Questions? Call us at CDA Insurance LLC: 1.800.884.2343

Tips for completing the application:

1. Please read everything carefully and answer all questions honestly. This document becomes part of your health insurance contract.
2. Please complete all sections to the best of your ability. Remember to fill out the Washington Standard Health Statement. ***One statement per person applying for coverage***. This may not be required, please refer to the Standard Health Questionnaire for who is exempt from completing the questionnaire. Please pay special attention to the Health History Section.

Prior Insurance?

Yes: Please make a photocopy of your health insurance card(s) or contact your insurance carrier and request a “Certificate of Credible Coverage.” Include this with your application.

No: If your application is approved, when the policy is sent to you, there will be a form that will need to be a 9 month waiting period on pre-existing conditions. There is a 12 month waiting period for Transplants.

Payment:

Monthly Bank Draft:
Please complete the Automatic Funds Transfer (section 5) carefully and attach a voided check or a savings account deposit slip.
Direct Bill:
Simply check Monthly and you are done.

Final check list before mailing:

- All sections completed including the Washington State Standard Health Questionnaire (if required)
- Copy of your Certificate of Credible Coverage (to waive the pre-existing conditions clause)
- Proof of Residency (Valid Washington Drivers License or ID card, Voter registration card or current utility bill in your name, including address
- Signed and Dated
- Voided check if selecting the automated monthly withdrawal

Send Completed Application to:

CDA Insurance LLC
P0 Box 26540
Eugene, 0regon 97402

Washington Individual Enrollment Application

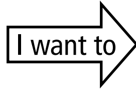
Effective January 1, 2012 (Non-grandfathered)

Please print your answers clearly in 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 application and may cause a delay in the effective date of your coverage, except for sections marked "optional."

1 My Enrollment Information

☐ I am a new applicant

☐ I am a current member
My subscriber ID# is ____________ (see your ID card)



☐ add my spouse ____________ (marriage date) or domestic partner

☐ add my newborn or newly-adopted child(ren): ____________ (placement date)

☐ add my dependent child(ren)

☐ change my plan

☐ Yes ☐ No If you or your dependents are under the age of 19 and applying outside an open enrollment period, was there a qualifying event that meets the criteria for loss of coverage? (See Section 2 for more information.)

☐ Yes ☐ No If any applicant(s) are not accepted for coverage, do you want us to enroll those who are eligible for the plan you select?

If you answer "No," your dependents under the age of 19 will **not** be eligible for coverage again until the next open enrollment period (unless they experience a loss of coverage—see Section 2).

2 Am I Eligible?

You're eligible to apply for a Premera plan if you are:

- A resident of and have a principal residence in the state of Washington.
- 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.

If you are a previous Premera Blue Cross individual plan member that has lost medical coverage due to non-payment or cancelled on or after September 1, 2011 and are age 19 or older, you are only eligible if it has been at least 12 months since your last date of Premera coverage. This provision does not apply to applicants under the age of 19.

Applicants 19 years of age or older can apply anytime throughout the year. For applicants under the age of 19, please refer to the table below to determine when you are eligible.

Age of Applicant or Dependent	Additional Information
a) 19 years of age and older	Applicants that are 19 years of age and older can apply for coverage as a subscriber or dependent anytime.
b) Under the age of 19	Applicants under the age of 19 can apply as a subscriber or dependent during an open enrollment period.
c) Under the age of 19 who have experienced a qualifying event	Applicants under the age of 19 with a qualifying event can apply within 31 days of when prior coverage ended. Review the top of page 2 for a list of qualifying events.
d) Newborns or newly-adopted children	Newborns or newly-adopted children can apply as a subscriber or dependent outside an open enrollment period within the first 60 days of birth or placement. Outside of the first 60 days, the criterion associated with "under the age of 19" applies as described above.

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

Producer #:

2 Am I Eligible? (continued)

Open Enrollment Periods (only applies to applicants under the age of 19)
An open enrollment period is the timeframe set by the state of Washington when applicants under the age of 19 can enroll. Please refer to **premera.com** for the dates of an open enrollment period. The completed enrollment application must be postmarked or received electronically before the end of the open enrollment period.

Qualifying Events (only applies to applicants under the age of 19)
Applicants under the age of 19 can apply outside of an enrollment period if they experience certain qualifying events. Refer to the table below to determine if your situation qualifies and the documentation you must submit as proof.

Qualifying Events (Application must be received within 31 days of the qualifying event)	**Submit a Copy of the Following Document(s)** (Supporting documents must be received within 31 days of the qualifying event)
A loss of employer sponsored coverage	Your COBRA offer letter **or** a letter from your employer listing each applicant that experienced a loss of coverage.
A loss of Medicaid or other public program providing health benefits	The letter from Medicaid or other program indicating ineligibility **or** loss of coverage.
A loss of coverage due to a dissolution of marriage	The divorce decree **or** annulment paperwork.
A loss of coverage due to a change in residence and your existing health plan does not provide coverage in your new area.	A utility bill from your prior address within the last 90 days **and** a verification letter from your prior carrier.
Loss of COBRA benefits	Your Certificate of Creditable Coverage from your prior carrier showing 18 months of coverage **or** a letter from your prior employer or administrator indicating loss of COBRA benefits.

3 I want to enroll my…

Self (Last, First, Middle Initial)	Social Security Number (optional)	Gender: ☐ M ☐ F
	Date of Birth / /	**I used tobacco in the last 12 months:** ☐ Y ☐ N
Legal Spouse or Domestic Partner (Last, First, Middle Initial)	Social Security Number (optional)	Gender: ☐ M ☐ F
	Date of Birth / /	**I used tobacco in the last 12 months:** ☐ Y ☐ N
Dependent Child—under 26 only (Last, First, Middle Initial)	Social Security Number (optional)	Gender: ☐ M ☐ F
	Date of Birth / /	
Dependent Child—under 26 only (Last, First, Middle Initial)	Social Security Number (optional)	Gender: ☐ M ☐ F
	Date of Birth / /	
Dependent Child—under 26 only (Last, First, Middle Initial)	Social Security Number (optional)	Gender: ☐ M ☐ F
	Date of Birth / /	
Dependent Child—under 26 only (Last, First, Middle Initial)	Social Security Number (optional)	Gender: ☐ M ☐ F
	Date of Birth / /	

Home Address (not P.O. Box) **required**	City / State / ZIP	County	Home Telephone Number ( )
Mailing Address (if different from Home Address)	City / State / ZIP	County	Work Telephone Number ( )
Billing Address (if different from Mailing Address)	City / State / ZIP	County	Cell Telephone Number ( )
E-mail Address of Primary Applicant			

4 Selecting my plan

I want this plan to begin on the ☐ 1st **or** ☐ 15th of ____________ (enter month) (no more than 60 days after the application is signed)
Effective dates for plan changes are on the first of each month.

Health Plan

Currently there is one plan option available: (check box)

Preferred 35 plan	→	☐ $1,800 deductible

5 Paying for my health plan (select one) Don't send payment

A government agency or any other third party may not sponsor or pay for your individual health plan, except as required by law.

☐ Monthly paper bill by mail (move on to Section 6)

☐ Automatic monthly withdrawal from my bank account. Here's my account information:

I have selected automatic monthly withdrawal and I hereby authorize Premera to initiate funds transfer from the bank or financial institution account indicated below. I authorize my financial institution to honor these transfers.

Account Holder's Name (print)	Financial Institution or Bank Name	
Financial Institution/Bank City, State, ZIP		☐ Checking ☐ Savings
Bank Routing Number (see picture below, number cannot begin with a "5")	Account Number (see picture below)	

⑆123456789⑆ 9876543210⑈ 0001

Bank Routing Number Account Number

Attach your voided check HERE

Additional Terms and Conditions:

- Funds are transferred on the 1st business day of each month to pay for that month's coverage. (For example, the deduction on February 1st pays for coverage in February.)
- I understand that if I choose the 15th of the month as my effective date, my first transfer amount will cover 15 days of the current month PLUS the next full month. The next transfer will not occur until the second full month of coverage.
- I understand that my monthly subscription charges will be automatically withdrawn from my bank account each month until I notify Premera that it should be cancelled. To ensure prompt cancellation, I must notify Premera no later than the 20th of the month to be effective for the following month's automatic withdrawal. I have the right to stop payment of a specific bank transfer at least 3 days prior to the next scheduled withdrawal date.
- It may take as long as 45 days to set up the funds transfer. I may receive a paper bill to cover the initial month(s) while the transfer is being set up.

Account Holder Signature X ______________________ **Date of Signature** ____ / ____ / ____

6 Do I need to complete a Standard Health Questionnaire (SHQ)?

This section is for applicants 19 years of age and older. It does not apply to applicants under the age of 19.

Each applicant 19 years of age or older must complete a Standard Health Questionnaire unless one of the following circumstances applies. For a detailed explanation on these exclusions, please refer to the first few pages of the Standard Health Questionnaire.

Important!
Unless you are positive that you satisfy one of these conditions, we need a SHQ from each applicant you want to enroll.

Check only one box if applicable. Be sure to attach your evidence of coverage based on the box you check below.

My Situation	Submit the Following Documents
☐ **Relocation:** I changed residences from one part of Washington to another and my previous health plan doesn't cover my new area of residence.	• A copy of a utility bill in your name from the prior address that's dated within the last 90 days; **AND** • A verification letter from your prior carrier verifying that you no longer reside in their service area
☐ **Provider cancellation:** My physician or other healthcare provider left my previous Individual health plan's provider network within the past 90 days but is a provider in the Premera network.	• A letter from your healthcare provider indicating that he/she has stopped being part of your current individual health plan's provider network within the last 90 days. This letter should also indicate: – That you have received services from that provider within the last 12 months prior to leaving your current health plan – The date the provider left the network – That your provider is part of Premera's provider network
☐ **COBRA** (not applicable to WA State Basic Health Plan applicants): In the past 90 days of the date of this application, I have: • exhausted my COBRA continuation coverage; • terminated my COBRA continuation coverage and had at least 24 months of continuous coverage; **OR** • experienced a COBRA qualifying event and I am choosing not to elect COBRA. I have also had at least 24 months of continuous coverage.	• The Certificate of Coverage you received from your prior carrier showing 24 months of continuous coverage; **OR** • A letter from your prior employer indicating one of the following: a) you've exhausted COBRA coverage, b) you've terminated COBRA coverage, c) you've elected not to take COBRA coverage and the date of your COBRA qualifying event
☐ **Employer is exempt from offering COBRA:** In the past 90 days, I had a COBRA qualifying event that caused me to be terminated from my employer's group health plan. I was on this group coverage for at least 24 continuous months. My employer is exempt from offering COBRA so I'm seeking Individual health coverage.	• A letter from your employer or former employer indicating the start and end dates of your group coverage (including church plans), the date of the COBRA qualifying event, and that the employer group is not eligible for COBRA; **OR** • The Certificate of Coverage showing 24 months of continuous group coverage
☐ **WA State Basic Health Plan:** I'm applying within 90 days of losing my government-sponsored Washington Basic Health Plan coverage that I've had for at least 24 months. This does not include DSHS or Medicaid plans.	• A letter of verification from your prior carrier indicating that you were covered under WA State Basic Health Plan and your start and end dates of coverage showing 24 months of eligibility with WA State Basic Health Plan; **OR** • The Certificate of Coverage indicating the start and end dates of your WA State Basic Health Plan coverage.
☐ **Newborn/newly-adopted child addition:** I'm adding my newborn or newly-adopted child to my existing Premera plan, within 60 days of the birth or placement for adoption.	• A copy of the adoption or placement paperwork
☐ **Employer Business Closure:** I am applying within 90 days from the date my employer discontinued or will discontinue group health plan coverage due to business closure. I was on this group coverage for at least 24 continuous months, and I am requesting an effective date within 90 days of my group health plan being discontinued.	• A verification letter from your prior carrier with your start and end dates of coverage showing 24 months of eligibility; **AND** • A letter from your employer/former employer indicating the date of expected business closure.

Need additional copies of the Standard Health Questionnaire? You can download a copy from the "Forms" section on premera.com, call Premera Customer Service at 800-752-6663 or contact your producer to have one mailed to you.

7 My Prior Health Coverage

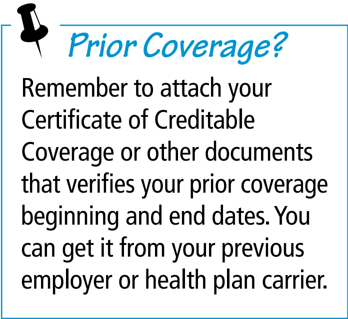
Have you had coverage in the past 9 months?

☐ Yes (complete the information below) ☐ No (move on to Section 8)

Do you intend to continue this current coverage if you are accepted by Premera?

☐ Yes ☐ No (Once accepted by Premera, remember to cancel your current health plan, including our corporate affiliates.)

By reporting your prior coverage, we may waive or credit the nine-month waiting period for pre-existing conditions. To help us determine if you qualify, please complete the following information. We must receive this completed application within 63 days of your prior coverage ending. See Section 14 for other provisions about waiting periods.



Prior Coverage?

Remember to attach your Certificate of Creditable Coverage or other documents that verifies your prior coverage beginning and end dates. You can get it from your previous employer or health plan carrier.

Name of Your Previous or Current Health Plan Carrier	Telephone Number ( )
Name of Subscriber (contract holder)	Subscriber ID # (include 3 letter prefix if applicable)
Names of All Enrollees on Prior Coverage	
Date Coverage Began / /	**Date Coverage Ended** / /
Deductible Amount (Circle one) $ individual / family per year	Out-of-Pocket Maximum (Circle one) $ individual / family per year
Type of Coverage ☐ Individual ☐ Group ☐ Healthy Options ☐ Basic Health Plan ☐ WSHIP	Type of Benefits (check all that apply): ☐ Medical ☐ Hospital Only ☐ Accident Only ☐ Prescription Drug ☐ Dental ☐ Vision

8 Health Information (optional)

To identify applicants who may benefit from our health management programs, please complete the following questions.
Note: *Do not list individuals who will not be enrolled for coverage.*

☐ Yes ☐ No Do you or any dependents applying for coverage have a disability, chronic health condition (i.e., diabetes, heart condition, etc.), or been advised in the last 12 months that hospitalization, surgery or treatment is needed or pending?

If you answered "Yes," please provide details below:

Name (first, last)	Describe the condition

9 Basic Terms of Enrollment

1) I understand and agree that this application is not an offer of coverage, and coverage does not begin until: a) This application is received, reviewed, and accepted by Premera and an effective date of coverage is assigned; and b) My complete and correct payment is received. Submission of this application does not guarantee I will receive coverage.
2) I understand and agree that this application becomes a part of my plan and to the extent that the application is inconsistent with the plan, the plan will govern.
3) I understand that this plan has a nine-month waiting period for pre-existing conditions. No benefits are provided for any medical condition for which treatment was received (or recommended), or for which a prudent person would have sought advice or treatment within the six months prior to the effective date of this plan. This waiting period does not apply to: Individuals under the age of 19, formula for treatment of phenylketonuria, and prenatal care (if the plan provides benefits for this). This waiting period may be credited or waived based on prior healthcare coverage.
4) I understand that this plan will not provide benefits for organ and bone marrow transplants for a period of 12 months from the effective date of my coverage. This waiting period may be credited or waived based on prior health care coverage.
5) I understand that no benefits are available under this plan for services or supplies related to an inpatient confinement that began prior to the effective date of coverage, unless the applicant is an "eligible individual" as defined by Federal law.
6) I understand that acceptance for coverage is dependent on: a) Persons listed on this application must be residents of the state of Washington in order to apply for and maintain coverage under this plan; and b) No one listed on this application is 65 years of age or older and eligible for Medicare on the date coverage would begin. "Resident" means a person who lives in the state of Washington, and intends to live in the state permanently or indefinitely. In no event will coverage be extended to an applicant who resides here for the primary purpose of obtaining healthcare coverage. The confinement of a person in a nursing home, hospital or other medical institution shall not by itself be sufficient to qualify such person as a resident. Premera may require proof of residency from time to time. Such proof shall include, but not be limited to, the street address of the individual's residence and not a post office box.
7) I understand and agree that only Premera may: a) Make or modify the terms of the application or contract; or b) Waive any of the Premera rights or requirements. I understand that I may receive benefits which are less than the amount billed by my provider when treatment is not received from a contracted provider.
8) I understand and agree that this coverage is issued as individual health coverage, is not sold or issued for use as a government, or third party sponsored health plan, and is not partially or fully paid for by a government agency or third party payer, either directly or indirectly, except as required by law.

10 Notice of Information Use and Disclosure

Type of Information to be Disclosed: I (We) authorize: any physician, health care provider, hospital, insurance or reinsurance company, pharmacy benefits manager or third party benefits administrator to disclose a copy of my (our) personal health information, including any and all diagnostic, procedural, treatment, claim, prescription or other health related information including records concerning alcohol and/or chemical dependency, reproductive health (including abortion), sexually transmitted diseases, HIV, AIDS, psychiatric disorders, mental illness to Premera or its representatives as allowed by law.

Purpose of Disclosure: I (We) understand that personal information will be used for underwriting, evaluating enrollment in the health plan, determining eligibility for benefits and paying claims.

Timeframe of Release: Unless I revoke it, this release will remain valid for twenty-four (24) months from the date of my signature below.

Revocation of Release: I understand that I may change my mind and revoke this release at any time. I will do this by letting Premera know of my decision. Any change will be effective five (5) business days after Premera receives my written notice at the address listed on this form. I understand that some or all of this information may already have been used by Premera to make decisions, which will not be affected by its revocation.

Redisclosure: Premera Blue Cross may be required to redisclose this information to another party that is not subject to state and federal privacy rules.

Effect of Not Authorizing: This authorization is a condition of your enrollment in our health plan or your eligibility for benefits. If you decide not to sign this authorization, we may decline to enroll you in our health plan or to give you benefits.

Please Note: You or your authorized representative will receive a copy of this authorization.

11 My final checklist:

Omissions or incomplete answers will result in the return of your application and may cause a delay in the effective date of your coverage, except for sections marked as "optional."

Did I remember to:

- ☐ Indicate in Section 3 whether my spouse/domestic partner or I use tobacco? This will ensure I pay the correct rate.
- ☐ Choose an effective date in Section 4?
- ☐ Complete a Standard Health Questionnaire for each applicant over the age of 19 unless one of the criteria listed in Section 6 applies?
  - ☐ If one of the criteria listed in Section 6 applies, did I attach evidence of my exemption qualification based on my selection in Section 6?
- ☐ Attach my Certificate of Coverage or other documentation as evidence of my prior coverage if I completed Section 7?

Remember to have all applicants age 18 or older sign this application in Section 12.

12 Signatures

I hereby apply for enrollment with Premera for myself and family members listed on this application for coverage under the Individual contract indicated on this form. I understand I will have the right to examine and return the contract within 10 days of its delivery to me. I certify that:

a) I have read this form, agree to its terms and I have supplied all of the required information on this form.

b) I have received and read a product information packet containing plan summaries and understand that a complete list of exclusions and limitations is detailed in the contract. If there is a conflict, the terms of the contract prevail.

c) I declare that, to the best of my knowledge, all of the information on all forms necessary for enrollment is true and complete, and that all of the persons for whom I am requesting enrollment are eligible for coverage. I understand that, if I have made false, incomplete, or misleading statements or answers on behalf of myself or any family members, all entitlements to benefits are void and this contract may be cancelled or modified retroactively to its effective date. I further understand that it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Approved applications postmarked or received by the 14th day of the month will be effective on the 15th of that month. A prorated subscription charge will apply for the partial month of coverage. Approved applications postmarked or received by the last day of the month will be effective on the first day of the following month. This does not apply to applicants enrolling during open enrollment.

Important! Signatures are required for all applicants age 18 or older.

Signature	Date of Signature
Signature of Primary Applicant (Parent/Legal Guardian) X	Date of Signature / /
Signature of Spouse/Domestic Partner X	Date of Signature / /
Signature of Dependent Child age 18 or older X	Date of Signature / /
Signature of Dependent Child age 18 or older X	Date of Signature / /

Mail completed application to:

Premera Blue Cross
PO Box 91120, MS 295
Seattle, WA 98111-9220

800-752-6663 Individual Plan Sales
800-722-1471 Customer Service

premera.com

➔ **Please return this page.** ➔

13 Your Household Information (optional)

The following information is collected for statistical purposes only, and is not used to determine your eligibility for coverage.

Total Number Of Individuals In Household (includes those not applying for coverage): ______

Household Income (check one):

☐ $0 to $19,999	☐ $20,000 to $39,999	☐ $40,000 to $59,999
☐ $60,000 to $74,999	☐ $75,000 to $99,000	☐ $100,000 or more

14 HIPAA Eligibility Requirements

If you meet all the requirements described below (excerpted from the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, 42 U.S.C. 300gg-41b), you may be considered an "eligible individual" for having waiting periods for pre-existing conditions and creditable coverage waived or credited.

- You have had 18 or more months of prior health care coverage, the most recent of which was through a group, governmental, or church health plan, with no lapse in coverage of more than 63 days.
- You are not eligible for Medicare or any other group coverage.
- You were not terminated from prior coverage due to nonpayment of premiums or fraud.
- You are either ineligible for COBRA or state continuation coverage, or if eligible, have exhausted that coverage.

Completion of this section BY THE PRODUCER is required if the producer wishes to be considered as producer of record for the applicant. All producer information must be provided below to ensure credit/commission for the application.	
Agency Name [illegible]	
Producer Name [illegible]	Premera Producer Number [illegible]
Producer Address [illegible]	
Producer Telephone Number [illegible]	Producer E-mail Address [illegible]
Producer Signature X	Date / /
Please Note: Producers who do not have a current appointment with Premera are not authorized to offer Premera products.	

Please return this page.