZIP	State/ZIP
Billing phone number	Guarantor billing phone number
Billing e-mail	Guarantor billing e-mail

*If a third party is paying premiums on behalf of the applicant, the third party is required to either set up a monthly electronic funds transfer or, if receiving a paper bill, submit one check per subscriber policy.

Special Instructions for Under Age 19

Individuals under the age of 19 must apply for coverage either as a subscriber, a dependent-only, or as a dependent of a subscriber, during an open enrollment period. Individuals under the age of 19 may also apply for coverage outside of an open enrollment period, if they experience a qualifying event which makes them eligible for special enrollment. Application must be made within 31 days of the event unless otherwise noted. More detail on qualifying events can be found in the Special Instructions for Under Age 19 Applicants sheet that accompanies this application. The five qualifying events are listed below.

Please check which qualifying event(s) apply to the applicant under age 19:

☐ **Loss of employer-sponsored coverage.**

Some examples of loss of employer-sponsored coverage include, but are not limited to: your position was eliminated, terminated, or you were a dependent under someone else's plan and that person lost their job or voluntarily dropped you from their plan.

Supporting documentation required: copy of the letter that indicates health plan coverage was lost, or COBRA offer letter.

☐ **Loss of eligibility under Medicaid or another public program providing health benefits.**

Supporting documentation required: copy of termination letter.

☐ **Loss of coverage as the result of dissolution of marriage.**

Supporting documentation required: copy of your divorce decree and a copy of the letter that indicates health plan coverage was lost, or COBRA offer letter.

☐ **A change in residence, and the health plan under which you were covered does not provide coverage in your new area.**

Supporting documentation required: include a copy of a utility bill in your name or in the name of your guarantor that lists the previous address and is dated within the last 31 days, and a letter of verification from your prior carrier verifying that because you moved, you no longer reside in their service area and they cannot provide coverage to you at your new location.

☐ **The addition of a newborn or newly adopted child.**

You are applying for coverage on behalf of a newborn, a child recently placed for adoption, or a child who has been adopted within sixty days of the application date. The sixty-day time period applies only to this qualifying event.

Supporting documentation required for newly adopted children only: court documents that indicate the date the child was placed for adoption.

Please check below if this section does not apply:

☐ **Section does not apply.**

SECTION 4. PLAN CHOICES

Check **one** box to indicate your health plan selection*:

Group Health Cooperative:	**Group Health Options, Inc.:**
☐ Welcome **1000** Plan – '12	☐ Balance **1750** Plan – '12
☐ Welcome **2000** Catastrophic Plan – '12†	☐ Balance **2500** Catastrophic Plan – '12†
☐ Welcome **3500** Catastrophic Plan – '12†	☐ Balance **5000** Catastrophic Plan – '12†

Group Health Cooperative:	**Group Health Options, Inc.:**
☐ HealthPays® Health Savings Account (HSA) **2000** Individual/**4000** Family Catastrophic Plan – 12†	☐ HealthPays® Health Savings Account (HSA) **2750** Individual/**5500** Family Catastrophic Plan – '12†
Do you want a banking arrangement with HealthEquity? ☐ Yes ☐ No	Do you want a banking arrangement with HealthEquity? ☐ Yes ☐ No

NOTE: Federal law places some limitations on HSA eligibility. Consult your tax advisor or materials available through the U.S. Treasury Dept. for this important information to make sure you're selecting the right HSA plan for your family. Subscribers under the age of 18 can enroll in the health plan but are not eligible for the Health Savings Account.

***Changing plans between Group Health Cooperative and Group Health Options, Inc. will require completion of a new Standard Health Questionnaire.** You can find this online at **ghc.org.** If you are changing from a higher deductible plan to a lower one within the same group, you **may** be required to complete a new Standard Health Questionnaire. Call Customer Service at **1-888-901-4636** for more information.

†These plans provide catastrophic coverage. If you decide at a later date to switch to a plan that provides greater coverage, your prior catastrophic coverage may not meet creditable coverage requirements for pre-existing conditions.

SECTION 5. OPTIONAL DENTAL COVERAGE

Choose **one** box below to indicate whether you'd like to elect, waive, or terminate optional dental coverage through Washington Dental Service, which is located at 9706 Fourth Ave. N.E., Seattle, WA 98115-2157.

☐ I would like dental coverage for myself and all eligible dependents.

- ☐ I would like to enroll a dependent under age 3.
  NOTE: Children under the age of 3 are **not** automatically enrolled in optional dental coverage.

☐ I am a new applicant or current member and would like to waive dental coverage for myself and all eligible dependents.‡

☐ I am a current member and I wish to terminate the existing dental coverage for myself and all eligible dependents.‡

‡If you waive or terminate dental coverage, you will not be able to reapply until the annual plan renewal in July.

SECTION 6. VOTING OPTIONS

☐ I would like Group Health Cooperative voting membership for myself and all eligible dependents.

SECTION 7. PRIOR OR CURRENT COVERAGE

Your contract contains coverage exclusions for Pre-Existing Conditions (PEC). These exclusions could be fully or partially waived based on prior or current coverage. Review this section carefully and complete the information requested for both you and your dependents to assure proper processing of your claims.

Name (first and last)	Current or previous carrier (include phone number)	COBRA	Date coverage began (mm/dd/yy)	Date coverage ended (mm/dd/yy)
		Yes ☐ No ☐		
		Yes ☐ No ☐		
		Yes ☐ No ☐		
		Yes ☐ No ☐		
		Yes ☐ No ☐		
		Yes ☐ No ☐		

Deductible amount per year: Individual _____ Family _____

Out-of-pocket limit per year: Individual _____ Family _____

Did/does your coverage include:

☐ Maternity ☐ Prescription drug ☐ Hospital only

What type of coverage are you coming from:

☐ Individual plan
☐ Group plan
☐ Federal plan (FEHBP/TriCare/Peace Corps Act)
☐ Healthy Options plan (DSHS)
☐ WSHIP
☐ State plan (PEBB)
☐ College/school/short-term insurance
☐ Indian Health Service or tribal organization
☐ State Children's Health Insurance Program (SCHIP)
☐ Basic Health plan
☐ Medicaid

The pre-existing condition wait period will be waived if you are an "eligible individual" under HIPAA. You qualify as an "eligible individual" if: you have 18 months or more of creditable coverage without a break of 63 full days or more before applying for coverage with Group Health; your most recent coverage was under an employer health plan, governmental plan, or church plan (or under health insurance coverage offered in connection with such a plan); you are not eligible for an employer health plan; you are not eligible for Medicare or Medicaid; you do not have other health insurance; you did not lose your most recent coverage because of nonpayment of premiums or fraud; and you elected and used up your available COBRA continuation coverage.

The pre-existing condition wait period may not be applied to applicants under the age of 19 per federal law.

☐ **Crediting PEC:** I am including a Certificate of Creditable Coverage which shows the beginning and ending dates of prior coverage in order to have my pre-existing condition wait period credited.

SECTION 8. STANDARD HEALTH QUESTIONNAIRE EXEMPTIONS

Is an applicant or dependent exempt from health screening? If so, check the reason below. Note that a primary subscriber's exemption DOES NOT carry over to spouse or dependent(s). You must submit a Standard Health Questionnaire for all individuals listed on this application who are not exempt. Refer to the Standard Health Questionnaire for more details.

☐ **Under 19 years of age:** Applicant under age 19 is enrolling during an open enrollment period or applicant has had a qualifying event. See "Special Instructions for Under Age 19," on page 5.

☐ **Relocation:** Applicant has relocated within Washington in the past 90 days, and prior health plan is not available. **Include:** a copy of a utility bill in applicant's name from the prior address dated within the last 90 days and a letter of verification from the applicant's prior carrier verifying that because the applicant moved, the applicant no longer resides in their service area and the prior carrier cannot provide health insurance at the applicant's new location.

☐ **Exhausted COBRA / Employer went out of business while on COBRA:** Termination must be within 90 days of dated application. **Include:** letter from COBRA Administration verifying COBRA coverage has been exhausted or a letter from the employer/COBRA administrator indicating the employer has gone out of business and COBRA benefits are being discontinued.

☐ **Refused COBRA:** Applying for coverage within 90 days of COBRA qualifying event* and was enrolled in group coverage for at least 24 continuous months prior to event and chose not to take COBRA. **Include:** a COBRA offer letter and Certificate of Creditable Coverage are required.

☐ **Terminated COBRA:** Applying for coverage within 90 days of voluntarily terminating COBRA coverage and applicant had at least 24 months of continuous group coverage prior to cancellation (not applicable to Basic Health applicants). **Include:** a most recent COBRA billing statement and a certificate of coverage for proof of 24 months of continuous group coverage.

☐ **Employer exempt from COBRA:** Applying for coverage within 90 days of an event that would qualify applicant for COBRA, had applicant's employer not been exempt from COBRA, and applicant had at least 24 months of continuous group coverage prior to such event? **Include:** letter of verification of COBRA exemption from employer, proof of qualifying event, and Certificate of Creditable Coverage.

☐ **Provider cancellation:** Health care provider left network of applicant's current individual plan within the last 90 days. **Include:** a letter of verification from the provider or carrier verifying service in the last 12 months, documentation showing provider is part of the Group Health network, and the date the provider left the network.

☐ **Washington Basic Health plan (BH):** Applying for coverage within 90 days of termination of the BH plan and was enrolled for at least 24 continuous months. **Include:** a letter of verification from applicant's carrier with dates of coverage for proof of your 24 months of eligibility from the BH plan, or a certificate of coverage.

☐ **New child:** Addition of newborn or newly adopted child to an existing plan, within 60 days of event. **Include:** documentation indicating date of placement or birth.

☐ **Group plan terminated because employer went out of business:** Applying for coverage 90 days before or after employer discontinued group coverage due to business closure and applicant had 24 months of continuous group coverage immediately prior to this event. Effective date for individual plan must fall on or within 90 days after the date group coverage was discontinued. **Include:** a letter from applicant's employer/administrator indicating the employer has gone out of business and benefits are being discontinued. A Certificate of Creditable Coverage showing 24 continuous months of coverage is also required.

*For a listing of COBRA qualifying events, visit **www.dol.gov/ebsa/faqs/faq-consumer-cobra.html**

SECTION 9. TERMS AND CONDITIONS

1. **Eligibility – Residence**

   You must reside in the Group Health service area, which includes the following counties: Benton, Columbia, Franklin, Grays Harbor (98541, 98557, 98559 and 98568), Island, King, Kitsap, Kittitas, Lewis, Mason, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom, Whitman, or Yakima. A photocopy of a valid Washington state driver's license, identification card, or similar proof of residency acceptable to Group Health may be requested.

2. **Eligibility – Medicare**

   You or your dependent(s) applying are not eligible for Medicare; if you are unsure of your Medicare eligibility please visit **medicare.gov.** If you or your dependent is 65 or older but not eligible for Medicare, please submit a "Not Eligible for Medicare" document from the Social Security Administration. If it is discovered that you or your dependent(s) were entitled to Medicare prior to enrolling on a Group Health individual and family plan, Group Health reserves the right to terminate coverage.

3. **Acceptance of application:** Group Health's acceptance of you and your dependents 19 years of age or older for coverage is based upon your score(s) determined by the Washington State Health Insurance Pool (WSHIP) Standard Health Questionnaire unless an exemption under the law applies. In order to process your application for one of our individual and family plans, we must receive the application signed by you and your spouse/domestic partner, signed questionnaire(s) for each family member over the age of 18, and any Certificates of Creditable Coverage (if available).

4. **Dependent children:** Each eligible child (under 26) will be charged the child rate of these terms and conditions. Dependents aged 19–26 may be enrolled at any time of year. Dependents under the age of 19 must be enrolled during selected open enrollment periods, unless they experience a qualifying event which makes them eligible for special enrollment.

5. **Adults applying as a Guarantor (dependent-only coverage):** Financial guarantors are only required for children under the age of 18. As a Guarantor, you hereby agree to accept the financial and contractual responsibilities for all dependents listed on the application. A Guarantor may enroll only dependent children who are under the age of 18 and dependents who are totally incapable of self-sustaining employment. For dependent-only coverage, the oldest/only child (noted as Applicant/Subscriber on the application) is charged the lowest adult age rate, while all additional children are charged the child rate.

6. **Coverage effective date:** The effective date of your application is based upon Group Health's receipt of your completed application documents as noted in number 3. All application documents must be received in the individual and family sales department at Group Health.

   - For application documents received on or before the 20th of the month, coverage will begin on the first day of the following month. (Example: If your application is received on or before Oct. 20, then enrollment is effective Nov. 1.)
   - For application documents received on the 21st through the end of the month, coverage will begin on the first of the month following the first full month after receipt. (Example: If your application is received Oct. 21–31, then your coverage begins Dec. 1.)

7. **Premium payments:** Premium payments are due on a calendar month basis on or before the first day of each month, subject to a grace period of 10 days. Payment can be set up through monthly billing, paid by check or money order, or as monthly automatic withdrawal from a checking or savings account. Premium amounts are subject to change upon 30 days written notice, which will be sent to the Contract Holder's mailing address unless there is a designated billing address provided on your application.

8. **Revoking coverage:** Failure to answer questions fully and correctly on your application documents may result in Group Health's refusal to extend coverage, cancellation of coverage, or rescission of coverage for you and/or your family members.

9. **Applicant's financial liability:** a) Pre-enrollment Services: If any hospital or medical service is rendered to you and/or your dependent(s) prior to your effective date of coverage, you will be responsible for paying for those services. These noncovered services will be billed to you at full schedule rates. Regardless of whether you and/or your dependents become a member, you will be responsible for payment of such charges; b) Prior Authorizations: Upon termination from any Group Health individual and family plan, all prior authorizations for health care coverage for the terminated individual(s) will no longer be valid, and you will be financially liable for any additional services obtained.

10. **Pre-existing conditions:** These plans include a nine-month pre-existing condition wait period that excludes coverage for any condition for which there has been any diagnosis, treatment (including prescribed drugs), or medical advice within the six-month period prior to the effective date of coverage. Section 7 of this application form will help us determine whether you have Creditable Coverage, which would allow Group Health to waive any pre-existing condition wait period(s) for you and/or your dependent(s). The pre-existing condition wait period does not apply to individuals who are under the age of 19; however, enrollment restrictions apply.

11. **Portability (Creditable Coverage):** If you have been covered within the last 63 days by a plan with equivalent or greater overall benefits than the plan you purchase, we will waive pre-existing conditions or credit that coverage. If you had a 64-day-or-more break in coverage, no portability credit will be applied for pre-existing conditions.

12. **Adding dependents:** Subject to your plan's terms, you may add eligible dependents over the age of 18 to your plan at a later date. Health screening may be required for these dependents prior to their enrollment, so please review the WSHIP Standard Health Questionnaire to determine whether or not the eligible dependents meet one of the exceptions. To add dependents under age 19, certain restrictions apply.

SECTION 10. PRODUCER INFORMATION (SECTION REQUIRED IF APPLICABLE)

Group Health sales representative or producer name

Group Health producer ID number

Company/house name (if applicable)

Group Health house ID number

Phone number

PRODUCER INFORMATION REQUIRED (IF APPLICABLE)

How did you hear about Group Health's individual & family health plans?

- ☐ Group Health employer plan
- ☐ Producer (broker/agent)
- ☐ Facebook
- ☐ Newspaper
- ☐ Current Group Health individual and family plan member
- ☐ Word of mouth/referral
- ☐ Twitter
- ☐ Direct Mail
- ☐ Former/prior member
- ☐ ghc.org/MyGroupHealth for Members
- ☐ Television
- ☐ Seminar
- ☐ Employer
- ☐ Other website
- ☐ Radio
- ☐ Other _____

SECTION 11. ACKNOWLEDGEMENTS & SIGNATURES

☐ **I acknowledge that:**

- This application becomes part of my Medical Coverage Agreement with Group Health.
- I have the right to examine and return the Medical Coverage Agreement within 10 days of receipt.
- Potential changes due to state or federal mandates, effective in January, may alter the benefits or rates of my current plan.
- Regardless of my enrollment date, my plan rate will renew July 1.
- If my/our physical residential address changes to a different county in the Group Health service area, my premium rates may be subject to change.
- The signatures shown below allow me, my spouse/domestic partner, or my producer (Section 10) to release to Group Health information about any person listed on my individual and family plan application documents, including information from the Standard Health Questionnaire.

- Under the Health Insurance Portability and Accountability Act (HIPAA), Group Health, without my authorization, may only release limited information to the selection of a plan to me, my spouse/domestic partner, adult/minor children, or my producer.
- Group Health may collect, use, or disclose the nonpublic personal information of persons listed on this application as required or permitted by law and to conduct routine business functions such as determining eligibility for enrollment, reviewing prior coverage for waiting periods, paying claims, and, if appropriate, coordinating benefits, and fulfilling other legal obligations specified in my Group Health Medical Coverage Agreement.
- **I have read and agree to the Terms and Conditions (Section 9) included with this application.**
- I authorize Group Health to disclose information about the selection of a plan to the producer of record for the duration of coverage and final reconciliation of the Group Health account. A signed **Authorization to Disclose Health Plan Information** form is required for all other disclosures to the producer of record.

I declare that, to the best of my knowledge, all information I have provided with this application 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 on behalf of myself or any family members, the Medical Coverage Agreement may be cancelled retroactively to its effective date. I further understand that it is a crime to knowingly provide false, incomplete, or misleading information for the purpose of fraudulently obtaining health coverage. Penalties may include imprisonment, fines, and denial of benefits.

Applicant/guarantor signature **Date**

Spouse/domestic partner signature **Date**

Documentation: I am enclosing all documentation as required. This includes a copy of the Standard Health Questionnaire for all persons listed on this application, or documentation outlined in Section 8 if exempt, and documentation to enroll an applicant under the age of 19 outside of the enrollment periods. Any missing information may delay processing of my application.

Signature: This application has been signed by me and my spouse/domestic partner (if applicable).

GroupHealth®