Regence

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

Regence BlueShield of Idaho, Inc.
Mail form to: PO Box 1106
Lewiston, ID 83501
Fax form to: 1-866-303-5117

Coversheet for Idaho Enrollment Application (for groups 51-100)

Please print in black ink. Incomplete and/or illegible information may result in delayed coverage.
If an item is not applicable, write "N/A."

GROUP ADMINISTRATOR: This section should be completed by the Group Administrator.

Group Number	Subgroup	Class	Group Name

Applicant's Last Name	First Name	Middle Initial

Eligibility Waiting Period Start Date

SECTION 1 – PLAN SELECTION

Refer to your Group Administrator for plan options available to you.

Dental

☐ Dental ☐ No Dental

Medical

☐ Regence HSA Healthplan 3.0℠ ☐ Regence Innova®
☐ Regence HSA Healthplan 2.0 ☐ Regence Classic℠ ☐ No Medical
Enter your deductible amount $ _____

HSA (health savings account) health plans only: If your employer has partnered with HealthEquity for your HSA bank account, it will be created for you automatically. No further action is required from you; however, you have the following alternative options:

☐ Send my claims data to HealthEquity. I have read and agreed to the *HSA Authorization Form*.
☐ No, I don't want a HealthEquity HSA.

Regence BlueShield of Idaho: 1602 21st Avenue, Lewiston, Idaho 83501

GROUP INFORMATION	TO BE COMPLETED BY GROUP ADMINISTRATOR Group Number _____ Effective Date _____ Subgroup _____ Class _____

IDAHO UNIVERSAL GROUP APPLICATION

FOR ENROLLMENT OUTSIDE OF THE IDAHO EXCHANGE

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

SECTION 1 EMPLOYER/EMPLOYMENT INFORMATION

1. Name of Employer			2. Phone Number *(include area code)*	
3. Address		4. City	5. State	6. Zip Code
7. Occupation	8. Hours Worked per Week	9. Original Date of Hire *(mm/dd/yyyy)*	10. Fulltime Date of Hire *(mm/dd/yyyy)*	

SECTION 2 APPLICANT INFORMATION (Employee)

1. **Legal** First Name, Middle Name, Last Name *(and suffix, if applicable)*			
2. Mailing Address *(Street, Route, P.O. Box)*			
3. City	4. State	5. Zip Code	6. County
7. Preferred **Daytime** Phone Number *(include area code)*	8. Email Address		9. Date of Birth *(mm/dd/yyyy)*
10. Gender ☐ Male ☐ Female	11. Social Security Number **(required)**	12. Marital Status ☐ Single ☐ Married ☐ Other _____	13. Type of Enrollment - Please contact your group administrator for plans available to you. ☐ Health ☐ Dental ☐ Vision ☐ Waive Coverage – see section 3

If you wish to waive coverage for you and/or any dependents at this time, please complete Section 3 – Waiver of Coverage. If you wish to enroll yourself and/or your dependents, please complete all sections except Section 3.

SECTION 3 WAIVER OF COVERAGE *(To be completed only if coverage is declined or refused by an eligible employee or dependents.)*

1. I decline coverage for:

   Self (name) _____ Dependent (name) _____

   Spouse (name) _____ Dependent (name) _____

   Dependent (name) _____ Dependent (name) _____

2. Reason for declining coverage (check all that apply):

   ☐ I and/or my dependents currently have other qualifying medical coverage with (name of carrier) _____

   through: ☐ My other employer ☐ My spouse's employer ☐ Individual policy ☐ Medicare ☐ Medicaid ☐ Tricare

   ☐ Indian Health Services **OR** ☐ Other reason for declining coverage (please explain): _____

SIGNATURE TO WAIVE**

I have decided to waive coverage as indicated above. I have been given the opportunity to apply for group coverage by the employer. Should I decide to apply for this coverage in the future, I realize and agree any coverage may be subject to additional probationary waiting periods.

****Signature** _____ **Date** _____

(sign only if waiving coverage) *mm/dd/yyyy*

Notice of enrollment rights: If you are declining enrollment for you or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 60 days after the marriage, birth, adoption or placement for adoption.

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SECTION 4 ENROLLMENT INFORMATION (check all that apply)

1. Are you: ☐ A new applicant ☐ Adding dependents ☐ Enrolling during your employer's open enrollment
2. If you are enrolling ***outside*** of your employer's open enrollment or adding dependents, please mark the appropriate reason below and provide the date of the event (mm/dd/yyyy) _____
   (documentation may be required) ☐ Marriage ☐ Divorce ☐ Birth ☐ Adoption
   ☐ Involuntary loss of ***employer*** coverage* ☐ Involuntary loss of ***individual*** coverage*
   *Provide name of carrier _____
   ☐ Involuntary loss of Medicaid
   ☐ Court order *(copy of court order required)* ☐ Other _____
3. Current employment status:
   ☐ Actively at work ☐ Retiree ☐ COBRA participant ☐ Disability ☐ Other _____

SECTION 5 DEPENDENT INFORMATION

(List all eligible dependents you wish to enroll, including any child who is under the age of 26; or who is medically certified as disabled and dependent on parent for support (copy of certification required). If you have more dependents to include, make a copy of this page and attach.)

Dependent's Name (first, initial, last)	**Relationship (spouse, child, stepchild, etc.)**	**Does Dependent live at the same address as you?**	**Social Security Number**	**Date of Birth (mm/dd/yyyy)**	**Gender**	**Type of Enrollment**
Dependent 1		☐ Yes ☐ No			☐ Male ☐ Female	☐ Health ☐ Dental ☐ Vision
Dependent 2		☐ Yes ☐ No			☐ Male ☐ Female	☐ Health ☐ Dental ☐ Vision
Dependent 3		☐ Yes ☐ No			☐ Male ☐ Female	☐ Health ☐ Dental ☐ Vision
Dependent 4		☐ Yes ☐ No			☐ Male ☐ Female	☐ Health ☐ Dental ☐ Vision
Dependent 5		☐ Yes ☐ No			☐ Male ☐ Female	☐ Health ☐ Dental ☐ Vision
Dependent 6		☐ Yes ☐ No			☐ Male ☐ Female	☐ Health ☐ Dental ☐ Vision

SECTION 6 OTHER COVERAGE INFORMATION

(Please complete the section below if you have other coverage that will remain in effect. If you have more policies to include, make a copy of this page and attach.)

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 insurance carrier can determine whose coverage is primary.

Other Policy

1. Other Insurance Carrier Information: Insurance Carrier Name, Policy Number, Phone Number

2. Policy Holder Name

3. Names of Covered Members

4. Types of Coverage *(check all that apply)*
   ☐ Group ☐ Medical
   ☐ Individual ☐ Dental
   ☐ Medicare ☐ Vision

5. Coverage Start Date *mm/dd/yyyy*

6. Is this coverage terminating?
   ☐ Yes (complete #7)
   ☐ No

7. Coverage End Date *mm/dd/yyyy*

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SECTION 7 OTHER INFORMATION

1. Are you or any of your dependents listed on this application currently disabled? ☐ No ☐ Yes

   Name of disabled person _____ Physician's name and phone _____

   Date of disability _____ Physician's address _____

   Nature of disability_____

2. Are you or any dependent listed on this application covered on Medicare or have received Social Security Disability or Worker's Compensation payments or are now eligible to receive such payments? ☐ No ☐ Yes

   If yes, give person's name, type of Coverage, and reason for entitlement: _____

3. Has any person listed on this application used a tobacco product on average four or more times a week within no longer than the past six months (anyone age 18 or older)? ☐ No ☐ Yes **If yes**, list names below:

   _____ _____

   _____ _____

SECTION 8 AFFIRMATION

I affirm the answers in this "Idaho Universal Group 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 I have made any misstatement or omission in this application, the insurance carrier may take any action available by law, including but not limited to, retroactive adjustment of premiums or claims. Further, I understand that any fraud or intentional misrepresentation of material fact on the part of the employer is cause for retroactive termination of coverage by the insurance carrier and/or other action available by law. I will promptly inform the insurance carrier in writing if anything happens before my coverage takes effect that makes an answer on this application incomplete or incorrect. Following receipt of a fully-executed application, coverage will be in force as of the effective date determined by the insurance carrier under applicable law.

SECTION 9 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 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 employer's group coverage for any intentional misrepresentation omission of fact by, concerning, or on behalf of any applicant by the employer 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.
- As proof of status of employment, I authorize my employer to release to the insurance carrier appropriate documents, including but not limited to W-2 Wage and Tax Statements and other wage and tax summaries or forms.
- Coverage for me and any eligible persons named on this application will begin on the effective date pursuant to the terms of the plan/ contract.
- I agree to abide by the terms of the group's master policy/member certificate, which sets forth all of the terms and conditions of my coverage. No agent or other person can change the terms of the master contract, any of its amendments, or this application, except with an amendment issued expressly for that purpose and signed by an authorized officer of the insurance carrier.
- 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.

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SECTION 10 ACKNOWLEDGMENT

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

Signature of Employee _____ Date *(mm/dd/yyyy)* _____

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GROUP INFORMATION	TO BE COMPLETED BY GROUP ADMINISTRATOR Group Number _____ Effective Date _____ Subgroup _____ Class _____

IDAHO UNIVERSAL HEALTH STATEMENT ADDENDUM

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

This addendum **does not** need to be **completed in all cases.**

Completion NOT required	Completion IS required	Completion requirement differs by carrier
Small employer plan with 50 or fewer eligible employees seeking ACA-compliant coverage	Employer plans with 51-100 eligible employees seeking fully insured coverage	- Employer plans participating in specialized funding or trust arrangements - Employer plans with healthcare reform “grandfathered” or “grandmothered” status

Please refer to your agent or sales representative for any additional clarification regarding the applicability of this addendum.

SECTION 1 EMPLOYER INFORMATION

1. Name of Employer

SECTION 2 APPLICANT/DEPENDENT INFORMATION

Applicant/Dependent’s Name (first, initial, last)	Relationship (spouse, child, stepchild, etc.)	Date of Birth (mm/dd/yyyy)	Height	Weight
Applicant				
Dependent 1				
Dependent 2				
Dependent 3				
Dependent 4				
Dependent 5				
Dependent 6				

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SECTION 3 HEALTH STATEMENT

PLEASE ANSWER BELOW	Have you or any family member listed on this application ever seen a doctor, been diagnosed with, had treatment, hospitalization, medications, tests or been advised to have treatment or surgery for any of the following? If yes, please provide details on grid below. NOTE: The list of specific conditions is not comprehensive.
a. Cancer/Tumor ☐Yes ☐No	Brain Breast Cervical Colon Leukemia Liver Lung Lymphoma Melanoma Non-Malignant Tumor Ovarian Prostate Testicular Other Cancer
b. Heart/Circulatory ☐Yes ☐No	Aneurysm Angina Angioplasty/Stent Blood Clots/Disorders Bypass Cholesterol/ Triglycerides Congestive Heart Failure Hemophilia High Blood Pressure Pacemaker/ICD Stroke
c. Reproductive ☐Yes ☐No	Breast Disorders Endometriosis Fibroids Infertility Menstrual Disorders
d. Intestinal/Endocrine/Liver ☐Yes ☐No	Chronic Pancreatitis Cirrhosis Colon Disorder Crohn's Diabetes (I/II) Gall Bladder Gastric Bypass Hepatitis B/C Liver Disorder Pituitary Disorder Reflux Ulcer Ulcerative Colitis
e. Brain/Nervous ☐Yes ☐No	ALS Alzheimer's Cerebral Palsy Cyst Head Injury Migraines Multiple Sclerosis Paralysis Parkinson's Disease Seizures/Epilepsy
f. Immune ☐Yes ☐No	AIDS Arthritis (Rheumatoid/Psoriatic) HIV+ Immunodeficiency Lupus Psoriasis Scleroderma
g. Lung/Respiratory ☐Yes ☐No	Allergies Asthma Chronic Bronchitis COPD Cystic Fibrosis Emphysema Lung Disorders Pneumonia Sarcoidosis Sleep Apnea Tuberculosis
h. Eyes/Ears/Nose/Throat ☐Yes ☐No	Acoustic Neuroma Cataracts Chronic Ear Infections Chronic Sinusitis Cleft Lip/Palate Deviated Septum Glaucoma Retinopathy
i. Urinary/Kidney ☐Yes ☐No	Bladder Disorders Kidney Disorders Kidney Stones Polycystic Kidney Disease Prostate Disorder Renal Failure
j. Bones/Muscles ☐Yes ☐No	Back Disorder Bulging/ Herniated Disc Chronic Pain Syndrome Fibromyalgia/Chronic Fatigue Syndrome Joint Injury Knee Disorder Neck Disorder Osteoarthritis Shoulder Disorder Spina Bifida
k. Behavioral Health ☐Yes ☐No	ADHD Alcohol/Drug Anxiety/Depression Autism Bipolar Depression Eating Disorder Inpatient Mental Health Manic Depression Substance Abuse Suicide Attempt
l. Transplant ☐Yes ☐No	Bone Marrow Discussed Possible Future Transplant Organ Stem Cell Transplant Complications
m. Pregnant ☐Yes ☐No	Are you or any family member listed on this application currently pregnant? If so, then on the grid below include due date, details about any complications, surrogacy information (if applicable), etc…
n. Hospital/Surgery ☐Yes ☐No	Have you or any family member listed on this application been hospitalized, or had surgery, during the last 5 years?
o. Future Treatment/Surgery ☐Yes ☐No	Have you or any family member listed on this application ever been advised to have any treatment and/or surgical operation(s) that you or any family member have not yet had?
p. Congenital Conditions ☐Yes ☐No	Do you or any family member listed on this application have any congenital conditions that have not previously been disclosed on the detail grid below for a previous question?
q. $5,000+ Claims ☐Yes ☐No	Have you or any family member listed on this application had claims in excess of $5,000 that have not previously been disclosed on the detail grid below for a previous question?
r. Other ☐Yes ☐No	Do you or any family member listed on this application suffer from any chronic or recurring ailments, illnesses or other departures from good health, regardless of whether a physician or other health care professional has been consulted that has not previously been disclosed on the detail grid below for a previous question?
s. Prescriptions ☐Yes ☐No	During the past 12 months, have you or any family member listed on this application received a prescription for medication from a physician or taken any prescribed medication not previously been disclosed on the detail grid below for a previous question?
t. Denied/Refused Coverage ☐Yes ☐No	Have you or any family member listed on this application ever been refused or issued restricted health insurance coverage?

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SECTION 3 HEALTH STATEMENT CONTINUED

Item (a – t) *from previous page*	Person Affected	Date Condition Began MM/YYYY	Name of Disease, Symptom or Condition – Include Type of Treatment	Name of Hospital and Number of Days	Date Last Treated	Was Recovery Complete?	Drugs – Include Type or Name, Dosage, Strength and Duration	Name of Physician

SECTION 4 AFFIRMATION

I affirm the answers in this "Idaho Universal Health Statement Addendum" are complete and correct. I am providing these answers as an addendum to my completed Idaho Universal Group Application, Form No. ID Grp App and understand this will become a part of that application. Any and all provisions delineated in the Idaho Universal Group Application apply to this addendum.

Signature of Employee _____ Signature Date (mm/dd/yyyy)_____

Signature of Spouse _____ Signature Date (mm/dd/yyyy)_____
(if applying for coverage)

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NONDISCRIMINATION NOTICE

Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Regence does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Regence:
Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, and accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

Medicare Customer Service
1-800-541-8981 (TTY: 711)

Customer Service for all other plans
1-888-344-6347 (TTY: 711)

If you believe that Regence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our civil rights coordinator below:

Medicare Customer Service
Civil Rights Coordinator
MS: B32AG, PO Box 1827
Medford, OR 97501
1-866-749-0355, (TTY: 711)
Fax: 1-888-309-8784
medicareappeals@regence.com

Customer Service for all other plans
Civil Rights Coordinator
MS CS B32B, P.O. Box 1271
Portland, OR 97207-1271
1-888-344-6347, (TTY: 711)
CS@regence.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW,
Room 509F HHH Building
Washington, DC 20201

1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-344-6347 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-344-6347 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-344-6347 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-344-6347 (телетайп: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS : 711)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-344-6347（TTY:711）まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (መስማት ለተሳናቸው:- 711)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिटिवाइ: 711

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-344-6347 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم TTY: 711)