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 1106, MS-LB1
Lewiston, ID 83501
Fax form to: 1-866-797-1786

Please do not include initial payment with application

2015 Utah Individual Application Cover Sheet

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

This cover sheet is for health care coverage purchased directly Regence BlueCross BlueShield of Utah (Regence). If you wish to purchase coverage through the exchange, you must apply directly through them.

Please print your answers clearly in black ink so we can process you application quickly. Be sure to return all pages to us. Omissions or incomplete answers will result in the return of your cover sheet and application and may cause a delay in the effective date of your coverage.

SECTION 1 - GENERAL INFORMATION

Applicant's Name (please print)_____ Social Security Number _____

A complete application is needed to complete the enrollment process. Complete application includes: 1) Individual Application Coversheet, and 2) Utah Individual Health Insurance Application.

Note: If you are requesting a change to your existing plan or deductible, your policy must be paid current in order for the change to be made.

SECTION 2 - AM I ELIGIBLE?

You're eligible to apply for a Regence BlueCross BlueShield of Utah plan if you are

- A resident of and have a principal residence in the state of Utah.
- Not entitled to Medicare. If you are 65 or older but not eligible for Medicare, please submit a "Not Eligible for Medicare" document from the Social Security Administration.
- Are applying during an open enrollment period or when you have a qualifying event as described below.

Eligible dependents that can enroll on your plan include your:

- spouse or domestic partner.
- natural or legally adopted/placed child(ren) under the age of 26.

Open Enrollment Periods: Individuals may apply for enrollment in a Regence plan during an open enrollment period. An open enrollment period is the time frame set by the state of Utah when applicants can enroll. Please refer to **regence.com** or sales brochure for the dates of an open enrollment period. The completed enrollment application must be received before the end of the open enrollment period.

Qualifying Events: Applicants can apply outside of an enrollment period if they experience certain qualifying events. Refer to the Special Enrollment Period portion in Section 2 to determine if your situation qualifies.

EMPLOYER CONTRIBUTION

☐ Yes ☐ No Is your employer reimbursing or paying for any portion of this policy's premium? Individual benefit plans are not intended for sale as an employer-sponsored health benefit plan for employees.

SECTION 2 - AM I ELIGIBLE? (continued)

SPECIAL ENROLLMENT PERIOD
Applications must be received within 60 days of a qualifying event (with evidence of qualifying event).
Please make your selection below by checking the box(s) that applies to you.

- ☐ Birth of a child.
- ☐ Adoption or placement of a child.
- ☐ A loss of group coverage due to death of the employee, termination of employee's employment, employee's reduction in working hours, divorce or legal separation, Medicare entitlement of employee, dependent child's loss of dependent status, or Chapter 11 bankruptcy of employer/sponsor.
- ☐ Loss of minimum essential coverage (other than for non-payment of premium or fraud/material misrepresentation).
  - ☐ Due to non-payment of premium.
  - ☐ Due to fraud/material misrepresentation.
- ☐ Gaining or becoming a dependent through marriage.
- ☐ Enrollment or non-enrollment in qualified health plan that is unintentional, inadvertent, or erroneous and caused by error, misrepresentation, or inaction of exchange officer, employee, or agent or HHS (or its instrumentalities) as evaluated and determined by the exchange.
- ☐ Adequate demonstration to the exchange of a qualified health plan's substantial violation of a material contract provision.
- ☐ New eligibility or ineligibility for advance payment of premium tax credit, or change in eligibility for cost-sharing reductions.
- ☐ Gain of access to a new qualified health plan due to permanent move.

SECTION 3 - PLAN SELECTION - Detailed benefit information can be found online at www.regence.com

MEDICAL PLANS (select ONE medical plan)

Deductibles are per member (family deductible is 2 times the individual amount)

- ☐ Direct Bronze HSA
- ☐ Direct Bronze HSA+
- ☐ Direct Silver HSA
- ☐ Direct Silver HSA+
- ☐ Direct Silver+
- ☐ Direct Gold HSA
- ☐ Direct Gold
- ☐ Direct Gold+
- ☐ Direct Bronze HSA with Dental, Vision, and Individual Assistance Program (IAP)
- ☐ Direct Silver+ with Dental, Vision, and Individual Assistance Program (IAP)
- ☐ Direct Gold with Dental, Vision, and Individual Assistance Program (IAP)
- ☐ Direct Gold+ with Dental, Vision, and Individual Assistance Program (IAP)

PROVIDER NETWORK (check one)

☐ Preferred FocalPoint ☐ Preferred ValueCare

POLICY TYPE

☐ Single ☐ Family ☐ Child only (please complete the next section)*

* Only one application is allowed per child for Child Only policies. Please complete one application per child.

SECTION 4 - PARENT OR GUARDIAN CONSENT
(Complete only if applicant is under age 18 and will be the only insured)

Notice is hereby given that _____ Social Security Number _____
who is under the age of eighteen 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 _____ (mm/dd/yyyy)

Print Name _____ Relationship to Child _____

Address _____ Phone Number ( ) _____ (xxx) xxx-xxxx

SECTION 5 - TOBACCO ABSTINENCE CERTIFICATION STATEMENT

A surcharge is applied to the regular Periodic Rate for an enrolled individual who is a Tobacco User. A Tobacco User is a person who may legally use tobacco and has used tobacco (in any form, but excluding any religious or ceremonial use) on average four or more times per week within the last six months.

By my signature below, I certify that I am not a Tobacco User.

PLEASE NOTE: An individual who has signed a tobacco abstinence certification statement and who subsequently becomes a Tobacco User must notify the Company immediately, and the surcharge then will apply to him or her. If false information about tobacco use is submitted or if you fail to notify the Company when changes in your tobacco use would subject you to the tobacco surcharge, the Company reserves the right to take any action available to it, including action to collect unpaid surcharge amounts and/or other damages.

Member Name	Member Name	Member Name
▶ Signature	▶ Signature	▶ Signature
(mm/dd/yyyy) Date	(mm/dd/yyyy) Date	(mm/dd/yyyy) Date
Member Name	Member Name	Member Name
▶ Signature	▶ Signature	▶ Signature
(mm/dd/yyyy) Date	(mm/dd/yyyy) Date	(mm/dd/yyyy) Date

SECTION 6 - MEMBER CARD (check one)

☐ **Family Level Card** (all members listed on the same card)
☐ **Member Level Card** (each member on a separate card)

SECTION 7 - CHILD CUSTODY INFORMATION

If natural parents are separated or divorced, please indicate below who has legal custody of the child(ren). Please use additional paper if needed. 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 carrier can determine whose coverage is primary.

Name of Child(ren)	Father	Mother	Joint	Other	Date awarded	Who is required to provide coverage for the child(ren)?
	☐	☐	☐	☐	(mm/dd/yyyy)	
	☐	☐	☐	☐	(mm/dd/yyyy)	
	☐	☐	☐	☐	(mm/dd/yyyy)	

SECTION 8 - CONTINUING COVERAGE

Will anyone listed on this application have other medical and/or dental insurance, including Medicare, while covered on this plan? ☐ Yes ☐ No

If answered yes above, please complete the following:

Policyholder of other coverage	Name of covered Members: Self and Dependent(s)	Insurance Company (Name & Phone Number)	Policy Number and Effective Date	Product and Coverage Type
		(xxx) xxx-xxxx	Policy Number Effective Date (mm/dd/yyyy)	**Coverage Type:** ☐ Group ☐ Individual **Product Type:** ☐ Medical ☐ Dental **Medicare:** ☐ PartA ☐ PartB ☐ PartD
		(xxx) xxx-xxxx	Policy Number Effective Date (mm/dd/yyyy)	**Coverage Type:** ☐ Group ☐ Individual **Product Type:** ☐ Medical ☐ Dental **Medicare:** ☐ PartA ☐ PartB ☐ PartD
		(xxx) xxx-xxxx	Policy Number Effective Date (mm/dd/yyyy)	**Coverage Type:** ☐ Group ☐ Individual **Product Type:** ☐ Medical ☐ Dental **Medicare:** ☐ PartA ☐ PartB ☐ PartD
		(xxx) xxx-xxxx	Policy Number Effective Date (mm/dd/yyyy)	**Coverage Type:** ☐ Group ☐ Individual **Product Type:** ☐ Medical ☐ Dental **Medicare:** ☐ PartA ☐ PartB ☐ PartD
		(xxx) xxx-xxxx	Policy Number Effective Date (mm/dd/yyyy)	**Coverage Type:** ☐ Group ☐ Individual **Product Type:** ☐ Medical ☐ Dental **Medicare:** ☐ PartA ☐ PartB ☐ PartD
		(xxx) xxx-xxxx	Policy Number Effective Date (mm/dd/yyyy)	**Coverage Type:** ☐ Group ☐ Individual **Product Type:** ☐ Medical ☐ Dental **Medicare:** ☐ PartA ☐ PartB ☐ PartD

Reason for Medicare Entitlement (if applicable): ☐ Age ☐ Disability ☐ Dual Entitlement ☐ ESRD

SECTION 9 - 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; and
- Acknowledge that you received an Outline of Coverage (OOC) in conjunction with this application.

SECTION 10 - 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 **regence.com.**

SECTION 11 - PRODUCER INFORMATION

FOR PRODUCER USE ONLY

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

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

SECTION 12 – PREMIUM BILLING OPTIONS

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

Name (First, Last)	County (*Required)
Address	City, State, ZIP Code

PAYMENT OPTIONS (check one):

If no payment option is checked, your policy will automatically default to Monthly Billing.

☐ Monthly Billing ☐ Electronic Funds Transfer (EFT) - premium is automatically deducted from your bank account on the 5th of each month.

If selecting the EFT option:

1. Complete the following **Authorization To My Bank** section.
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.*

AUTHORIZATION TO MY BANK

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, Utah. 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 or Bank Name	Transit/Routing Numbers	Account Number

Check One: ☐ Checking Account ☐ Savings Account

Account Holder's Name (please print)

▶

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

(mm/dd/yyyy)

Date

SECTION 13 - CONSENT TO ELECTRONIC DISTRIBUTION

Regence BlueCross BlueShield of Utah (Regence) is engaged in efforts to increase the use of technology and curb the use of paper. In support of those efforts, Regence has established a process under which communications to members can be posted to a secured account that a member establishes on Regence.com. An e-mail notice is sent to a member-supplied e-mail account when a new communication is posted on Regence.com.

By my electronic signature below, I consent, on behalf of myself and any covered dependents, to the electronic distribution of communications related to the coverage applied for and understand that:

- To access electronically distributed communications, I and each of my covered dependents will need to establish Regence.com accounts for use on a system meeting the outlined requirements and I represent that we each have and will continue to have access to such a system or systems.
- Not all member communications are currently available electronically, but I agree that my consent will apply to the following materials available, or as they become available, for electronic distribution: (i) notices of enrollment and/or effective date of coverage, (ii) acknowledgements of receipt of claims, requests for additional information related to claims and notices of associated delays in processing, and determinations on submitted claims, (iii) general informational disclosures required by law, including but not limited to notices of rights under the Women's Health and Cancer Rights Act, state patient protection acts, and privacy laws, (iv) communications regarding complaints, grievances, or appeals, including but not limited to acknowledgements of receipt, requests for additional information and notices of associated delays, and notices of determinations, (v) summaries of benefits and coverage and uniform glossary of terms, (vi) notices of benefit changes or policy modifications, (vii) renewal information, (viii) notices of discontinuation, (ix) notices of termination and continuation coverage rights, (x) certificates of creditable coverage, (xi) billing notices and statements.
- Until a communication can be distributed electronically, a paper copy will be provided.
- Once available, any electronically distributed communications may be printed from the Regence.com account where they are posted, or a paper copy of any particular communication may be requested at any time using Regence.com or by contacting Customer Service at the number provided on my member card.
- I may change the e-mail address for receipt of notice of electronic distributions or withdraw consent (returning to paper distribution) at any time and without charge using Regence.com or by contacting Customer Service. I understand it may take up to three working days to update Regence.com with this change.

The e-mail address for receipt of notice of electronic distributions is Email address _____

☐ I do not want electronic distribution. Unless my consent is not required for an electronic distribution, I elect to receive communications related to this coverage in a paper format.

Signature ▶ _____ Date (mm/dd/yyyy) _____

UTAH INDIVIDUAL HEALTH INSURANCE APPLICATION

Only for use outside the Federally Facilitated Marketplace

A. APPLICANT INFORMATION

Please check one of the following boxes: ☐ New Application ☐ Dependent Addition

Name (Last) _____ (First) _____ (MI) _____

Marital Status ☐ Legally Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partner

Mailing Address _____ Apt. _____ City _____ State _____ Zip _____

Street Address _____ Apt. _____ City _____ State _____ Zip _____

Applicant's county of residence: _____

Home/Cell Phone (xxx)xxx-xxxx _____ Business Phone (xxx)xxx-xxxx _____

Driver's License Number: _____ Email Address: Email address

Are all persons applying for coverage a U.S. citizen or U.S. national? ☐ Yes ☐ No If no, provide name(s):_____

If a person applying for coverage is not a U.S. citizen or U.S. national, do they have eligible immigration status? ☐ Yes ☐ No

If yes, provide your document type and ID number below.

Immigration document type: _____ Document ID number: _____

Lived in the U.S. since 1996? ☐ Yes ☐ No Veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

Is any person applying for coverage incarcerated or jailed? ☐ Yes ☐ No If yes, provide name(s):_____

B. APPLICANT AND DEPENDENT INFORMATION

In the section below, list yourself and all eligible family members to be included under the policy. Eligible family members include spouse, natural child, stepchild, adopted child, child placed for adoption, and child for whom you are appointed as legal guardian by the court. To be eligible for coverage, children must be under the age of 26 unless the child meets the requirements of children with a disability. Any dependent not listed will not be considered for coverage. Attach a separate sheet if necessary.

	Name(Last, First, MI)	Social Security # (for insurer use only)	Date of Birth MM/DD/YYYY	Gender	Tobacco Use
Self			(mm/dd/yyyy)	☐ Male ☐ Female	☐ Yes ☐ No
Spouse/ Domestic Partner			(mm/dd/yyyy)	☐ Male ☐ Female	☐ Yes ☐ No
Dependent			(mm/dd/yyyy)	☐ Male ☐ Female	☐ Yes ☐ No
Dependent			(mm/dd/yyyy)	☐ Male ☐ Female	☐ Yes ☐ No
Dependent			(mm/dd/yyyy)	☐ Male ☐ Female	☐ Yes ☐ No

Does any listed proposed insured live, reside, work or attend school outside the state of Utah at any time during the year? ☐ Yes ☐ No

If yes, name of proposed insured and % of time outside the state: _____

C. CURRENT COVERAGE INFORMATION

Please indicate for EACH person listed on this application any health care coverage, including Medicare or Medicaid, currently in effect. This information will be used to determine if benefits will be coordinated. If no health care coverage was in effect, please indicate NONE. 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 dependents' health care coverage so that the insurer can determine whose coverage is primary. Attach a separate sheet if necessary.

Name of Individual	Insurer (List policyholder name, insurer name and phone number)	Date of Coverage MM/YY Start Date	End Date	Will coverage continue?	Type of Coverage (Check all that apply)
Applicant:				☐ Yes ☐ No	☐ Employer group ☐ Individual ☐ Medicare ☐ Governmental ☐ Other_____
Spouse/ Domestic Partner:				☐ Yes ☐ No	☐ Employer group ☐ Individual ☐ Medicare ☐ Governmental ☐ Other_____
Dependent:				☐ Yes ☐ No	☐ Employer group ☐ Individual ☐ Medicare ☐ Governmental ☐ Other_____
Dependent:				☐ Yes ☐ No	☐ Employer group ☐ Individual ☐ Medicare ☐ Governmental ☐ Other_____
Dependent:				☐ Yes ☐ No	☐ Employer group ☐ Individual ☐ Medicare ☐ Governmental ☐ Other_____

D. EMPLOYMENT INFORMATION

Employer _____ Group Insurer _____ Job Title _____ Hrs/Week _____
Spouse's Employer _____ Spouse's Group Insurer _____ Spouse's Job Title _____ Hrs/Week _____

1. Is any employer reimbursing or paying for any portion of this policy? ☐ Yes ☐ No
2. Does your employer offer health insurance? ☐ Yes ☐ No
3. Are you self-employed? ☐ Yes ☐ No If self-employed, do you have any full or part-time employees? ☐ Yes ☐ No

E. ACKNOWLEDGMENT & SIGNATURE

I hereby apply to be enrolled with my listed dependents, if applicable, for coverage. When incorporated with the policy, this application will become part of the policy. Once fully signed and executed, insurer and I agree to terms set forth in the policy. In connection with both this application and any coverage that may be obtained, I am acting as agent and/or as natural guardian for my spouse and other dependents. I agree to act on behalf of myself and my dependents. I understand that coverage is dependent upon my satisfaction of applicable eligibility criteria. I also understand that no benefits will be provided for any services which begin before the policy is effective; and that except as expressly provided in the policy, benefits will not extend beyond the termination of either my coverage or the policy.

CONSENT AT ENROLLMENT.
I understand that it is my continuing responsibility to report to the insurer changes in the eligibility of any applicants who become enrolled.

I understand that the data obtained by the use of this authorization will only be used to determine eligibility for coverage and for future benefit administration.

I understand that my choice of health care providers whose services will be covered may be restricted by the policy.

I understand there may not be participating providers in all specialty fields.

I agree that coverage for any services that are obtained without or contrary to required preauthorization/precertification requirements in the policy may be denied

NOTICE TO APPLICANT REGARDING REPLACEMENT OF HEALTH BENEFIT PLAN.
According to information furnished, you may intend to lapse or otherwise terminate an existing health benefit plan and replace it with a new policy. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

You may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

I hereby declare that to the best of my knowledge and belief, the information given on this application is correctly recorded, true, and complete. I understand that material omissions or intentional misrepresentations regarding information provided on this application could cause an otherwise covered service to be denied and/or could void any coverage issued. If I subsequently become aware of information different from that provided in this application, I agree to provide that additional information promptly to the insurer. A change of information prior to the effective date of the policy may void an offer to provide coverage. If any information provided is false or incomplete, the insurer may without advance notice pursue any remedies available under state or federal law, including but not limited to: declaring the policy null and void and canceling the policy retroactive to its original effective date.

If the policy contains a voluntary arbitration provision: ANY MATTER IN DISPUTE BETWEEN YOU AND THE INSURER MAY BE SUBJECT TO ARBITRATION AS AN ALTERNATIVE TO COURT ACTION PURSUANT TO THE RULES OF THE AMERICAN ARBITRATION ASSOCIATION OR OTHER RECOGNIZED ARBITRATOR, A COPY OF WHICH IS AVAILABLE ON REQUEST FROM THE INSURER. THE INSURER SHALL BEAR THE COSTS OF ARBITRATION, FILING FEES, ADMINISTRATIVE FEES AND ARBITRATOR FEES. OTHER EXPENSES OF ARBITRATION, INCLUDING, BUT NOT LIMITED TO: ATTORNEY FEES, EXPENSES OF DISCOVERY, WITNESSES, STENOGRAPHER, TRANSLATORS, AND SIMILAR EXPENSES, WILL BE BORNE BY THE PARTY INCURRING THOSE EXPENSES. ANY DECISION REACHED BY ARBITRATION SHALL BE BINDING UPON BOTH YOU AND THE COMPANY. THE ARBITRATION AWARD MAY INCLUDE ATTORNEY'S FEES, IF ALLOWED BY STATE LAW, AND MAY BE ENTERED AS A JUDGMENT IN ANY COURT OF PROPER JURISDICTION.

I attest that all information on this form is accurate. I have read the Acknowledgment of this document and agree to its terms.

Applicant Signature _____ Date (mm/dd/yyyy)
(A faxed signature shall be valid as an original signature.)

Spouse/Domestic Partner Signature _____ Date (mm/dd/yyyy)
(Required if applying for coverage. A faxed signature shall be valid as an original signature.)

Requested Effective Date (mm/dd/yyyy)
(Coverage is not in force until the insurer approves your application and determines the effective date.)

F. PRODUCER AGREEMENT AND COMPENSATION DISCLOSURE (If applicable)

I understand and agree that in acting as the producer for this applicant:
1. The application was completed by the applicant.
2. I am in possession of a valid license issued by the State of Utah that authorizes me to sell and service accident and health insurance;
3. I have no authority to: a) make, alter, interpret, or discharge an application or policy in the name of a insurer; or b) waive any of the terms or conditions of the policy.
4. I have no authority to assign effective dates or to effect member changes.

Producer Name _____ License # _____ Agency _____ Phone ((xxx) xxx-xxxx _____

Producer Signature _____ Date Signed (mm/dd/yyyy) _____

(A faxed signature shall be valid as an original signature.)

Producer Compensation Disclosure:
(Compensation includes commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options, gifts, prizes, or any other form of valuable consideration.)

I have received written disclosure that the producer will receive compensation from the insurer or a third party administrator for the placement of insurance, including the amount or type of compensation.

Applicant Signature _____ Date (mm/dd/yyyy) _____