



Regence BlueShield of Idaho is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueShield of Idaho
1602 21st Avenue
Lewiston, ID 83501
Mail form to: PO Box 1106, MS-LB1
Lewiston, ID 83501

Transfer and Rate Review

Policyholder Name (please print) _____

Producer Name _____ Producer Number _____

NOTE: All family members currently active on this policy will be included in the policy change.

TYPE OF REQUEST (check one) - Most changes are effective the first of the month following receipt of this form

- Review Renewal Rate. Select plan and complete all questions below. If request is received within the 90 days prior to your renewal month, any change will be effective on your renewal month.
Move to an individual plan from an active group plan. If moving to lesser benefits, select plan and complete questions below. If moving to better benefits, discard this form and complete an Idaho Individual Application. Group Cancel Date
Note: Your policy must be paid current in order for a plan change to be made. If your policy cancels for non-payment, you will need to re-apply by submitting a new individual application.

PLAN SELECTION - Detailed benefit information can be found online at www.regence.com

MEDICAL PLANS (select ONE)

Evolve Core
Deductibles are per member (2 individual deductibles satisfy the family deductible)
\$2,500 \$5,000 \$7,500 \$10,000

Evolve HSA
Self-Only Deductibles Family Deductibles
\$1,500 with 50% coinsurance \$3,000 with 50% coinsurance
\$1,500 with 80% coinsurance \$3,000 with 80% coinsurance
\$3,500 with 50% coinsurance \$7,000 with 50% coinsurance
\$3,500 with 80% coinsurance \$7,000 with 80% coinsurance

Evolve HSA 100
\$5,000 self-only deductible \$10,000 family deductible

DENTAL OPTIONS (check one)

- No Dental
Dental Option 1 - 100/80/50; \$750 annual maximum benefit that may increase over time to \$1,500
Dental Option 2 - 100% of first \$200 and 50% of next \$1,100 (\$750 annual maximum benefit)

- Are you a resident of the state of Idaho? If Yes: _____ years _____ months
Are you or any enrolled family member now pregnant?
If Yes, list name and relationship to self _____ Due Date _____
Please list complications anticipated _____ Multiple Birth? _____
Have you or any family member on this policy used tobacco during the last 12 months?
If Yes, list name(s) _____
Has future surgery, diagnostic testing or medical treatment been advised for any person listed on this application?
If Yes, give details _____
Have you or any enrolled family members consulted with a physician or been hospitalized in the past 90 days?
If Yes, complete the following:

Table with 5 columns: Patient Name, Doctor and/or Hospital, Reason Seen, Date, Recovery Complete?

6. List all persons covered under your current plan who are eligible for coverage under another plan, including group plan, Medicare, or Medicaid:

I certify that all statements contained herein are true to the best of my knowledge. I understand that any misrepresentation, omission, or inaccurate information required herein shall prevent recovery under the policy if such answer is fraudulent or materially affects the risk assumed by Regence BlueShield of Idaho.

Policyholder's Signature _____ Date _____

Member ID Number _____ Social Security Number _____ Phone Number (____) _____

Street Address _____ Mailing Address _____