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-LC1NW
Lewiston, ID 83501-1106
Fax form to: 1-866-797-1786

Please do not include initial payment with application

IndElig@Regence.com

2017 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 through 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 your 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.

For more information, please contact your producer or call our Sales department toll-free at 1-888-REGENCE (1-888-734-3623).

SECTION 2 - ELIGIBILITY

You are eligible if you are:

- A resident of and have a primary residence in the state of Utah. A photocopy of a valid Utah state driver's license, identification card, or similar proof of residency acceptable to Regence BlueCross BlueShield (Regence) may be requested.
- 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. Any individual eligible or enrolled in Medicare (or who will be on the requested effective date) is ineligible to apply for private individual or family health coverage and should not be included in the application.
- 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 3 to determine if your situation qualifies.

You are not eligible if:

- You are currently eligible and/or enrolled on Medicaid or Medicare Part A, B, or D. Participation in a government program does not allow enrollment on an individual product.
- You have a third-party payer paying for any portion of this policy.

SECTION 3 - SPECIAL ENROLLMENT QUALIFYING EVENTS

Complete this section only if applying outside of open enrollment. During special enrollment, you can apply for insurance or make changes to your existing insurance only if you have a major life change such as the loss of a job or the birth of a child. You have 60 days from the date of the event to apply. Check the box(es) to indicate which event(s) have occurred and include the date of the event.

Date of Event _____	
Qualifying Events:	**Submit the following documentation:**
☐ Birth of a child.	Copy of birth certificate.
☐ Adoption or placement of a child.	Copy of adoption or placement papers.
☐ Loss of group coverage due to the death of the employee, voluntary or involuntary termination of employee's job, reduction in employee's working hours, divorce or legal separation, Medicare entitlement of employee, dependent child's loss of dependent status, Chapter 11 bankruptcy of employer sponsor.	◆ Employer letter on company letterhead, Certificate of Coverage or evidence of other creditable coverage. ◆ Letter from employer on company letterhead indicating your Qualifying Event and Qualifying Event Date.
☐ Loss of minimum essential coverage as defined in federal law, including but not limited to most government-sponsored programs (e.g., Medicare, Medicaid, CHIP), employer-sponsored plans, and individual market plans in the state (except due to nonpayment of premium or fraud/intentional material misrepresentation).	◆ Employer letter on company letterhead, Certificate of Coverage or evidence of other creditable coverage. ◆ Coverage termination reason.
☐ Gaining or becoming a dependent through marriage.	Marriage Certification.
☐ 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 Health and Human Services (or its instrumentalist) as evaluated and determined by the Exchange.	Documentation from the Exchange.
☐ Adequate demonstration to the exchange of a Qualified Health Plan's substantial violation of a material contract provision.	◆ A copy of the Qualified Health Plan contract. ◆ A statement of the provision that is claimed violated ◆ Proof of the violation.
☐ New eligibility or ineligibility for advance payment of premium tax credit, or change in eligibility for cost-sharing reductions.	Letter from Health and Human Services or Internal Revenue Services or the Exchange.
☐ Gain of access to a new Qualified Health Plan due to permanent move.	◆ A copy of a utility bill in your name from your prior address dated within the last 60 days. **AND** 1) A valid picture I.D. enlarged 125% indicating physical residential address ◆ Utah driver's license ◆ Utah state-issued identification card ◆ tribal identification card ◆ military identification card 2) An additional document that shows the physical residential address ◆ Current full month of service (bill date not older than 60 days) utility bill for utility services (needs to include both service and mailing addresses) ◆ Signed rental agreement for current residence (signed by all parties-tenant/landlord) ◆ Copy of voter's registration card that has your residential address on it ◆ Current bank checking account statement or copy of a voided check ◆ Current student enrollment or letter from college/university registrar noting residence

SECTION 4 - PLAN SELECTION - Detailed benefit information can be found online at www.regence.com

MEDICAL PLANS (select ONE medical plan)

You must visit in-network providers to receive plan benefits. That makes choosing the right network important.

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

- ☐ Gold 1000 EPO
- ☐ Silver HSA 2500 EPO*
- ☐ Silver 3000 EPO
- ☐ Silver Essential 3500 EPO
- ☐ Bronze HSA 5000 EPO*
- ☐ Bronze Essential 7150 EPO

Provider Network (check one):

- ☐ FocalPoint (Service area is Cache, Weber, Davis, Salt Lake, Utah, and Box Elder Counties)
- ☐ Preferred ValueCare (Service area covers the entire state)

You **must** use the doctors and hospitals within your network because there is no coverage for care outside of your network (except in emergencies). If you go to a doctor or hospital that is not in your network, you'll pay all costs. Visit regence.com to learn which doctors and hospitals are in each network.

OPTIONAL BENEFITS (only available in addition to the selection of a medical plan)

- ☐ Dental, Vision, and Individual Assistance Program (IAP)

If you selected an HSA plan, please answer the following:

- ☐ *Yes, I authorize Regence to share my eligibility information and my claims information with HealthEquity for the purposes of establishing and administering my HealthEquity Health Savings Account (Social Security Number must be provided in section B of the Utah Individual Health Insurance Application).

For additional disclosures and information, view the HealthEquity terms and conditions at http://healthequity.com/legal.aspx. Terms and conditions of the Health Savings Account will be mailed with your HealthEquity HSA Visa Card.

- ☐ *No, do not share my information with HealthEquity; I have/will open my own HSA bank account.

Please Note: To take advantage of pre-tax savings of your HSA fund from day one, you must have your account open for your effective date.

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 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 - RESIDENCY

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 the proposed insured and percent of time out of the state _____

Please indicate the reason:
☐ Reside ☐ Work ☐ School - Provide student enrollment documentation ☐ Other _____

SECTION 7 - MEMBER PREFERENCES

Spoken Language Preference if other than English (optional) _____

Preferred communication method for application processing: ☐ United States Postal Mail ☐ Secure Email

Go paperless! Regence can send secure communications about your insurance claims and benefits to a Regence.com account! Once registered, an email or text (your choice) will notify you when a new communication is posted.

Yes, please set up an account for me and email me a link to access and personalize it.
My email address: _____

SECTION 8 - 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)?
	☐	☐	☐	☐		
	☐	☐	☐	☐		
	☐	☐	☐	☐		

SECTION 9 - MY OTHER COVERAGE

Will anyone listed on this application have other medical and/or dental insurance, including Medicare and Medicaid, 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
			Policy Number Effective Date	**Coverage Type:** ☐ Group ☐ Individual ☐ Medicaid **Product Type:** ☐ Medical ☐ Dental **Medicare:** ☐ PartA ☐ PartB ☐ PartD
			Policy Number Effective Date	**Coverage Type:** ☐ Group ☐ Individual ☐ Medicaid **Product Type:** ☐ Medical ☐ Dental **Medicare:** ☐ PartA ☐ PartB ☐ PartD
			Policy Number Effective Date	**Coverage Type:** ☐ Group ☐ Individual ☐ Medicaid **Product Type:** ☐ Medical ☐ Dental **Medicare:** ☐ PartA ☐ PartB ☐ PartD
			Policy Number Effective Date	**Coverage Type:** ☐ Group ☐ Individual ☐ Medicaid **Product Type:** ☐ Medical ☐ Dental **Medicare:** ☐ PartA ☐ PartB ☐ PartD
			Policy Number Effective Date	**Coverage Type:** ☐ Group ☐ Individual ☐ Medicaid **Product Type:** ☐ Medical ☐ Dental **Medicare:** ☐ PartA ☐ PartB ☐ PartD
			Policy Number Effective Date	**Coverage Type:** ☐ Group ☐ Individual ☐ Medicaid **Product Type:** ☐ Medical ☐ Dental **Medicare:** ☐ PartA ☐ PartB ☐ PartD

SECTION 10 - 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 11 - TOBACCO USAGE

PLEASE NOTE: You state on the Utah Individual Health Insurance Application whether you or any other individual you are enrolling is a Tobacco User (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. A surcharge is applied to the regular Periodic Rate for each enrolled Tobacco User. If an enrollee becomes a Tobacco User after you apply, you must notify the Company immediately and a surcharge will be added for that enrollee. The Company reserves the right to take any action available to it, including collection of unpaid surcharges, if false information about tobacco use is submitted or if you fail to notify the Company of a change in an enrolled individual's tobacco usage.

SECTION 12 - 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 13 - 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 F of the Utah Individual Health Insurance Application. Producers will not be compensated if this information is incomplete.

SECTION 14 – 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

THIRD PARTY CONTRIBUTION

1. Is any third-party payer including employers, providers, or not-for-profit agencies paying for any portion of this policy? ☐ Yes ☐ No

We do not accept any third-party payments, except as required by law.

2. Are you Self-Employed? ☐ Yes ☐ No

If yes, please provide the name of your business _____

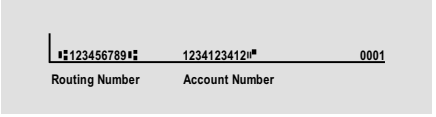
PAYMENT OPTIONS (check one):

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.*
3. Sign and date the Account Holder lines at the bottom of this section.



If more than one month's premium is due upon first draft, do you authorize Regence to pull all amounts? ☐ Yes ☐ No

SECTION 14 – PREMIUM BILLING OPTIONS (continued)

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) Date

SECTION 15 - REPLACEMENT OF COVERAGE

Will this policy replace any other accident and sickness insurance currently in force? ☐ Yes ☐ No

If YES, please review the "Notice of Applicant Regarding Replacement of Accident and Health Insurance" contained in the Acknowledgment & Signature Section of the Utah Individual Health Insurance Application.

NOTE: If your plan selection includes optional Dental, Vision and IAP coverage, **the policy provides dental and vision benefits only. Review your policy carefully.**

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 _____ _____ Business Phone _____ _____

Driver's License Number: _____ 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				☐ Male ☐ Female	☐ Yes ☐ No
Spouse/ Domestic Partner*				☐ Male ☐ Female	☐ Yes ☐ No
Dependent				☐ Male ☐ Female	☐ Yes ☐ No
Dependent				☐ Male ☐ Female	☐ Yes ☐ No
Dependent				☐ Male ☐ Female	☐ Yes ☐ No

*Check with your employer to determine if domestic partner coverage is available.

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

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

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