

Statement of Understanding

By signing this application, I represent that all my answers are complete and accurate, and that I understand and agree to the following conditions:

- No Independent Producer, agent or employee of Blue Cross of Idaho may alter any part of this application or waive the requirement that I answer all questions completely and accurately, nor may any such person change the terms of the policy, except by endorsement issued expressly for that purpose over the signature or facsimile signature of the President of Blue Cross of Idaho.
- Blue Cross of Idaho may, at its discretion, request supplemental information from me, any family member listed on this application, or any health care providers before deciding whether to approve or reject the application.
- Blue Cross of Idaho may deny benefits or terminate or rescind my policy retroactive to its effective date for any misrepresentation, omission, or concealment of fact by, concerning, or on behalf of any persons listed on this application that was or would have been material to Blue Cross of Idaho's acceptance of a risk, extension of coverage, provision of benefits, or payment of any claim.
- If this application is not approved for the program(s) applied for upon initial review, any payment submitted with this application will be refunded. Upon the refund of the payment, Blue Cross of Idaho will have no further obligations to me or any family member listed on this application.
- If this application is approved, coverage for myself and any eligible family members named on this application will begin on the date assigned by Blue Cross of Idaho.
- If this application is approved, I understand a copy of the application will be attached to my policy. I approve the inclusion of any needed alterations to the application as long as I have been consulted by a duly authorized employee of Blue Cross of Idaho or a licensed and duly appointed Independent Producer representing me, the alterations are duly noted in the "Processing Notations" section of the application, and I have had an opportunity to review the application that will be attached to my policy.

- 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 enrollment 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. For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Blue Cross of Idaho Notice of Privacy Practices that is available at www.bcidaho.com.
- I have been advised that if I am declined coverage under the plan I am applying for, I may be eligible for my choice of the High Risk Basic, Standard, Catastrophic A, Catastrophic B or Idaho HSA plans. I have also been advised that I may be eligible for one of the High Risk Basic, Standard, Catastrophic A, Catastrophic B or Idaho HSA plans if Blue Cross of Idaho refuses to issue a health benefit plan providing coverage substantially similar to coverage offered under an equivalent High Risk Pool plan except at a rate exceeding the rate of the High Risk Pool plan.
- If you have had group or individual health coverage or a government health care program for at least 12 months, you are entitled to receive a Certificate of Creditable Coverage from your previous employer or insurance company. This document will state the effective date of prior coverage and the termination date of coverage for you and any covered dependents. Your previous employer or insurance company will furnish you this certificate upon request. If you need assistance in obtaining a certificate, Blue Cross of Idaho can assist you.
- **I affirm that I have reviewed all the answers given on this application and, if an Independent Producer or other person has filled out the answers for me and on my behalf, I verify the answers accurately reflect all the information given by me. I certify that the answers given on the "Health Statement" section are complete and accurate. I understand that this application will become part of any agreement or policy that Blue Cross of Idaho issues.**

If selecting the Essential Blue Policy:

The Essential BlueSM policy provides limited benefits.

Review your policy carefully.

X _____ Date
Applicant's Signature
(Parent or Guardian's signature if applicant is under age 18)

X _____ Date
Spouse's Signature (if listed on application)

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 preexisting 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 18 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.

Medicare Part D Creditable / Non-creditable

Blue Cross of Idaho's individual products are categorized as "creditable" or "non-creditable" for purposes of Medicare Part D. If you are a person nearing age 65 or an individual under 65 who is entitled to Medicare, the creditable/non-creditable information is important to you.

When you become eligible for Medicare, you can enroll in Medicare Part D. If you do not sign up when first eligible, you may generally enroll between November 15 and December 31 of each year.

If you do not sign up when first eligible and/or if you go 63 days or longer without prescription drug coverage that is creditable (at least as good as the standard Medicare prescription drug coverage), you may have to pay a higher monthly premium.

- The higher premium is based on the number of months you did not have creditable coverage.
- The penalty is 1% per month without creditable coverage. For instance, if you went 19 months without creditable coverage and then signed up for Medicare Part D, your premium would be 19% higher than the premium rate at the time you sign up.

Creditable prescription drug coverage is that which, on average, is expected to pay out as much as the standard Medicare prescription drug coverage.

Non-creditable prescription drug coverage is that which, on average, is **not** expected to pay out as much as the standard Medicare prescription drug coverage.

-OFFICE USE ONLY-	
POLICY NUMBER	POLICY EFF. DATE

IDAHO INDIVIDUAL APPLICATION

Type of Enrollment:

- New Applicant
 Adding Dependents

Requested effective date:

_____ (Subject to insurance carrier approval)

Change current enrollment because of the following event:

- Marriage Divorce Birth
 Death Adoption
 Court order (copy of court order required)
 Other _____

Date event occurred _____ / _____ / _____
MM DD YY

Please type or print legibly in black ink and complete all applicable sections. Thank you.

APPLICATION INFORMATION

Applicant / Insured Name		Occupation		<input type="checkbox"/> Single	<input type="checkbox"/> Married
				<input type="checkbox"/> Other _____	
Street Address	City	State	Zip	Home Phone No.	
Mailing Address	City	State	Zip	Work Phone No.	
Billing Address	City	State	Zip	E-mail Address	

List all family members you wish to enroll, including any unmarried child who is under age 21; or who is under age 25, a full-time student and financially dependent upon you; or who is medically certified as disabled and dependent upon you for support (copy of certification required).

Self and Dependent's Names (First, Initial, Last)	Relationship to Applicant	Date of Birth	Sex	Full-time Student?	Weight	Height	Social Security Number
Applicant / Insured	Self			<input type="checkbox"/> Yes <input type="checkbox"/> No			
Spouse				<input type="checkbox"/> Yes <input type="checkbox"/> No			
Child				<input type="checkbox"/> Yes <input type="checkbox"/> No			
Child				<input type="checkbox"/> Yes <input type="checkbox"/> No			
Child				<input type="checkbox"/> Yes <input type="checkbox"/> No			

List all other eligible dependents not applying for coverage at this time:

CURRENT / PRIOR COVERAGE INFORMATION

Please indicate for EACH person listed on this application any health insurance coverage (including Medicare, Medicaid, FEHBP, uniformed services, Indian Health Service, high risk pool or other creditable coverage) in effect within 12 months prior to the proposed effective date of this coverage. Each person applying for coverage must be listed below. If no health insurance coverage was in effect within the past 12 months, please indicate NONE. If you have had coverage within 63 days of this coverage effective date, a Certificate of Health Plan Coverage or proof of existing coverage must be provided to accurately credit your waiting periods. If you have cancelled High Risk Pool (Basic, Standard, Catastrophic A or B, HSA) coverage within the past 12 months, you may not be eligible for coverage unless you are a federally defined eligible individual. Please read the Notice of Federal Eligibility on the bottom of page 3 of this application.

Applicant's Name	Insurance Company (Policy # and Phone #)	Dates of Coverage MONTH / DAY / YEAR		Will continue any current coverage?	Type of Coverage	
		FROM	TO			
Applicant / Insured		MM / DD / YY	MM / DD / YY	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> High Risk Pool	<input type="checkbox"/> Individual <input type="checkbox"/> Cobra
Spouse				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> High Risk Pool	<input type="checkbox"/> Individual <input type="checkbox"/> Cobra
Child				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> High Risk Pool	<input type="checkbox"/> Individual <input type="checkbox"/> Cobra
Child				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> High Risk Pool	<input type="checkbox"/> Individual <input type="checkbox"/> Cobra
Child				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> High Risk Pool	<input type="checkbox"/> Individual <input type="checkbox"/> Cobra

List applicants eligible for coverage under any other plan (Group, Medicare, Medicaid, etc.) and type of plan eligibility:

HEALTH STATEMENT

INSTRUCTIONS:

- 1.) Each medical question below applies to all persons listed on this application who desire coverage.
- 2.) The questions apply to both past and present symptoms, conditions, diseases, illnesses, accidental injuries, or deformities (health conditions).
- 3.) Answer the questions below either Yes or No. Each of the questions must be answered. Answer Yes to a question if you or any family member for whom you want to obtain coverage now has, or at any time in the past has experienced or received care for the health condition or event specified in that question.
- 4.) Answer each question accurately and explain any conditions you answered yes to in the boxes provided below.
- 5.) Do not leave any question unmarked.
- 6.) No agent or any other person can waive these requirements or is authorized to set forth anything less than a complete and accurate response to each of the questions. The Insurance Carrier shall not be bound by an attempted waiver of complete answers to the questions set forth below.
- 7.) If you learn at any time before approval of coverage by the Insurance Carrier that any answer on this application is incomplete, you must advise the Insurance Carrier.

<p style="text-align: center;">Yes No</p> <p>1. Are you, your spouse, any eligible dependent child, or mate, whether or not listed on this application, now pregnant? <input type="checkbox"/> <input type="checkbox"/></p> <p>Due Date _____</p> <p>Complications anticipated? <input type="checkbox"/> <input type="checkbox"/></p> <p>Prior or anticipated multiple births? <input type="checkbox"/> <input type="checkbox"/></p> <p>2. Used any medication or drug within the past 12 months? (list below) <input type="checkbox"/> <input type="checkbox"/></p> <p>3. Positive test for HIV (Human Immunodeficiency Virus) infection <input type="checkbox"/> <input type="checkbox"/></p> <p>4. Acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC) <input type="checkbox"/> <input type="checkbox"/></p> <p>5. Alcoholism, drinking problem, drug abuse, or convicted of DUI/DWI <input type="checkbox"/> <input type="checkbox"/></p> <p>6. Allergies or Hay Fever <input type="checkbox"/> <input type="checkbox"/></p> <p>7. Anemia or blood condition <input type="checkbox"/> <input type="checkbox"/></p> <p>8. Arthritis or rheumatism <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, list type</p> <p>9. Asthma or chronic bronchitis <input type="checkbox"/> <input type="checkbox"/></p> <p>10. Attempted suicide <input type="checkbox"/> <input type="checkbox"/></p> <p>11. Back or joint condition <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, pins in place?</p> <p>12. Bladder or kidney condition <input type="checkbox"/> <input type="checkbox"/></p> <p>13. Bone infection <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: center;">Yes No</p> <p>14. Bodily deformity or congenital disease/defect <input type="checkbox"/> <input type="checkbox"/></p> <p>15. Breast condition or fibrocystic breast disease <input type="checkbox"/> <input type="checkbox"/></p> <p>16. Cancer <input type="checkbox"/> <input type="checkbox"/></p> <p>17. Colon / Bowel / Rectal condition <input type="checkbox"/> <input type="checkbox"/></p> <p>18. Depression <input type="checkbox"/> <input type="checkbox"/></p> <p>19. Diabetes <input type="checkbox"/> <input type="checkbox"/></p> <p>20. Disorders of the female reproductive organs/Infertility <input type="checkbox"/> <input type="checkbox"/></p> <p>21. Disorders of the male reproductive organs including the prostate/infertility <input type="checkbox"/> <input type="checkbox"/></p> <p>22. Dizziness or headaches <input type="checkbox"/> <input type="checkbox"/></p> <p>23. Epilepsy or seizure condition <input type="checkbox"/> <input type="checkbox"/></p> <p>24. Eye, ear, nose or throat condition <input type="checkbox"/> <input type="checkbox"/></p> <p>25. Gallstone or gall bladder condition ... <input type="checkbox"/> <input type="checkbox"/></p> <p>26. Heart or cardiovascular condition <input type="checkbox"/> <input type="checkbox"/></p> <p>27. Hernia or rupture <input type="checkbox"/> <input type="checkbox"/></p> <p>28. High blood pressure <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, last reading and date</p> <p>29. High cholesterol <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, last reading and date</p> <p>30. Liver conditions, cirrhosis or hepatitis <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, list type</p>	<p style="text-align: center;">Yes No</p> <p>31. Lung conditions or emphysema <input type="checkbox"/> <input type="checkbox"/></p> <p>32. Lupus <input type="checkbox"/> <input type="checkbox"/></p> <p>33. Melanoma <input type="checkbox"/> <input type="checkbox"/></p> <p>34. Mental or nervous conditions <input type="checkbox"/> <input type="checkbox"/></p> <p>35. Mental retardation <input type="checkbox"/> <input type="checkbox"/></p> <p>36. Neurological conditions <input type="checkbox"/> <input type="checkbox"/></p> <p>37. Phlebitis / Blood clot <input type="checkbox"/> <input type="checkbox"/></p> <p>38. Polio <input type="checkbox"/> <input type="checkbox"/></p> <p>39. Sinus conditions <input type="checkbox"/> <input type="checkbox"/></p> <p>40. Stomach conditions or ulcers <input type="checkbox"/> <input type="checkbox"/></p> <p>41. Stroke or paralysis <input type="checkbox"/> <input type="checkbox"/></p> <p>42. Thyroid or pituitary conditions <input type="checkbox"/> <input type="checkbox"/></p> <p>43. Tuberculosis <input type="checkbox"/> <input type="checkbox"/></p> <p>44. Tumor, growth, or cyst <input type="checkbox"/> <input type="checkbox"/></p> <p>45. Ulcerative colitis or Crohn's Disease <input type="checkbox"/> <input type="checkbox"/></p> <p>46. Varicose Veins <input type="checkbox"/> <input type="checkbox"/></p> <p>47. Any other condition or treatment in the last 5 years <input type="checkbox"/> <input type="checkbox"/></p> <p style="text-align: center;">Other Information</p> <p>48. Are you a U.S. Citizen? <input type="checkbox"/> <input type="checkbox"/></p> <p>49. Are you a resident of the state of Idaho? <input type="checkbox"/> <input type="checkbox"/></p> <p>years _____ months _____</p> <p>50. Do you have a family doctor? <input type="checkbox"/> <input type="checkbox"/></p> <p>Name _____</p>
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If you answered Yes to any question above, please explain below. Use extra paper if necessary.

Item NO.	Patient's Name	Diagnosis/Condition Type of Treatment	Physician's Name and Address	Date of Illness	Date of Last Visit	Was Recovery Complete?

List any medications or drugs taken by all applicants within the past 12 months. Use extra paper if necessary.

Item NO.	Patient's Name	Medication Name	Prescribing Physician and Address	Condition Requiring Medication	Still Taking?

Are you or any of your dependents currently disabled? Yes No

Name of Disabled Person

Physician's Name and Phone Number

Date of Disability

Physician's Address (street, city, state, and zip code)

Nature of Disability

Has any person listed on this application used tobacco during the past twelve (12) months? Yes No

If yes, list applicant's name(s) _____

Has surgery, diagnostic testing, medical treatment or follow up visit been advised (but not yet performed) for any person listed on this application? Yes No

If Yes, give person's name and details: _____

Has any named person incurred medical expenses or claims exceeding \$10,000 in the past 24 months? Yes No

If Yes, give person's name and details: _____

Are you or any family members listed on this application covered on Medicare or have received Social Security Disability or Workers' Compensation payments or are now eligible to receive such payments? Yes No

If Yes, give person's name and details: _____

Has any insurance carrier refused, restricted (including waiver or condition), or rated any health coverage for you or any dependents listed on this application? Yes No

If Yes, please explain (list applicant's name, medical condition and whether refusal, waiver, or restriction) _____

Name of Insurance Carrier _____ Date of refusal, etc. _____
(Please attach a copy of refusal letter, if applicable)

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 18 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.

AFFIRMATION

I affirm the answers given in this "Idaho Individual Application" are complete and correct. I am providing these answers as part of the application procedure required by this insurance carrier to enroll in its insurance coverage. I understand that the insurance carrier will rely on each answer in making its determination to extend coverage and to determine the type of coverage offered. I understand if this application contains any material misstatements or omissions, the insurance carrier may, within the first 24 months of coverage, deny coverage retroactively and / or take any other legal action available by law. I will promptly inform the insurance carrier in writing if anything happens before my coverage takes effect that makes any answer in this application incomplete or incorrect. I understand that a twelve month waiting period for coverage of pre-existing conditions may apply. I understand and agree no coverage shall be in force until approved by the insurance carrier. If approved, coverage will be in force as of the effective date determined by the carrier.

STATEMENT OF UNDERSTANDING

By signing this application, I represent that all my answers are complete and accurate to the best of my knowledge and belief and that I understand and agree to the following conditions:

- No independent producer, agent or employee of the insurance carrier, or of my employer can change any part of this application or waive the requirement that I answer all questions completely and accurately.
- The insurance carrier may terminate or rescind an insured's coverage for any misrepresentation, omission of fact by, concerning, or on behalf of any insured that was or would have been material to the insurance carrier's acceptance of a risk, extension of coverage, provision of benefits or payment of any claim.
- If this application is approved, coverage for me and any eligible persons named on this application will begin on the effective date assigned by the insurance carrier.
- I understand that this application will become part of the contract between the insurance carrier and me.
- **I affirm that I have reviewed all answers given on this application and, regardless of whether an independent producer or other person has filled out the answers for me, I verify that the answers are true and complete.**
- **NOTE:** A pre-existing condition is a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the effective date of coverage; a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage; or a pregnancy existing on the effective date of coverage.

I have been advised that if I am declined coverage under the plan I am applying for, that I may be eligible for my choice of the High Risk Basic, Standard, Catastrophic A, Catastrophic B, or HSA plans. I have also been advised that I may be eligible for one of the High Risk Basic, Standard, Catastrophic A, Catastrophic B, or HSA plans, if my insurance carrier refuses to issue a health benefit plan providing coverage substantially similar to coverage offered under an equivalent High Risk Pool plan except at a rate exceeding the rate of the High Risk Pool plan.

ACKNOWLEDGEMENT

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are eligible for benefits coverage and are listed on the enrollment form) 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 group 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).

This acknowledgement does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

Signature of Applicant _____ Date _____

Signature of Spouse _____ Date _____

AGENT INFORMATION

Agent's Name _____ ID No. _____

Signature of Agent _____ Date _____