Questions? Call us at CDA Insurance LLC at 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:

The payment options are monthly bank draft or direct bill.

Monthly Bank Draft:
Please complete the Surepay Authorization section carefully and attach a voided check.
Direct Bill:
Simply check either Monthly or Quarterly, 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

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

Regence BlueShield
1800 Ninth Avenue
Seattle, Washington 98101
Mail form to: PO Box 1106, MS-LB1
Lewiston, ID 83501

Individual Application

Please read carefully and make sure all sections of the application are answered completely. Use ink to complete, sign and date the application to avoid having it returned to you.

SECTION 1 - ELIGIBLE TO APPLY FOR COVERAGE?

1. Applicants **19 years of age or older** can apply any time throughout the year. If you are currently eligible for Medicare, or will be on the requested effective date of coverage for which you are applying, you are not eligible for private individual or family health coverage and should not fill out this application.

   Eligible family members who are **under age 19** can apply for coverage at the open enrollment period defined in rules from the state insurance department. The annual open enrollment periods are currently:
   - **March 15th** through **April 30th**
   - **September 15th** through **October 31st**

2. **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. A photocopy of a valid Washington state driver's license, identification card, or similar proof of residency acceptable to Regence BlueShield may be requested.

For more information, or to see if there are exceptions to the open enrollment period for which you may qualify, please contact your producer or call our Sales department toll-free at 1-888-REGENCE (1-888-734-3623).

SECTION 2 - EFFECTIVE DATE

Your application is subject to review and approval by Regence BlueShield. Complete applications received in our office by 5:00 PM Pacific Time on the last business day of the month will be eligible for an effective date of the first of the following month, unless otherwise indicated. Incomplete applications may receive a later effective date.

Requested Effective Date ____________________

SECTION 3 - TYPE OF APPLICATION (check one)

☐ **New enrollment** (applying to become a new Regence member)
☐ **Addition of a spouse/domestic partner and/or child to my existing policy**
☐ **Change to existing individual plan or deductible** (existing Regence member applying to change benefit plans)

Note: Your policy must be paid current in order for a plan change to be made. If your policy cancels due to non-payment, you will need to reapply by submitting a new Individual Application.

SECTION 4 - ENROLLMENT INFORMATION

List all eligible family members to be covered. Eligible family members include a spouse/domestic partner, and/or any child who is under age 26 or who is medically certified as disabled. Copy of certification required.

Last Name	First Name, MI	Relationship to Subscriber	Gender	Age	Height	Weight	Birthdate	Social Security Number
		Subscriber						
		☐ Spouse ☐ Registered Domestic Partner ☐ Non-Registered Domestic Partner*						

*Non-Registered Domestic Partners must submit an Affidavit of Domestic Partnership

SECTION 5 - ADDRESS AND PHONE NUMBER

Residence Street Address		Mailing Address (if different than residence street address)
City, State, ZIP Code	County	E-Mail Address (will not be disclosed outside of the company)

Home Phone Number	Cell Phone Number	Work Phone Number
( )	( )	( )

SECTION 6 - MEMBER CARD (check one)

☐ **Family Level Card** (all members listed on the same card)
☐ **Member Level Card** (each member on a separate card)

SECTION 7 - PLAN SELECTION (Detailed benefit information can be found online at regence.com)

MEDICAL PLANS (check one) 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 pre-existing 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 pre-existing waiting period, should you later change to another individual health plan. **The pre-existing waiting period may not apply to any members under the age of 19.**

Evolve Core

Deductibles are per member (maximum of 3 deductibles per family)

☐ $2,500 - Catastrophic ☒ $5,000 - Catastrophic ☐ $7,500 - Catastrophic ☐ $10,000 - Catastrophic

Evolve Plus

Deductibles are per member (maximum of 3 deductibles per family)

☐ $1,000 - Comprehensive ☐ $2,500 - Catastrophic ☐ $5,000 - Catastrophic ☐ $7,500 - Catastrophic

Evolve HSA

Self-Only Deductibles	Family Deductibles
☐ $2,000 with 50% coinsurance - Catastrophic	☐ $4,000 with 50% coinsurance - Catastrophic
☐ $2,000 with 80% coinsurance - Catastrophic	☐ $4,000 with 80% coinsurance - Catastrophic
☐ $3,500 with 50% coinsurance - Catastrophic	☐ $7,000 with 50% coinsurance - Catastrophic
☐ $3,500 with 80% coinsurance - Catastrophic	☐ $7,000 with 80% coinsurance - Catastrophic

Evolve HSA 100

☐ $5,000 self-only deductible - Catastrophic ☐ $10,000 family deductible - Catastrophic

DENTAL OPTIONS (check one)

☐ **No Dental**
☐ **Dental Option 1** - 100/80/50; $750 annual maximum benefit that may increase over time to $1,500
☐ **Dental Option 2** - 100% of first $200 and 50% of next $1,100 ($750 annual maximum benefit)

SECTION 8 - OTHER COVERAGE INFORMATION

1. Do you or any family members have other active health or medical coverage? ☐ Yes ☐ No
   If yes, do you intend to replace your current plan with this contract? ☐ Yes ☐ No
2. Are you currently enrolled in an Regence BlueShield Individual medical plan and wish to cancel that coverage? ☐ Yes ☐ No

   If you answered yes, please sign the statement below:

   I wish to terminate my current individual medical coverage from Regence BlueShield on the effective date of this new individual policy.

   Signature ____________________ Date ____________________

Regence BlueShield Individual Plans contain a 9-month pre-existing condition limitation period. The pre-existing waiting period may not apply to any members under the age of 19. Please provide the following information for all applicants, 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. If current coverage is still active, the Certificate of Coverage can be provided at a later date.

Name (First, Last)	Insurance Company	Policy Number	Dates of Coverage		Type of Coverage
			Date Coverage Began mm/dd/yyyy	Date Coverage Ended (indicate active if you are currently covered) mm/dd/yyyy	• Employer Group • Individual • Medicare • COBRA • High Risk Pool • Other (describe)
1.					
2.					
3.					

Deductible=$ __________ per individual/per year Out-of-pocket (stoploss)=$ __________ per individual/per year

Deductible=$ __________ per family/per year Out-of-pocket (stoploss)=$ __________ per family/per year

SECTION 9 - DO YOU NEED TO COMPLETE A STANDARD HEALTH QUESTIONNAIRE (SHQ)?

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 of these exclusions, please refer to the first few pages of the Standard Health Questionnaire.

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

CIRCUMSTANCE FOR EXEMPTION OF SHQ	SUBMIT THE FOLLOWING DOCUMENTS
☐ **1. You are under 19 years of age:**	Contact your producer, or call our Sales department at 1-888-REGENCE (1-888-734-3623) or the OIC Consumer Hotline at 1-800-562-6900, for information on special open enrollment periods for children under 19 and coverage options outside of special enrollment periods. • Child or subscriber through whom he/she was covered loses employer-sponsored insurance. Please provide a certificate of coverage showing coverage end date within 31 days. • Child or subscriber loses Medicaid or other public health benefit plan eligibility. Please provide a letter or a certificate of coverage showing coverage end date within 31 days. • Child or subscriber through whom he/she was covered loses coverage as a result of dissolution of marriage. Please provide court documents indicating divorce caused loss of coverage within 31 days. • Child or subscriber through whom he/she was covered changed residence and the health plan through which they were covered does not provide coverage in that service area. Please provide a copy of a utility bill from your prior address dated within the last 31 days. A letter from your prior carrier is needed to verify that because you have moved, you no longer reside in their service area and they cannot provide health insurance at your new location. • Child or subscriber born or adopted within 60 days from date of birth or date of placement. Please provide adoption paperwork indicating date of placement.
☐ **2. 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 relocation.	• 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.

☐ **3. Provider Cancellation:** Your physician or other healthcare provider left your previous individual health plan's provider network within the past 90 days and is a provider in the Regence BlueShield provider 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 Regence BlueShield's provider network.

☐ **4. COBRA Exhaustion:** You are applying for individual health coverage within 90 days of using up your COBRA coverage. (This includes loss of COBRA coverage due to your employer going out of business or discontinuing its health plan while you are on COBRA).	• A letter from the COBRA administrator or your prior carrier verifying that you have exhausted your Federal COBRA benefits, **OR** • A letter of certification from your employer or carrier indicating that the company is going out of business or discontinuing its health plan while you were on Federal COBRA.

SECTION 9 - DO YOU NEED TO COMPLETE A STANDARD HEALTH QUESTIONNAIRE (SHQ)? - continued

CIRCUMSTANCE FOR EXEMPTION OF SHQ	SUBMIT THE FOLLOWING DOCUMENTS
☐ **5. Employer is exempt from offering COBRA:** You have been covered by a group plan provided by an employer that is exempt from COBRA, and you are applying for individual health coverage within 90 days of an event which would qualify you for COBRA if your employer had not been exempt from COBRA, and you had at least 24 months of continuous group coverage prior to such event.	◆ A certificate of coverage from the prior insurance carrier showing proof of 24 or more months continuous group coverage; **AND** ◆ A letter from your employer or former employer indicating the COBRA qualifying event, the date of the COBRA qualifying event, and that the employer is not eligible for COBRA.
☐ **6. COBRA Termination:** You are applying for individual health coverage within 90 days of terminating your COBRA coverage and you had at least 24 months of continuous group coverage prior to termination. (Not applicable to BHP applicants.)	◆ A letter from your COBRA administrator verifying you are currently on Federal COBRA; **AND** ◆ A certificate of coverage from your prior insurance carrier showing proof of 24 or more months of continuous group coverage.
☐ **7. COBRA Eligible:** You are applying for individual health coverage 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 choose not to take COBRA coverage. (Not applicable to BHP applicants.)	◆ A certificate of coverage from the prior insurance carrier showing proof of 24 or more months continuous group coverage; **AND** ◆ A letter from your employer or former employer indicating the COBRA qualifying event, the date of the COBRA qualifying event, and that the employer is eligible for Federal COBRA or a Federal COBRA election notice.
☐ **8. WA State Basic Health Plan:** You have been enrolled in the Washington State Basic Health Plan for at least 24 continuous months, and you are submitting your application within 90 days of disenrollment.	◆ A letter of verification from your WA State Basic Health Plan carrier indicating your start and end dates of coverage showing proof you were covered for 24 continuous months.
☐ **9. Newborn/newly-adopted child addition:** You are adding your newborn or newly-adopted child to your existing Regence BlueShield plan within 60 days of the birth or placement for adoption.	◆ If adding a Newborn: no additional paperwork is necessary. ◆ If adding a Newly-Adopted Child: A copy of the adoption or placement paperwork showing the date of placement.
☐ **10. Employer Business Closure:** You are applying within 90 days from the date your employer discontinued or will discontinue group health plan coverage due to business closure. You were on group coverage for at least 24 continuous months, and are requesting an effective date within 90 days of your group health plan being discontinued.	◆ A certificate of coverage from your prior insurance carrier showing proof of 24 or more months continuous group coverage; **AND** ◆ A letter from your employer/former employer indicating the date of expected business closure.

SECTION 10 – PREMIUM BILLING OPTIONS (if application is approved)

BILLING ADDRESS (Complete only if billing should be sent to an address other than the Residence Street or Mailing Address listed in Section 5 of the application.)

Name (First, Last)	
Address	City, State, ZIP Code

☐ Yes ☐ No Is your employer reimbursing or paying for any portion of this policy's premium? Individual benefit plans are not intended for sale as an employer-sponsored health benefit plan for employees.

PAYMENT OPTIONS (check one):

☐ Monthly Billing ☐ Quarterly Billing

☐ Surepay (premium is automatically deducted from your bank account on the 5th of each month).

It may take 45 - 90 days from the approval of your application to set up Surepay. To cover initial month(s) you will receive an invoice and need to make your payment by check in order to keep your account paid current.

If selecting the **Surepay** 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.*

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 BlueShield, Seattle, Washington. 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 11 - PRODUCER CERTIFICATION

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

FOR PRODUCER USE ONLY

I, (the producer) certify I have explained the eligibility provisions to the applicant. I have not made any statements about benefits, conditions or limitations of the contract except through written material furnished by Regence BlueShield. I have informed the applicant that the effective date of coverage is assigned only by Regence BlueShield. **I CERTIFY THAT THE INFORMATION SUPPLIED TO ME BY THE APPLICANT HAS BEEN TRULY AND ACCURATELY RECORDED HERE.**

Producer Name (please print or type)		Regence Producer Number
[illegible]		[illegible]
Producer's Mailing Address	Producer's E-mail Address	Producer's Phone Number
[illegible]	[illegible]	[illegible]
Producer's Signature (Required) X		Date (Required)

SECTION 12 - NON-SMOKER CERTIFICATION STATEMENT

Have you 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? **Applicant** ☐ Yes ☐ No **Spouse/Domestic Partner** ☐ Yes ☐ No

PLEASE NOTE: Regence 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.

SECTION 13 - CERTIFICATION, AUTHORIZATION AND SIGNATURE

Be sure to **sign** and **date** this application. Spouse/Domestic Partner and/or child's (age 18-25) signature is required, if applicable. Signature applies to both "Certification of Completion and Correctness" and "Authorization for Use and Disclosure of Protected Health Information".

Certification of Completion and Correctness

I affirm that the answers given in this application are complete and correct. I am providing these answers as part of the application procedure required by Regence BlueShield to enroll in their coverage. I understand that Regence BlueShield will rely on each answer in making coverage and rating determinations. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. If coverage is rescinded for fraud or intentionally misleading statements, Regence BlueShield will reimburse premium less any claims paid and will pursue reimbursement for claims paid exceeding any premium. I will promptly inform Regence BlueShield in writing if anything happens before my coverage takes effect that makes this application incomplete or incorrect. I understand and agree that no coverage shall be in force until approved by Regence BlueShield. Regence BlueShield may contact me to clarify answers on this application. As the applicant, I understand I have the right to inspect the information in my file.

Authorization for Use and Disclosure of Protected Health Information

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the application form) from time to time 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 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 authorization may not be used for psychotherapy notes** (notes recorded and separately maintained by a mental health professional documenting or analyzing the contents of a conversation during a counseling session). A separate authorization will be required.

* For more information about such uses and disclosures, 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** or by telephone request at **1 (800) 365-3155.**

SIGNATURES

Signature of applicant, parent or legal guardian if applicant is under 18 years of age or legally incompetent * **X**	Relationship	Date
Signature of applicant's legal spouse or eligible domestic partner * **X**		Date
Signature of child between 18 and 25 years of age * **X**		Date
Signature of child between 18 and 25 years of age * **X**		Date

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

Personal Representative's Name (please print)______________________________

Relationship to Individual ______________________________ (Attach legal documentation if other than parent of a minor child)

If additional health information is required to qualify you or a family member for coverage, we may send you a separate authorization form for the purpose of obtaining medical information.