APPLICATION FOR INDIVIDUAL COVERAGE

ASURIS NORTHWEST HEALTH

528 E. Spokane Falls Blvd.
Suite 301
Spokane, Washington 99202

MAIL APPLICATION TO:
PO Box 1107
1602 21st Ave. MS LC1NW
Lewiston, ID 83501

All answers must be complete and accurate. Omissions or incomplete answers will result in the return of your application and may cause delays. In most cases, a valid application received in our office by 5:00 p.m. on the last business day of the month will be considered for an effective date of the first of the following month.

SECTION 1. TYPE OF APPLICATION (Check all that apply.)

❒ New Application ❒ Changing Coverage Type ❒ Transferring from another carrier	❒ Transferring from Asuris Northwest Health Group or COBRA Coverage ❒ Adding Dependent(s). (Dependent(s) may be added only to your current plan/deductible option, skip to Section 3.)

SECTION 2. TYPE OF NEW COVERAGE (SELECT ONLY ONE PLAN.)

PREFERRED PLANS — Deductible Options:				
Catastrophic*		**Comprehensive**	**HSA Catastrophic***	**HSA Comprehensive**
Asuris Clarity℠ 50 ❒ $2,500 ❒ $5,000	**Asuris Core Plan℠** ❒ $2,500 ❒ $5,000 ❒ $7,500 ❒ $10,000	**Asuris Clarity℠ 70** ❒ $1,000 ❒ $3,000	**Asuris HSA Healthplan** ❒ $2,500 Member/ $5,000 Family ❒ $3,500 Member/ $7,000 Family	**Asuris HSA Healthplan Comprehensive** ❒ $1,500 Member/ $3,000 Family

***Enrollment in a catastrophic health plan may not provide portability if you later decide to enroll in another individual health plan. "Portability" means that you will receive credit for a plan's preexisting condition waiting period based on prior coverage. By enrolling in a catastrophic plan, you may lose portability rights and have to satisfy the nine-month preexisting condition waiting period, should you later change to another individual health plan.**

SECTION 3. PAYMENT TYPE (Select one of the following payment options.)

❒ Monthly ❒ Quarterly ❒ Semiannually ❒ Annually ❒ Automatic Bank Withdrawal
Complete the enclosed Subscriber Agreement for Preauthorized Bill Payment (monthly only).

SECTION 4. MEMBER INFORMATION To be eligible to apply for our individual plans, you must reside in our service area for at least 30 days prior to submitting your application and continue to live in our service area for six months out of the year. Eligible dependents include your spouse/eligible domestic partner and/or children under the age of 25. Proof of residence within the Asuris Northwest Health service area may be required. (See the Application Checklist on page 4 for acceptable forms of proof.) Please list subscriber, spouse/eligible domestic partner, and eligible dependent children for whom you are requesting coverage. Please provide Social Security numbers for yourself and all dependents over one year of age. **PLEASE PRINT.** (Persons who are eligible for Medicare coverage are not eligible for coverage under individual contracts.)

Name			Social Security Number	Sex	Birth Date
First	**MI**	**Last**			
Applicant					
❒Spouse ❒Registered Domestic Partner ❒Non-Registered Domestic Partner*					

Street Address	City	State	ZIP Code	County
Mailing Address	City	State	ZIP Code	Home Telephone Number
Billing Address (if different)	City	State	ZIP Code	E-mail Address (optional)

*Non-Registered Domestic Partner must submit an Affidavit of Domestic Partnership.

Name and Health Insurance Claim Number of anyone listed on this form that is covered by Medicare.

ASURIS NORTHWEST HEALTH USE ONLY				
Date Application Substantially Complete	**COB**	**Effective Date**	**Package Number**	**Producer Number**

SECTION 5. EXCEPTIONS FOR THE STANDARD HEALTH QUESTIONNAIRE

Please read the full explanation of the exceptions listed on the Standard Health Questionnaire (SHQ). Additional conditions and requirements may apply.

Name of person(s) not required to complete the Standard Health Questionnaire: _____

Do your circumstances match any of the exceptions described in the SHQ? If so, please complete this section (check one):

❒ **Relocation:** You changed residences from one part of Washington state to another part where your current health plan is not offered **and** you are submitting your application within 90 days of this event. *Include a copy of a utility bill in your name from the prior address dated within the last 90 days and a letter of verification from your prior carrier verifying that because you have moved, you no longer reside in their service area and they cannot provide health insurance at your new location.*

❒ **Provider Cancellation:** The health provider from whom you have received service during the last 12 months has left the provider network on your current individual medical plan, **and** you are submitting the application within 90 days of your provider leaving your current health plan's network. This provider must be within the Asuris Northwest Health provider network. *Include a letter of verification from the provider or carrier verifying service in the last 12 months and the date the provider left the network.*

❒ **COBRA Exhaustion:** You are applying within 90 days of using up your COBRA coverage, or you lost coverage due to your employer going out of business or discontinuing its health plan while you were on COBRA. *Include a letter from the COBRA Administrator verifying that you have exhausted your COBRA benefits. Include a letter of certification from your employer or carrier that is going out of business or discontinuing its health plan while you were on COBRA.*

❒ **Employer's Plan Not Subject to COBRA:** You have lost or are losing coverage under an employer's plan that was not subject to COBRA coverage **and** you are applying within 90 days of an event which would qualify you for COBRA if your employer had not been exempt from COBRA **and** had at least 24 months of continuous group coverage before such loss. *Include a letter of verification of COBRA exemption and the reason for your loss of coverage from your employer and a certificate of coverage for proof of 24 months of continuous group coverage.*

❒ **COBRA Termination:** You are terminating your COBRA coverage and you had at least 24 months of continuous group coverage prior to termination. (Not applicable to BHP applicants.) *Include a letter of verification from your employer addressing your termination of COBRA and a certificate of coverage for proof of 24 months of continuous group coverage.*

❒ **COBRA Eligible:** You are applying within 90 days of an event which qualifies you for COBRA, **and** you had at least 24 months of continuous group coverage prior to such event but you chose not to take COBRA coverage. (Not applicable to BHP applicants.) *Include a letter of verification from your employer addressing your COBRA eligibility and a certificate of coverage for proof of 24 months of continuous group coverage.*

❒ **Loss of Basic Health Plan (BHP) Coverage:** You have lost or are losing BHP coverage and you had at least 24 months of continuous BHP coverage before such loss and you are submitting your application within 90 days of disenrollment. *Include a letter of verification from your carrier with dates of coverage for proof of your 24 months of eligibility from BHP, or a certificate of coverage.*

In addition to the exceptions listed above, the Standard Health Questionnaire is not required for the **subscriber's** natural newborn or newly adopted child if the Company receives the application for coverage within 60 days of birth or placement of adoption (to be effective from date of birth or placement of adoption *if the subscriber has active coverage on the date of birth or placement of adoption).*

Are you adding a newborn to your existing policy? ❒ Yes

Are you adding a newly adopted child to your existing policy? ❒ Yes *(Include documentation indicating date of placement.)*

SECTION 6. OTHER COVERAGE INFORMATION

Are you or any dependents who are applying for coverage currently covered on any group, individual, or self-insured plan? ❒ Yes ❒ No

If Yes, do you intend to replace your current plan with this contract? ❒ Yes ❒ No

Asuris Northwest Health Individual Plans contain a nine-month preexisting condition waiting period. In certain circumstances, we will waive or credit this waiting period based on current or prior coverage. To help us determine if you qualify for crediting the preexisting condition waiting period, please provide the following information, and attach a copy of your Certificate of Coverage from your current or prior carrier or a similar document showing the beginning and ending dates of your current coverage, if applicable. Please note: If your prior coverage was with an Asuris Northwest Health group plan, it is not necessary to include a copy of your Certificate of Coverage. SEE THE APPLICATION CHECKLIST ON PAGE 4 FOR MORE INFORMATION.

Name (First, Last)	Birth Date	Insurance Company	Policy Number	Dates of Coverage		Type of Coverage
				Date Coverage Began	Date Coverage Ended (indicate Active if you are currently covered)	• Employer Group • Individual • Medicare • COBRA • High Risk Pool
1.						
2.						
3.						
4.						
5.						

Deductible amount: $ _____ per individual per year

Deductible amount: $ _____ per family per year

Out-of-pocket (stoploss) amount: $ _____ per individual per year

Out-of-pocket (stoploss) amount: $ _____ per family per year

SECTION 7. NON-SMOKER CERTIFICATION STATEMENT

Complete this section only if you or your spouse/eligible domestic partner is applying for a non-smokers' discount.

I certify that I have not smoked cigarettes, cigars, pipes, or used chewing tobacco, smokeless tobacco or any other form of tobacco or illegal drug substance within the past 12 months. PLEASE NOTE: The Company reserves the right to cancel coverage and collect claims payments or other damages if false information is submitted. If you fail to notify us you are no longer eligible for the non-smoker discount, we reserve the right to change the non-smoker discount to the regular rate.

Subscriber's Signature	Date	Spouse's/Eligible Domestic Partner's Signature (if applying)	Date

SECTION 8. RELEASE OF INFORMATION

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 application) 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.

*For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Asuris Consumer Privacy Notice. A copy is available from our Web site (www.asuris.com) or by phone at 1-866-704-2708.

SECTION 9. APPLICATION AGREEMENT

I hereby apply for myself and/or for any spouse/eligible domestic partner and/or dependent(s) listed on this application for coverage under the individual Contract indicated on this form or currently in effect if adding dependent(s). Contracts are offered through Asuris Northwest Health (the Company). I understand I will have the right to examine and return the Contract (if new) within 10 days of its delivery to me. I certify that my listed dependents and I meet the eligibility requirements set forth in **Section 4. Member Information**.

I agree to pay in advance the appropriate rates for myself and listed dependents and authorize rate increases as the Company deems necessary.

I have read and understand the waiting period provisions of the plan for which I am applying. I understand that under certain circumstances the Company may impose a **nine-month waiting period** for preexisting conditions as defined in the Contract.

I understand that this application is not an offer of coverage from Asuris Northwest Health and that submission of this application does not guarantee I will receive coverage. Please sign and date **Section 10. Signature and Date**

SECTION 10. SIGNATURE AND DATE

I have provided these answers as part of the application procedure required by Asuris Northwest Health to enroll in coverage and I certify that all information completed on this form and the Standard Health Questionnaire (if applicable) is true, correct, and complete. I understand that Asuris Northwest Health will rely on each answer in making coverage and rating determinations. For the protection of all of our members, fraud or misrepresentation of material fact by you for the purposes of defrauding Asuris Northwest Health may result in Asuris Northwest Health taking any action allowed by law or Contract, including termination or rescission of coverage, denial of benefits, and/or pursuit of criminal charges and penalties.

SUBSCRIBER SIGNATURE:* _____ **DATE:** _____

*If signature by a personal representative of the member/enrollee, please complete the following:

Personal Representative's Name: _____

Relationship to Individual: ❒ Parent ❒ Legal Guardian† ❒ Holder of Power of Attorney†

(†Attach legal documentation if legal guardian or Holder of Power of Attorney)

SPOUSE/ELIGIBLE DOMESTIC PARTNER SIGNATURE: _____ **DATE:** _____
(If applying)

Dependent Signature: _____ **Dependent Signature:** _____
(If age 18 or over) (If age 18 or over)

In most cases, a valid application received in our office by 5:00 p.m. on the last business day of the month will be considered for an effective date of the first of the following month.

To select a later effective date, please indicate here: _____ / 01 /_____ (no more than two months from date of application).

HOW DID YOU HEAR ABOUT ASURIS NORTHWEST HEALTH?

Please check the box that best describes how you heard about Asuris Northwest Health.

❒ Asuris Group Plan ❒ Web site ❒ Seminar ❒ Producer ❒ Radio

❒ Television ❒ Newspaper ❒ Direct mail ❒ Word of mouth

❒ Other: _____

APPLICATION CHECKLIST

To ensure timely processing of your application, please review this checklist.

✓ Proof of residency may be required with all new applications. A photocopy of one of the following may be requested as proof of residency:

A. Valid Washington state driver's license or identification card.

B. Current utility bill with name and address.

✓ Did you indicate the type of coverage you are selecting in **Section 2. Type of New Coverage**? (Not required when adding dependent(s) to current coverage.)

✓ If you chose automatic bank withdrawal in **Section 3. Payment Type**, did you complete the **Subscriber Agreement for Preauthorized Bill Payment** form enclosed? Please pay your paper billing until you are notified that your electronic funds transfer has been initiated. Processing can take up to 60 days. (Not required when adding dependent(s) to current coverage.)

✓ Have you completed the **Standard Health Questionnaire** for yourself and each dependent you want to cover, if required?

✓ If you or your dependents do not have to complete the Standard Health Questionnaire, did you include the required proof (see **Section 5. Exceptions for the Standard Health Questionnaire**)?

✓ Did you complete **Section 6. Other Coverage Information**? Please provide us with documentation of current or prior coverage showing beginning and ending dates of coverage for you and/or your dependent(s) unless the current or prior coverage was with Asuris Northwest Health. Examples of documentation of coverage could include a copy of your Certificate of Coverage from your current or prior carrier. If you do not have a Certificate of Coverage, you may provide other documentation in accordance with federal law.

✓ If you and/or your dependent spouse/eligible domestic partner are non-smokers, did you read **Section 7. Non-Smoker Certification Statement** and sign, if applicable?

✓ Please read **Section 8. Release of Information** and **Section 9. Application Agreement**.

✓ Did you sign and date this application (including all family members age 18 and over) in **Section 10. Signature and Date**?

✓ If a producer is helping you complete these forms, he or she must complete the **Producer Information** section.

Do not send a rate payment with your application. You will receive a statement from us upon acceptance of your application.

PRODUCER INFORMATION

IF APPLICATION IS BEING MADE THROUGH A PRODUCER, HE/SHE MUST PROVIDE THE INFORMATION BELOW.

NOTE: Producers who do not have a current appointment with Asuris Northwest Health are not authorized to enroll members.

Producer Name	Firm or Agency	
Producer Address		Producer Telephone Number
I certify I have verified that all persons applying for coverage are eligible. I further certify, to the best of my knowledge, the information on this application and the Standard Health Questionnaire (if applicable) has been completed truthfully by the applicant(s). _____ Producer Signature _____ Date		
Producer's Washington State License Number	Expiration Date	Asuris Northwest Health Producer Number
Contact Person		

If you have a producer, that producer may receive bonuses, commissions, administrative service fees, or other compensation, including non-cash compensation, from Asuris Northwest Health. Incentives may be based on any of several factors, including the products you buy, your producer's volume of business with Asuris, and the other services your producer provides to you. These incentives may have an indirect impact on your rates. For more information, please contact your producer.