



# Regence

Regence BlueCross BlueShield of Oregon

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



## Washington Individual and Family Plans

**Regence Breakthru<sup>SM</sup>**  
**Blue Selections PPO**  
**Regence HSA Healthplan**  
**Regence HSA Comprehensive Healthplan**

## WASHINGTON APPLICATION

**Thank you for selecting  
Regence BlueCross BlueShield of Oregon  
as your individual health plan company.**

PLEASE NOTE: THIS PLAN IS NOT A CONVERSION PLAN. IF YOU ARE APPLYING FOR CONVERSION COVERAGE FOLLOWING TERMINATION OF GROUP HEALTH BENEFITS THROUGH REGENCE BLUECROSS BLUESHIELD OF OREGON, PLEASE CALL 1 (800) 365-3155 TO OBTAIN CONVERSION INFORMATION AND ENROLLMENT FORMS.

**Section 1 - Instructions**

- ◆ Read carefully.
- ◆ **Use ink to complete and sign this application. An application completed in pencil will be returned to you.**
- ◆ Make sure all sections of the application are answered completely.
- ◆ You may also need to complete a Washington Standard Health Questionnaire for each family member requesting enrollment (see exceptions on page 3).
- ◆ If you need assistance completing this application, please contact your agent or call our Customer Service department at 1 (800) 365-3155.

**Section 2 - Plan Selection**

**YOU MAY SELECT ONE MEDICAL PLAN PER APPLICATION.**

**I am applying for:**

- New enrollment    
  Addition of a dependent to my existing policy    
  Change to my current individual plan  
 (SKIP TO SECTION 3)

| Catastrophic*   | Comprehensive   |   | HSA Catastrophic*  | HSA Comprehensive  |
|---|---|---|--|--|
| <b>Regence Breakthru<sup>SM</sup> 50</b><br><br><b>DEDUCTIBLES:</b><br><input type="checkbox"/> \$2,500<br><input type="checkbox"/> \$5,000 | <b>Regence Breakthru<sup>SM</sup> 70</b><br><br><b>DEDUCTIBLES:</b><br><input type="checkbox"/> \$1,000<br><input type="checkbox"/> \$3,000 | <b>Blue Selections PPO</b><br><br><b>DEDUCTIBLES:</b><br><input type="checkbox"/> \$1,000<br><input type="checkbox"/> \$2,500<br><input type="checkbox"/> \$5,000 | <b>Regence HSA Healthplan</b><br><br><b>DEDUCTIBLES: Single/Family</b><br><input type="checkbox"/> \$2,500/\$5,000<br><input type="checkbox"/> \$3,500/\$7,000 | <b>Regence HSA Comprehensive Healthplan</b><br><br><b>DEDUCTIBLES: Single/Family</b><br><input type="checkbox"/> \$1,500/\$3,000 |
| You must receive care from Regence BlueCross BlueShield of Oregon Preferred Providers in order to receive maximum benefits under this plan. |   |   | You must receive care from Regence BlueCross BlueShield of Oregon Participating Providers in order to receive maximum benefits under this plan.                |  |

**DENTAL (optional)**

- I wish to enroll in the optional Individual Dentacare plan for an additional monthly premium.  
 Disenroll all family members on my policy from Individual Dentacare. I understand that I/we cannot reenroll for 9 months.  
**Please note:** Individual Dentacare must be purchased with one of our medical plans, dental only coverage is not available. If selected, Individual Dentacare must be added for all applicants listed on this form.

**\*Enrollment in a catastrophic health plan may not provide portability if you later decide to enroll in another individual health plan. "Portability" means that you will receive credit for a plan's preexisting condition waiting period based on prior coverage. By enrolling in a catastrophic plan, you may lose portability rights and have to satisfy the nine-month preexisting condition waiting period, should you later change to another individual health plan.**

You may request an effective date of coverage in the future (no more than 90 days later than the date you signed the application). Effective dates are available on the 1st and 15th of each month following acceptance and approval.  
**Please indicate month** \_\_\_\_\_  1st of the month      15th of the month

**(Please initial)**   X   "My employer is not paying the premium for this individual policy (including cafeteria plans)."

Individual benefit plans are not intended for sale as an employer-sponsored health benefit plan for employees. For information on small employer health benefit plans, contact the Regence BlueCross BlueShield of Oregon (Regence BCBSO) Group Marketing department at (503) 225-5406.

### Section 3 - Enrollment Information

**LIST ALL FAMILY MEMBERS TO BE COVERED**

| OFFICE USE | Last Name of Family Member | First Name, Middle Initial | Sex | Age | Birthdate | Social Security Number | OFFICE USE: OED |
|------------|----------------------------|----------------------------|-----|-----|-----------|------------------------|-----------------|
| 31-1       | Applicant                  |                            |     |     |           |                        |                 |
| 32-1       | Legal Spouse               |                            |     |     |           |                        |                 |
| 33-1       | Child                      |                            |     |     |           |                        |                 |
| 33-1       | Child                      |                            |     |     |           |                        |                 |
| 33-1       | Child                      |                            |     |     |           |                        |                 |
| 33-1       | Child                      |                            |     |     |           |                        |                 |

Explain the relationship to the applicant for any person(s) listed above whose last name is different from the applicant's.

**RESIDENCE ADDRESS**

|                                |  |
|--------------------------------|--|
| Name                           |  |
| Residence/Mailing Address      | PO Box (if applicable)                     |
| City, State, ZIP Code          | OFFICE USE<br>CO CODE                      |
| Home Phone Number<br>(       ) | Work Phone Number<br>(       )      County |

**BILLING ADDRESS (complete only if billing should be sent to an address other than listed above)**

|                       |
|-----------------------|
| Name                  |
| c/o                   |
| Address               |
| City, State, ZIP Code |

To be eligible for coverage, you must be a permanent resident of Clark County, in the State of Washington. In order to process your application, we need proof of your place of residency. Please include a photocopy of one of the following with your application: 1) Washington State driver's license, 2) Washington State ID Card, 3) Voter registration card, or 4) current utility bill.

**Please Note:** The address on your proof of residency must match your address listed on the application.

Yes    No   Do you or any family members listed on this application use tobacco in any form?

### Section 4 - Preexisting Conditions

This contract has a 9-month waiting period for preexisting conditions. However, you and each family member will be credited for each month of prior creditable coverage toward the preexisting conditions waiting period if any of the following situations apply to you. *Please complete section 5, Other Coverage Information below.*

- PRIOR COVERAGE:** Within the last 63 days, applicant or dependent had health plan coverage. *Include a copy of your certificate(s) of coverage.\**
- RELOCATION:** Applicant has relocated to Clark County from another part of Washington State within the last 90 days, and prior plan is no longer available. *Include a photocopy of a utility bill in your name showing the prior address (not more than 90 days prior to the date of this application.)*
- PROVIDER CANCELLATION:** Applicant's provider has left the prior plan's network within the last 90 days prior to the date of this application and is in this plan's network. Prior plan must have been an individual plan, not group. *Include a copy of a letter of verification from the provider or carrier.*



## Section 7 - Certification, Authorization and Signature

Be sure to sign and date the application below. Spouse's signature is required if applicable. Signature applies to both "Certification of Completeness and Correctness" and "Authorization for Use and Disclosure of Protected Health Information":

### CERTIFICATION OF COMPLETION AND CORRECTNESS

I affirm that the answers given in this application are true, complete, and correct. I am providing these answers as part of the application procedure required by Regence BlueCross BlueShield of Oregon (Regence BCBSO) to enroll in their coverage. I understand that Regence BCBSO will reply on each answer in making coverage and rating determinations. For the protection of all our members, fraud or misrepresentation of material fact by me for the purposes of defrauding Regence BCBSO may result in Regence BCBSO taking any action allowed by law or contract, including termination or rescission of coverage, denial of benefits, and/or pursuit of criminal charges and penalties. If coverage is rescinded for fraud or intentionally misleading statements, Regence BCBSO will reimburse premium less any claims paid and will pursue reimbursement for claims paid exceeding any premium. I will promptly inform Regence BCBSO in writing if anything happens before my coverage takes effect that makes this application incomplete or incorrect. I understand and agree that no coverage shall be in force until approved by Regence BCBSO. Regence BCBSO may phone me to clarify answers on this application. As the applicant, I understand I have the right to inspect the information in my file.

I further affirm that I received a disclosure statement and outline of coverage from Regence BCBSO or its authorized agent describing the individual contract.

### AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the application form) from time to time 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 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). A separate authorization will be required for psychotherapy notes.

I understand that if this application contains any material misstatements or omissions, Regence BlueCross BlueShield of Oregon may deny coverage, modify or cancel coverage and/or take any other legal action available to us by law.

\* For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Regence Consumer Privacy Notice. A copy is available on our Web site at [www.regence.com](http://www.regence.com) or by telephone request at 1 (800) 365-3155.

|   |              |      |
|---|--------------|------|
| <b>X</b><br>Signature of applicant or current contract holder, parent or legal guardian if applicant is under 18 years of age or legally incompetent* | Relationship | Date |
| <b>X</b><br>Signature of applicant's legal spouse*  |              | Date |
| <b>X</b><br>Signature of dependent(s) over 18 years of age*   |              | Date |

\* If signature by a personal representative of the member/enrollee please complete the following:

Personal Representative's Name (please print) \_\_\_\_\_

Relationship to Individual \_\_\_\_\_ (Attach legal documentation if other than parent of a minor child)

### **THIS AUTHORIZATION MAY NOT BE USED FOR PSYCHOTHERAPY NOTES**

(Notes recorded and separately maintained by a mental health professional documenting or analyzing the contents of a conversation during a counseling session.)

**Section 8 - Premium Billing Options (if application is approved)**

**PLEASE DO NOT SEND MONEY WITH THIS APPLICATION.**

**Please indicate one billing option:**

- Monthly (checking account deductions - see below)
- Quarterly Bill (every three months)
- Monthly Bill

**SUREPAY AUTHORIZATION**

Surepay is a simple and convenient way to keep your health coverage in force. If you select the Surepay option of paying for your Regence BCBSO health insurance the payment will be deducted automatically from your account on the 3rd business day of the month or 15th of the month depending on your effective date of coverage. This will provide several advantages to you:

- ◆ Your payment will always be made on time (if funds are available in your account).
- ◆ You won't have to worry about your coverage accidentally lapsing due to overlooked payments.
- ◆ Your monthly bank statement will show a withdrawal notation which is your receipt of payment.
- ◆ Please pay your paper bill until you are notified that your electronic funds transfer has been started. Processing may take up to 60 days.

**GETTING STARTED is as easy as 1 - 2 - 3:**

1. **Complete**, date and sign the authorization below.
2. **Write "void"** on one of your checks.
3. **Return** this completed form and your "voided" check (not a deposit slip).

**SOME SUGGESTIONS:**

- ◆ **Check register reminder:** When you receive your monthly statement be sure to enter the payment amount in your check register. This will help you keep your account in balance and avoid overdraft problems.
- ◆ **If you change your bank or wish to cancel your automatic deduction.**
  1. Do this at least 15 days before your next premium is due. We suggest you leave enough money in your old bank account to cover your payments in case there is a delay in processing the change.
  2. Just send us a copy of your new "voided" check and a note explaining that you have changed banks.
  3. Changes may also be made by calling Customer Service at 1 (800) 365-3155.

**SUREPAY AUTHORIZATION**

- 1. COMPLETE** and sign this authorization form.      **2. ATTACH** your voided check (**not** a deposit slip).  
**3. RETURN** to Regence BlueCross BlueShield of Oregon (PO Box 1271, MS5K, Portland, OR 97201-1271).

**AUTHORIZATION TO MY BANK**

Checking Account     Savings Account

As a convenience and on behalf of the Account Holder identified below, I/we hereby request and authorize you to pay and charge to the account identified below, checks or electronic debits drawn on the account by and payable to the order of Regence BlueCross BlueShield of Oregon, Portland, Oregon. I/we agree that your rights to each such check or electronic debit shall be the same as if it were an actual check drawn on you and signed by me/us. This authority is to remain in effect until revoked by me/us in writing, and until you actually receive such notice, I/we agree that you shall be fully protected in honoring any such check. I/we further agree that if any checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. A photocopy of this executed authorization shall be as valid as the original.

| Financial Institution | Transit/Routing Numbers | Account Number |
|-----------------------|-------------------------|----------------|
|                       |                         |                |

Account Holder's Name (please print)

Account Holder's Authorized Signature(s) - as it appears on bank records

Date

## Section 9 - Producer Certification

### FOR INSURANCE PRODUCER USE ONLY

I, (the Producer) certify I have explained the eligibility provisions to the applicant. I have not made any statements about benefits, conditions or limitations of the contract except through written material furnished by Regence BCBSO. I have informed the applicant that the effective date of coverage is assigned only by Regence BCBSO, and provided the disclosure information required.

I CERTIFY THAT THE INFORMATION SUPPLIED TO ME BY THE APPLICANT HAS BEEN TRULY AND ACCURATELY RECORDED HERE.

|  |                         |                                     |
|--|-------------------------|-------------------------------------|
| Producer Name (please print or type)                 | Producer e-mail         | Regence BCBSO Producer Number       |
| Agency Name  | Phone Number<br>(     ) | Fax Number<br>(     )               |
| Street Address                                       | City                    | State                      ZIP Code |
| Producer's Signature (required)<br><b>X</b>          | Date                    |                                     |
| <b>PRODUCER: COLLECT NO PREMIUM WITH APPLICATION</b> |                         |                                     |

## Section 10 - Washington Individual and Family Plans Application Checklist

Thank you for completing, signing, and dating this Washington Individual and Family Plans Application.

Effective January 1, 2001, Washington State law requires that anyone applying for individual health coverage **MUST COMPLETE BOTH AN APPLICATION FORM FROM THE CARRIER AND A WASHINGTON STANDARD HEALTH QUESTIONNAIRE** (One questionnaire form is required for each family member applying for coverage. See Section 6 for exceptions).

We have provided a checklist below to help ensure that your application is complete, and to avoid any unnecessary delay in the processing of your application.

- I have used ink when completing this application.
- I have chosen a plan in Section 2 and an Individual Dentacare plan (if desired).
- I have read and initialed in Section 2 that my employer is not paying for premiums for this application.
- I have provided all requested information about all family members in Section 3.
- I have completed section 4.
- I have completed section 5, and provided all requested information for each family member. I have provided a copy of a certificate of coverage, if applicable.
- I have completed Section 6 and included proof of the exception, if applicable.
- I have carefully read Section 7 and I have signed and dated the application in the space(s) indicated. Furthermore, I understand that this application cannot be processed if it is incomplete or if I have not signed and dated this application. The incomplete application will be returned to me and this will delay processing.
- My spouse has read, signed, and dated this application if he/she is listed in Section 3 of this application.
- My dependents over 18 years of age, if listed in Section 3 of this application, have read, signed and dated this application.
- A parent or legal guardian has completed and signed this application for children under age 18, if applicable.
- I have not attached my premium payment with this application. I understand that Regence BCBSO will bill me upon acceptance.
- I have chosen a billing option in Section 8. (Note: If selecting automatic bank withdrawal, upon acceptance, please pay your paper bill until you are notified that your electronic funds transfer has been initiated. Processing may take up to 60 days.)
- I have completed a Washington Standard Health Questionnaire for myself and each family member applying for coverage. (See Section 6 for exceptions).



# Regence

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***Do not send payment with your application. We will bill you upon acceptance of your application.***

**Please return this application to:  
 Regence BlueCross BlueShield of Oregon  
 Attn: Individual Enrollment Services, Mail Station E-8U  
 P.O. Box 1271  
 Portland, OR 97207-1271  
 1 (800) 365-3155**

| FOR OFFICE USE ONLY   |  |  |  |  |  |
|---|--|--|--|--|--|
| Additional telephone information received by Regence BlueCross BlueShield of Oregon |  |  |  |  |  |
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| 5                   | 6            | 17                    | 30 |              |                      | 65       |