Idaho Individual Application Cover Sheet
For enrollment outside of the Idaho Exchange

REGION: SOUTHWEST
For residents of Ada, Adams, Blaine, Boise, Butte, Camas, Canyon, Cassia, Custer, Elmore, Gem, Gooding, Idaho, Jerome, Lincoln, Minidoka, Owyhee, Payette, Twin Falls, Valley, and Washington counties

Welcome to Blue Cross of Idaho

To apply for **medical** and/or **dental** coverage in 2019, please complete this form and the Idaho Individual Universal Application. Plan information is available at ***shoppers.bcidaho.com***.

Instructions: Please complete this form and return it with the completed Idaho Individual Universal Application to Blue Cross of Idaho. This completed application must be received by Blue Cross of Idaho no later than the last day of the month 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.

Mail to: Blue Cross of Idaho, Attn: Meridian District Office, PO Box 7408, Boise, ID 83707 — Fax: 208-331-7582 — Email: *iss@bcidaho.com*

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 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 (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)	All medical plans require a Primary Care Provider			
	Enrolling in Medical?	*Enrolling in Dental?	Name of 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.

SECTION 2 SELECT A MEDICAL PLAN

These Qualifying Health Plans (QHP) require a Primary Care Provider (PCP) for the applicant and each covered dependent. Each member of your family may choose a different PCP if desired. Enter the PCP for each family member in Section 1c.

Need help choosing a PCP? Use our online provider directory at ***shoppers.bcidaho.com***. For Connected Care Saint Alphonsus Health Alliance, visit ***bcidaho.com/SAHASouthwest***. For IDID Southwest, visit ***bcidaho.com/IDIDSouthwest***. For CarePoint St. Lukes Health Partners, visit ***bcidaho.com/SLHP***. You may also call customer service at 855-230-6862 to choose a PCP.

ConnectedCare℠ SAINT ALPHONSUS HEALTH ALLIANCE	IDID INDEPENDENT DOCTORS OF IDAHO	CarePoint℠ ST. LUKE'S HEALTH PARTNERS
Available in the following counties: Ada*, Boise, Canyon*, Elmore, Gem*, Owyhee*, Payette*, Valley, and Washington*.	**Available in the following counties: Ada* Boise, Canyon*, Elmore, Gem, Owyhee*, Payette, and Washington.**	**Available in the following counties: Ada, Adams*, Blaine*, Boise*, Butte, Camas*, Canyon, Cassia, Custer, Elmore*, Gem, Gooding*, Idaho, Jerome*, Lincoln*, Minidoka, Owyhee, Payette, Twin Falls*, Valley*, and Washington.**
❑ SAHA Southwest Catastrophic Connect 7900	❑ IDID Southwest Catastrophic 7900	❑ SLHP Catastrophic CarePoint 7900
❑ SAHA Southwest Bronze Connect 5500	❑ IDID Southwest Bronze 5500	❑ SLHP Bronze CarePoint 5500
❑ SAHA Southwest Bronze HSA Connect 6000	❑ IDID Southwest Bronze HSA 6000	❑ SLHP Bronze HSA CarePoint 6000
❑ SAHA Southwest Bronze HSA Connect 6550	❑ IDID Southwest Bronze HSA 6550	❑ SLHP Bronze HSA CarePoint 6550
❑ SAHA Southwest Bronze Connect 7900	❑ IDID Southwest Bronze 7900	❑ SLHP Bronze CarePoint 7900
❑ SAHA Southwest Silver Connect 3500	❑ IDID Southwest Silver 3500	❑ SLHP Silver CarePoint 3500
❑ SAHA Southwest Silver Connect 4000	❑ IDID Southwest Silver 4000	❑ SLHP Silver CarePoint 4000
❑ SAHA Southwest Silver Connect 6000	❑ IDID Southwest Silver 6000	❑ SLHP Silver CarePoint 6000
❑ SAHA Southwest Gold Connect 2000* (only available in * counties)	❑ IDID Southwest Gold 2000* (only available in * counties)	❑ SLHP Gold CarePoint 2000* (only available in * counties)

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.

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 ELECTRONIC COMMUNICATION DELIVERY AGREEMENT

To provide you with a convenient and mobile avenue to access all of your health insurance documents and to reduce the use of paper, Blue Cross of Idaho sends communications to members through a secured member account at members.bcidaho.com and provides notification by email to the email address you supply in your application when we post a new communication to your secure account.

Unless I reject electronic distribution by checking the checkbox below, I consent by my signature on behalf of myself and any covered dependents to the electronic distribution of communications related to the coverage I have applied for, and agree that I consent to:

- Electronically receive any materials that are currently available electronically as well as those that become available in the future; printed and mailed copies will be sent to your mailing address prior to the availability of electronic copies.
- Electronically receive the following materials: explanation of benefits statements (EOBs); enrollment or effective date notices; acknowledgements of claims receipts; requests for additional information; and determinations on submitted claims, including adverse benefit determinations; legally required information and notifications, including but not limited to notices about the Women's Health and Cancer Rights Act, any federal or state rules and regulations, or privacy protection laws; information regarding complaints, appeals, or grievances; summaries of benefits and coverage (SBCs) and uniform glossaries of terms; benefit change notices; policy changes or updates; renewal information; discontinuation or termination notices; continuation of coverage rights; certificates of creditable coverage; billing notices or statements; and any health and wellness information I have requested or has been requested on my behalf by my employer.
- To receive a printed copy of any electronic notice, you can print a copy from your secure member account or call Customer Service at the number listed on the back of your member ID card.
- To easily change your communication preferences, log into your member account, select My Account from the top menu or visit your member preference center found at the footer of any email you receive.

o No, I do not want electronic distribution of communications. Unless my consent is not required for an electronic distribution, I elect to receive communications related to my coverage in a paper format.

SECTION 6 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. 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.
2. 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.

SECTION 7 PAYMENT OPTIONS

❍ Monthly statement *(A $4 monthly service fee will apply for statement billings.)*
❍ Automatic no service fee monthly bank withdrawal *(Please complete the section below.)*

To set up your checking account to automatically withdraw your monthly premium payment, complete the form below:

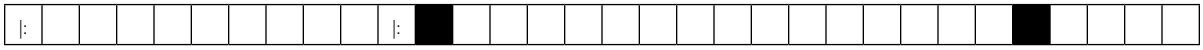
- Please include a voided check. (No deposit slips.)
- We will draft the total amount due (not to exceed two months' premium).
- It may take a couple of billing cycles for our system to begin automatic withdrawals from your account. You should continue to submit your full payment each month to avoid termination for nonpayment.
- Payments are withdrawn on the 28th or the 5th of the month. If you choose the 28th, the payment will apply to your next month's premium. If you choose the 5th, the payment will apply to the current month's premium.

AUTOMATIC WITHDRAWAL AUTHORIZATION AGREEMENT

By completing and returning the information below, I authorize and request Blue Cross of Idaho to obtain payment for premiums by withdrawing the funds from my account. Blue Cross of Idaho assumes full responsibility for correctly informing the financial institution of the specific amount of each deduction. I may terminate this agreement at any time by notifying Blue Cross of Idaho or my financial institution. Blue Cross of Idaho will terminate automatic withdrawal within a reasonable time after receiving the request.

Complete Account Information Below

Routing # (9 digits) Account # Check #



If payment day is not selected, we will withdraw your payment on the 28th of each month.

❍ Withdrawal Date ❍ 28th (for the next month's premium) ❍ 5th (for the current month's premium)

Would you like us to process a one-time eCheck for your first month's premium payment when we set up automatic withdrawal?

❍ YES, process a one-time eCheck with the bank information above.
❍ NO, I have submitted my payment by another method.

SECTION 8 THE EFFECT OF NON-PAYMENT

If your coverage is terminated for non-payment, you may be required to pay your past due balance prior to reenrolling in a new health insurance policy with Blue Cross of Idaho in the future.

SIGNATURES

Signature _____ Date _____
Applicant or Responsible Party

Signature _____ Date _____
Spouse, if applying for coverage

Nondiscrimination Statement: Discrimination is Against the Law

Blue Cross of Idaho complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Blue Cross of Idaho does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Blue Cross of Idaho:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Blue Cross of Idaho's Customer Service Department. Call 1-800-627-1188 (TTY: 1-800-377-1363), or call the customer service phone number on the back of your card.

If you believe that Blue Cross of Idaho has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with Blue Cross of Idaho's Grievances and Appeals Department at:

Manager, Grievances and Appeals
3000 East Pine Avenue, Meridian, Idaho 83642
Telephone: (800) 274-4018 ext.3838, Fax: (208) 331-7493
Email: grievances&appeals@bcidaho.com
TTY: 1-800-377-1363

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Grievances and Appeals team is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at ***https://ocrportal.hhs.gov/ocr/portal/lobby.jsf***, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TTY).

Complaint forms are available at ***http://www.hhs.gov/ocr/office/file/index.html. Reference: https://federalregister.gov/a/2016-11458***

Language Assistance

ATTENTION: If you speak Arabic, Chinese, French, German, Korean, Japanese, Persian (Farsi), Romanian, Russian, Serbo-Croatian, Spanish, Sudanic Fulfulde, Tagalog, Ukrainian, or Vietnamese, language assistance services, free of charge, are available to you. Call 1-800-627-1188 (TTY: 1-800-377-1363).

Arabic
ملظوحة: إذ كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-627-1188 (رقم هاتف الصم والبكم: 1-800-377-1363).

Chinese 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-627-1188 (TTY：1-800-377-1363)。

French ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-627-1188 (ATS : 1-800-377-1363).

German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-627-1188 (TTY: 1-800-377-1363).

Japanese 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-627-1188 (TTY: 1-800-377-1363）まで、お電話にてご連絡ください。

Korean 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-627-1188 (TTY: 1-800-377-1363)번으로 전화해 주십시오.

Persian-Farsi
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: 1-800-377-1363) 1-800-627-1188 تماس بگیرید.

Romanian ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-627-1188 (TTY: 1-800-377-1363).

Russian ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-627-1188 (телетайп: 1-800-377-1363).

Serbo-Croation OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-627-1188 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-377-1363).

Spanish ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-627-1188 (TTY: 1-800-377-1363).

Sudanic Fulfulde MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-800-627-1188 (TTY: 1-800-377-1363).

Tagalog PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-627-1188 (TTY: 1-800-377-1363).

Ukrainian УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-627-1188 (телетайп: 1-800-377-1363).

Vietnamese CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-627-1188 (TTY: 1-800-377-1363).

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 must be a resident of the state of Idaho on or before the effective date of 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 the primary applicant was not a resident upon the effective date of the policy and/or failed to maintain residency in the state of Idaho.

   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 *(include area code)*	18. Alternate Phone Number *(include area code)*	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 application 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 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 10 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 _____ Signature Date *(mm/dd/yyyy)* _____

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

SECTION 11 INDEPENDENT PRODUCER (AGENT) INFORMATION

Agent's Name _____ ID No._____

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

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