



Regence

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

Regence BlueCross BlueShield of Utah
2890 E. Cottonwood Parkway
Salt Lake City, Utah 84130-0270
Mail form to: PO Box 30270 MS:23
Salt Lake City, UT 84130-0270

Individual Application Cover Sheet (to be used with the Utah Individual Health Insurance Application)

SECTION 1 - GENERAL INFORMATION

Applicant's Name (please print) _____

Social Security Number _____

EFFECTIVE DATE: Upon approval, you will be eligible for an effective date of the first of the month following the date the completed application was received in our office, unless otherwise indicated. Incomplete applications may receive a later effective date.

Yes No I want to do my part for the environment and reduce waste. Please send my Explanation of Benefits (and when possible, other communications) electronically.

A complete application is needed to begin the underwriting process. Complete application includes:

- ◆ Individual Application Cover Sheet
- ◆ Utah Individual Health Insurance Application
- ◆ Authorization Form

SECTION 2 - PLAN SELECTION (Detailed benefit information can be found online at www.regence.com)

BASE PLANS (select ONE medical plan)

Evolve Core

- \$2,500 deductible per member (maximum of 2 deductibles per family)
- \$5,000 deductible per member (maximum of 2 deductibles per family)
- \$7,500 deductible per member (maximum of 2 deductibles per family)
- \$10,000 deductible per member (maximum of 2 deductibles per family)

Evolve Plus

- \$500 deductible per member (maximum of 2 deductibles per family)
- \$1,000 deductible per member (maximum of 2 deductibles per family)
- \$1,500 deductible per member (maximum of 2 deductibles per family) - NetCare Comparable low deductible plan
- \$2,500 deductible per member (maximum of 2 deductibles per family)
- \$4,000 deductible per member (maximum of 2 deductibles per family) - NetCare Comparable high deductible plan
- \$7,500 deductible per member (maximum of 2 deductibles per family)

Evolve HSA

- | | |
|---|--|
| <input type="checkbox"/> \$1,200 self-only deductible / 50% coinsurance (Utah Basic Health Care Plan) | <input type="checkbox"/> \$2,400 family deductible / 50% coinsurance |
| <input type="checkbox"/> \$1,200 self-only deductible / 80% coinsurance (Utah Basic Health Care Plan) | <input type="checkbox"/> \$2,400 family deductible / 80% coinsurance |
| <input type="checkbox"/> \$2,000 self-only deductible / 50% coinsurance | <input type="checkbox"/> \$4,000 family deductible / 50% coinsurance |
| <input type="checkbox"/> \$2,000 self-only deductible / 80% coinsurance | <input type="checkbox"/> \$4,000 family deductible / 80% coinsurance |
| <input type="checkbox"/> \$3,500 self-only deductible / 50% coinsurance | <input type="checkbox"/> \$7,000 family deductible / 50% coinsurance |
| <input type="checkbox"/> \$3,500 self-only deductible / 80% coinsurance | <input type="checkbox"/> \$7,000 family deductible / 80% coinsurance |

Evolve HSA 100

- \$5,000 self-only deductible
- \$10,000 family deductible

DENTAL OPTIONS (select ONE of the following dental options)

- 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)
- No Dental**

PROVIDER NETWORK (select ONE provider network)

- Participating** (Traditional)
- Preferred** (ValueCare)

SECTION 3 - PARENT OR GUARDIAN CONSENT (Complete only if applicant is under age 16 and will be the only insured)

Notice is hereby given that _____ Social Security Number _____ who is under the age of sixteen years is making application for individual health care coverage, with my full knowledge and consent. I request that you consider the child for such health care coverage. I accept full responsibility for the payment of monthly premium and the contents of the application attached hereto.

Signature _____ Date _____

Print Name _____ Relationship to Child _____

Phone Number _____



SECTION 4 – PREMIUM BILLING OPTIONS (if application is approved)

BILLING ADDRESS (complete only if billing should be sent to an address other than the Mailing Address listed on the application.)

Name		Relationship to Applicant
Address		City, State, ZIP Code

Please indicate which billing option you want to use. (If billing option is left blank, your policy will automatically default to Monthly Billing).

- Monthly Billing
- Quarterly Billing
- Surepay (monthly automatic bank deduction)

Note: If selecting Surepay, please fill out the information below.

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 BlueCross BlueShield of Utah health insurance the payment will be deducted automatically on the draft date you choose below. 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. This will serve as receipt of payment.
- ◆ Claims will be paid promptly due to your policy always being paid current.

GETTING STARTED IS EASY by mail or phone:

1. **Complete**, date and sign the Surepay Authorization information below.
2. **Write** "void" on one of your checks and return your "voided" check with this application (not a deposit slip). *For savings account please provide proof of ownership of the account.*

SUREPAY AUTHORIZATION

Please indicate which day you want your payment made.

- 5th of the month** - will pay the current month's charges
- 15th of the month** - will pre-pay the next month's charges
- 25th of the month** - will pre-pay the next month's charges

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 Utah, Salt Lake City, UT. 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 5 - MEDICARE

If you or any listed dependents have Medicare, please list family member's name and the Medicare Health Insurance Claim (HIC) number shown on his/her Medicare card:

SECTION 6 - ACKNOWLEDGEMENT

By signing the attached Individual Application, you understand and agree to the terms and conditions set forth on this cover sheet as well as the terms and conditions set forth on the attached application.

SECTION 7 - YOUR PRIVACY

For information about the use and disclosure of health information, 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.

SECTION 8 - PRODUCER INFORMATION

FOR PRODUCER USE ONLY

Producer Name (please print or type)	Regence Producer Number
Producer's Street Address	Producer's E-Mail Address

PRODUCERS: Please also complete the **Producer Agreement and Compensation Disclosure** in Section J of the Utah Individual Health Insurance Application. Producers will not be compensated if this information is incomplete.

