



INSURERS OF IDAHO

HEALTH INSURANCE SPECIALIST

Dear Applicant,

Thank you for choosing INSURERS OF IDAHO. We look forward to assisting you, please feel free to contact us with any questions.

☐ **I would like confirmation that you have received my application.**

☐ Please email me.

☐ Please call me.

☐ **I would like to be updated periodically on the applications status.**

☐ Please update me by email.

☐ Please call me with updates.

In most situations we can submit your application to multiple carriers. This can be beneficial for many reasons. For example company **A** might issue a policy rated because of a prescription drug for high blood pressure. Company **B** might issue a similar policy at standard rates. Submitting applications to multiple carriers insures you get the best rates, and it creates no additional obligations.

☐ **Yes, please submit my application to multiple carriers.**

Your Contact Information

Email:

Best daytime phone number:
Alternative daytime phone number:

Mail completed applications to:

Insurers of Idaho/ Applications
5660 E. Franklin Rd. Suite 300
Nampa, ID 83687



NOTICE TO APPLICANT

WILL THE PROGRAM YOU ARE APPLYING FOR REPLACE ANY OTHER ACCIDENT AND SICKNESS INSURANCE PRESENTLY IN FORCE?

- ☐ No Print Name: _____
Signature: _____
Social Security Number: _____ Date of Birth: _____
- ☐ Yes If Yes, please read and sign below.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to the application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Blue Cross of Idaho. 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.

1. Health conditions which you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits present under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent 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.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on: _____
Date

Print Name

Signature

Social Security Number: _____

Date of Birth: _____

Blue Cross of Idaho member ID number (if applicable): _____

IDAHO INDIVIDUAL APPLICATION

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

SECTION 1—ENROLLMENT INFORMATION		
Are you: ☐ a new applicant ☐ adding dependents	Are you a resident of the state of Idaho? ☐ Yes ☐ No If yes: _____ years _____ months	REQUESTED EFFECTIVE DATE <i>(subject to insurance carrier approval)</i>

SECTION 2—APPLICANT INFORMATION							
FIRST NAME				LAST NAME		MIDDLE INITIAL	
STREET ADDRESS				CITY, STATE, ZIP CODE			
MAILING ADDRESS <i>(Street, Route, P.O. Box) (if different than street address)</i>				CITY, STATE, ZIP CODE			
BILLING ADDRESS <i>(if different than mailing address)</i>				CITY, STATE, ZIP CODE			
PREFERRED PHONE NUMBER		ALTERNATE PHONE NUMBER		E-MAIL ADDRESS			
MARITAL STATUS ☐ Single ☐ Married ☐ Divorced ☐ Other <i>(explain)</i> _____		DATE OF BIRTH	AGE	GENDER ☐ Male ☐ Female	WEIGHT	HEIGHT	SOCIAL SECURITY NUMBER

SECTION 3—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). <i>Refer to Section 8.h. for dependent eligibility requirements for High Risk Pool plans. Use extra paper if necessary.</i>							
DEPENDENT'S NAMES <i>(first, initial, last)</i>	RELATIONSHIP TO APPLICANT <i>(spouse, child, etc.)</i>	DATE OF BIRTH <i>(mm/dd/yy)</i>	AGE	GENDER ☐ Male ☐ Female	WEIGHT	HEIGHT	SOCIAL SECURITY NUMBER

SECTION 4— CURRENT/PRIOR COVERAGE (For proper crediting of preexisting condition waiting periods AND Coordination of Benefits, please complete the section below.) Use extra paper if necessary.						
If any person listed on this application has been covered during the 12 months prior to the requested effective date of this application, with a 63-day or less break in coverage, please complete the following information. Please provide a Certificate of Creditable Coverage from your prior insurance carrier or other appropriate documents to establish prior creditable coverage. 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 (please use additional paper if needed) .						
To reduce the 12-month exclusion period by your creditable coverage, you should give your new insurance carrier a copy of any Certificates of Creditable Coverage you have. If you do not have a certificate, but you do have prior health coverage, you should work with your prior plan or insurer to obtain evidence of coverage. Please contact your new insurance carrier if you need help demonstrating creditable coverage.						
If you have cancelled state of Idaho individual High Risk Pool mandated plan 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.						

Other Insurance Carrier Information: Insurance Carrier Name, Policy Number, Phone Number	Policyholder Name	Names of Covered Members: Self and Dependent(s)	Coverage Start Date <i>(mm/dd/yy)</i>	Coverage End Date <i>(mm/dd/yy)</i>	Type of Coverage	Will <u>this</u> coverage continue?
					☐ Group ☐ HRP ☐ Indiv ☐ COBRA	☐ Yes ☐ No
					☐ Group ☐ HRP ☐ Indiv ☐ COBRA	☐ Yes ☐ No
					☐ Group ☐ HRP ☐ Indiv ☐ COBRA	☐ Yes ☐ No
					☐ Group ☐ HRP ☐ Indiv ☐ COBRA	☐ Yes ☐ No
					☐ Group ☐ HRP ☐ Indiv ☐ COBRA	☐ Yes ☐ No

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

SECTION 5B—HEALTH STATEMENT (If you answered Yes to any question in Section 5A, please complete the information in this section. Use extra paper if necessary.)

Question #	Person Affected	Name of Disease, Symptom or Condition	Type of Treatment	Complete Recovery? (Y/N)
	Date of Onset (mm/yy) Last Treated (mm/yy)	Name of Physician and/or Hospital	Medication Name	Frequency/Last Date Taken
Question #	Person Affected	Name of Disease, Symptom or Condition	Type of Treatment	Complete Recovery? (Y/N)
	Date of Onset (mm/yy) Last Treated (mm/yy)	Name of Physician and/or Hospital	Medication Name	Frequency/Last Date Taken
Question #	Person Affected	Name of Disease, Symptom or Condition	Type of Treatment	Complete Recovery? (Y/N)
	Date of Onset (mm/yy) Last Treated (mm/yy)	Name of Physician and/or Hospital	Medication Name	Frequency/Last Date Taken
Question #	Person Affected	Name of Disease, Symptom or Condition	Type of Treatment	Complete Recovery? (Y/N)
	Date of Onset (mm/yy) Last Treated (mm/yy)	Name of Physician and/or Hospital	Medication Name	Frequency/Last Date Taken

List any medications or drugs (that are not listed in previous sections) taken by all applicants within the past 12 months. Use extra paper if necessary.

Patient's Name	Type or Name of Drug	Dosage or Frequency of Use	Date Last Taken or Ongoing	Condition Requiring Medication	Physician's Name

35. Are you or any of your dependents listed on this application currently disabled?..... ☐ Yes ☐ No
 Name of disabled person _____ Physician's Name and Phone _____
 Date of Disability _____ Physician's Address _____
 Nature of Disability _____
36. Has any person listed on this application used a tobacco product during the past 12 months? ☐ Yes ☐ No
 If Yes, list name(s) _____ Quit date(s) _____
37. Has surgery, diagnostic testing, medical treatment or follow-up visit been advised (but not yet performed)..... ☐ Yes ☐ No
 for anyone on this application? **If Yes**, list person's name and details? _____

38. 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: _____

39. Are you or any dependent 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, specific type and details: _____

40. 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)

SECTION 6—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 in Idaho.

- You have at least 12 months of continuous creditable coverage without any break in coverage greater than 63 days
- Your most recent coverage was under a group health plan, a governmental plan or a church plan (or health insurance offered in connection with such a plan)
- You are not covered under another group health plan
- Your most recent coverage was not cancelled because you did not pay your premiums or because you committed fraud
- You are not currently eligible for Medicare or Medicaid

If you are HIPAA eligible, you will lose your right to get individual coverage without an exclusion unless you submit an application for individual coverage within 63 days after the day your group coverage or continuation coverage ends. Act promptly to protect your rights.

SECTION 7—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 preexisting 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 insurance carrier.

SECTION 8—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:

- a. No independent producer, agent or employee of the insurance carrier can change any part of this application or waive the requirement that I answer all questions completely and accurately.
- b. 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.
- c. 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.
- d. I understand that this application will become part of the contract between the insurance carrier and me.
- e. 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.

- f. The following preexisting condition exclusion applies to NON-HIGH RISK POOL (HRP) PLANS:

For individuals enrolled in a grandfathered policy effective prior to January 1, 2014, the following preexisting condition exclusion will be applied:

“A preexisting condition is (i) 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; (ii) 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 (iii) a pregnancy existing on the effective date of coverage.”

This exclusion may last up to 12 months from your first day of coverage; however, the exclusion period will be reduced by the number of days of your prior “creditable coverage.” Most prior health coverage is considered creditable coverage and can be used to reduce the preexisting condition exclusion period if you have not experienced a break in coverage of 63 days or more.

This preexisting condition exclusion **does not** apply to a child who is enrolled in the plan within 60 days after birth, adoption or placement for adoption.

The preexisting condition exclusion defined above **will not** be applied to individuals under the age of 19 years who are enrolled in a non-grandfathered plan, beginning with renewals on or after September 23, 2010, as provided in the federal Patient Protection and Affordable Care Act (PPACA).

- g. The following preexisting condition exclusion applies to HIGH RISK POOL (HRP) PLANS:

A preexisting 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.

This exclusion may last up to 12 months from your first day of coverage or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior “creditable coverage.” Most prior health coverage is considered creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days.

- h. If enrolling in a High Risk Pool plan, eligible dependents include any unmarried child who is under the age of 25 and more than ½ financially dependent on parent for support; or who is medically certified as disabled and dependent on parent for support (copy of certification required).

I understand that if I am declined coverage under the plan I am applying for, that I may be eligible for my choice of the state of Idaho individual High Risk Pool mandated plans. I also understand that I may be eligible for one of the state of Idaho individual High Risk Pool mandated 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.

SECTION 9—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 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.

Signature of Applicant _____ Date _____

Signature of Spouse _____ Date _____
(if applying for coverage)

SECTION 10—PARENTAL OR GUARDIAN CONSENT TO APPLICATION

I, the undersigned, represent that the person listed as the applicant on this application is under 18 years of age and is making application for health coverage with my full knowledge and consent. I hereby accept full responsibility for the payment of premiums and the answers and information provided in this application.

Signature _____	Print Name _____	Date (mm/dd/yy) _____
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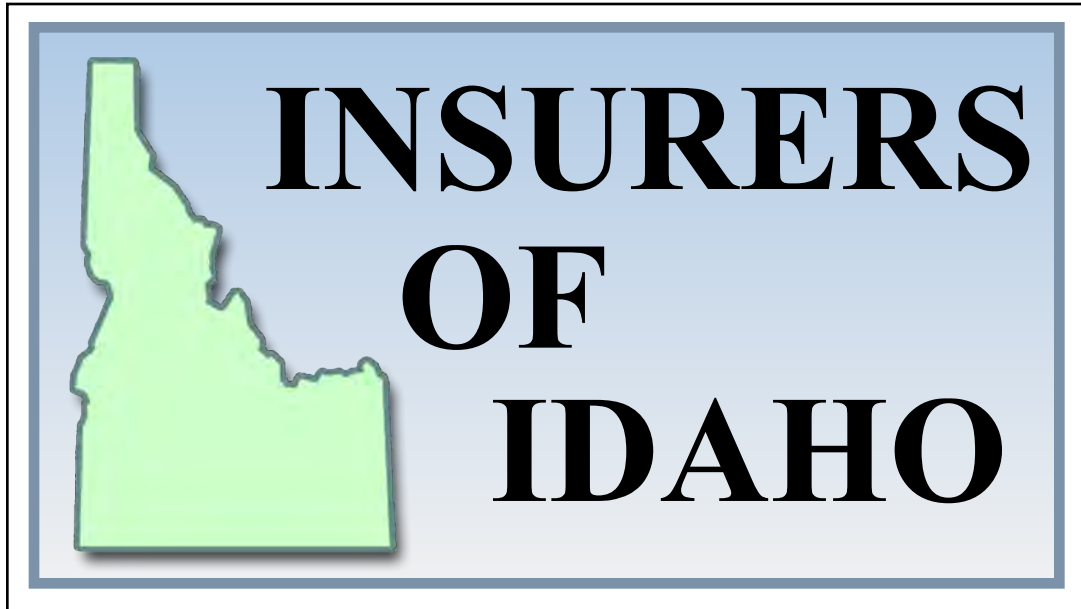
SECTION 11—AGENT INFORMATION

Agent’s Name David J. Watton ID No. 6297BC

Signature of Agent _____ Date _____

Additional Application Information

Additional Application Information



CERTIFICATE OF DIGITAL SECURITY

This health insurance application has been digitally signed by the person indicated below at the indicated time and date. We have kept a record of the digital signature for future verification.

Name:

Date:

Time:

Document ID:

Document Verification Key: