



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

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

## Individual Application Cover Sheet (to be used with the Idaho Individual Application)

### SECTION 1 - GENERAL INFORMATION

Applicant's Name (please print) \_\_\_\_\_

Social Security Number \_\_\_\_\_ Idaho Driver's License Number \_\_\_\_\_

(Note: If applying for underage child only, please list parent/legal guardian's Idaho Driver's License Number)

If you are currently eligible for Medicare, or will be on the requested effective date of coverage for which you are applying, you are not eligible for private individual or family health coverage and should not fill out this application cover sheet or the Individual Application.

### SECTION 2 - EFFECTIVE DATE

Your application is subject to review and approval by Regence BlueShield of Idaho. Complete applications received in our office by 5:00 PM Pacific Time on the last business day of the month will be eligible for an effective date of the first of the following month, unless otherwise indicated. Incomplete applications may receive a later effective date.

Requested Effective Date \_\_\_\_\_

### SECTION 3 - MEMBER CARD (check one)

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

### SECTION 4 - PLAN SELECTION (Detailed benefit information can be found online at [regence.com](http://regence.com))

#### MEDICAL PLANS (check one):

##### Evolve Core

Deductibles are per member (maximum of 2 deductibles per family)

- \$2,500    \$5,000    \$7,500    \$10,000

##### Evolve Plus

Deductibles are per member (maximum of 2 deductibles per family)

- \$2,500    \$5,000    \$7,500    \$10,000

##### Evolve HSA

Self-Only Deductibles

- \$1,500 with 50% coinsurance
- \$1,500 with 80% coinsurance
- \$3,500 with 50% coinsurance
- \$3,500 with 80% coinsurance

Family Deductibles

- \$3,000 with 50% coinsurance
- \$3,000 with 80% coinsurance
- \$7,000 with 50% 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 \$1,000 (\$750 annual maximum benefit)



**SECTION 5 - 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 \_\_\_\_\_

Print Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_

Address \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

**SECTION 6 - DEFINITION OF DEPENDENT**

Dependent means: (1) The legal spouse or domestic partner of the Policyholder; and/or (2) the child of a Policyholder or Policyholder's spouse or domestic partner, up to the age of twenty-six (26); or (3) a child of any age who is medically certified as disabled. The term "children" includes natural, step, or adopted children, or children in the process of adoption from the time placed with the Policyholder.

**SECTION 7 - 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 8 - 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. If you are declined the coverage you applied for, the carrier must offer the High Risk Pool (HRP) Plans.

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. I understand this request will be underwritten to determine the extent of my eligibility, and that Regence BlueShield of Idaho will consider all medical information currently on file. I hereby expressly authorize any physician or hospital, or any other health care provider, to disclose to Regence BlueShield of Idaho any information obtained by having attended me or hereafter attending or examining me, and I understand that Regence BlueShield of Idaho will not disclose any information so obtained.

**SECTION 9 - 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](http://regence.com).

**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 pre-existing 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.

- ◆ You have at least 12 months of continuous creditable coverage without any break in coverage greater than 63 days.
- ◆ Your most recent coverage was under a group health plan, a governmental plan, or a church plan (or health insurance offered in connection with such a plan).
- ◆ You are not covered under another group health plan.
- ◆ Your most recent coverage was not cancelled 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 health coverage or continuation coverage ends. Act promptly to protect your rights.



