# Washington Individual Enrollment Application

P.O. Box 91120
M.S. 295
Seattle, WA 98111-9220

LIFEWISE | HEALTH PLAN OF WASHINGTON

Please read all accompanying material before completing this application. **All questions must have complete and accurate answers.** Omissions or incomplete answers will result in the return of your application and may cause a delay in the effective date of your coverage. Please **PRINT**, sign and date in ink. You must be a resident of the state of Washington, and not eligible for Medicare to apply.

## SECTION 1 – TYPE OF APPLICATION (check one box)

❒ New Enrollment Application: Requested effective date: _____ (month) ❒ 1st ❒ 15th

❒ Plan Change **(from and to a current LifeWise Plan)**: Subscriber ID# _____ (first of the month effective date only)

❒ Adding Spouse: Subscriber ID# _____ Date of Marriage: ____/____/____

❒ Adding Child: Subscriber ID# _____ ❒ Newborn ❒ Adoption - Date of birth / placement ____/____/____

## SECTION 2 - PRIMARY APPLICANT, SPOUSE & DEPENDENT INFORMATION

| Name (26 character max) (Last, First, Middle Initial) | Social Security # | Gender (M/F) | Date of Birth (MM/DD/YYYY) | Relationship to Subscriber |
|---|---|---|---|---|
| | - - | | / / | SELF |
| | - - | | / / | LEGAL SPOUSE |
| | - - | | / / | DEPENDENT CHILD (under 23 only) |
| | - - | | / / | DEPENDENT CHILD (under 23 only) |
| | - - | | / / | DEPENDENT CHILD (under 23 only) |

| 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 | | | |

## SECTION 3 – BENEFIT PLAN SELECTION

**Check one box** to indicate your family's plan selection and deductible option:

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1. | Essentials 25 | Deductible Options: | ❒ | $1,500* | ❒ | $2,500* | | | |
| 2. | Essentials 50 | Deductible Options: | ❒ | $1,500* | ❒ | $2,500* | | | |
| 3. | Passport 20 | Deductible Options: | ❒ | $1,000 | ❒ | $1,500* | | | |
| 4. | Passport 30 | Deductible Options: | ❒ | $500 | ❒ | $1,000 | ❒ | $1,500* | |
| 5. | Passport 50 | Deductible Options: | ❒ | $500 | ❒ | $1,000 | ❒ | $1,500* | ❒ $2,000* |
| | **Health Savings Account (HSA) Qualified Plans** | | | | | | | | |
| 6. | LifeWise HSA Plus (Individual) | Deductible Options: | ❒ | $1,250 | | | | | |
| 7. | LifeWise HSA Plus (Family) | Deductible Options: | ❒ | $2,500 | | | | | |
| 8. | LifeWise HSA (Individual) | Deductible Options: | ❒ | $1,700* | ❒ | $2,500* | | | |
| 9. | LifeWise HSA (Family) | Deductible Options: | ❒ | $3,400* | ❒ | $5,000* | | | |

* Catastrophic Plan.

plan. "Portability" means that you will receive credit for a plan's pre-existing condition waiting period based on prior coverage. By enrolling on a catastrophic plan, you may lose portability rights, should you later change to another individual health plan.

## SECTION 4 – ELIGIBILITY

To be eligible for coverage, applicants:

- Must be a resident of, and have a principal residence located within, Washington State. We may require proof of residency.
- Must not be entitled to Medicare (including entitlement due to disability):
  - ❒ If over 65 years of age and not eligible for Medicare, attach a "not eligible for Medicare document" from the Social Security Administration.

## SECTION 5 – RATE/BILLING INFORMATION

**PAYMENT OPTIONS: Select One (Subscription charges for this contract cannot be paid or sponsored by an employer)**

❒ Monthly Billing ❒ Monthly Automatic Funds Transfer withdrawn 1st of the month (Complete Section 6.)
( include: checking account-voided check or savings account-deposit slip)

**TOBACCO USE INFORMATION:**

The smoker rate will ap
application. That person's rate(s) will be the Smoker rate(s). **Not checking a box will result in paying the higher rate.**

- I have used tobacco products during the prior 12 months: ❒ Yes ❒ No
- My spouse has used tobacco products during the prior 12 months: ❒ Yes ❒ No

## SECTION 6 – AUTOMATIC FUNDS TRANSFER AUTHORIZATION

I have selected the Automatic Funds Transfer (AFT), and I hereby authorize LifeWise Health Plan of Washington (LifeWise) to initiate funds transfer from the bank or depository financial institution account indicated below. I authorize my financial institution to honor these transfers.

| | |
|---|---|
| Financial Institution or Bank Name: | |
| Account Holder's Name (print): | |
| City, State, ZIP: | Account Number: |
| Bank Routing Number: | ❒ Checking ❒ Savings |

**9-digit number at bottom of check (for checking account) or deposit slip (for savings account)**

**Additional Terms and Conditions:**

- Funds are to be transferred on the **1st business day of each month** or as soon thereafter as practical, paying for that month's coverage. (For example: The deduction on January 1st pays for coverage in January.)
- I understand that if I have chosen an effective date of the 15th of the month, the initial transfer will be for the initial **prorated** month PLUS the first full month's subscription charge. Subsequent transfers will be for single months.
- I understand that this Automatic Funds Transfer Authorization will remain in effect until LifeWise has received notice from me that it should be cancelled. To ensure prompt cancellation of my Automatic Funds Transfer, this notice must be submitted at least 20 days prior to my next scheduled transfer. I have the right to stop payment of a specific transfer from my depository financial institution at least 3 days before the next scheduled withdrawal date.
- It may take as long as 45 days to set up an AFT. You may receive an invoice to cover initial month(s).

***Please enclose a voided check (for checking account) or deposit slip (for savings account) from the account TO BE DEDUCTED.***

Signature of Bank Account Holder: X _____ Date (MM/DD/YYYY): ____/____/_____

## SECTION 7 – STANDARD HEALTH QUESTIONNAIRE FOR WASHINGTON STATE

***Attach a completed Standard Health Questionnaire for each applicant.***

**Please refer to the Standard Health Questionnaire for specific information on who is exempt from completing the questionnaire.**

If not attaching the questionnaire(s), please indicate the reason below:

❒ **Relocation:** Applicant has relocated within Washington, and the prior health plan is not available. *Include a photocopy of a utility bill in your name showing the prior address (dated no more than 90 days prior to the date of this application).*

❒ **Provider cancellation:** Applicant's health care provider has left the prior plan's network within the last 90 days of this application and is in this plan's network. Prior plan must have been an **Individual plan**, not group. *Include a letter of verification from the provider or carrier.*

❒ **COBRA:** Applicant has exhausted all COBRA continuation coverage within 90 days of the date of this application.*

❒ **Non-COBRA Continuation:** Applicant is applying for coverage within 90 days of a qualifying event through an employer too small for COBRA that was in effect for at least 24 months.**

❒ **Conversion**: Applicant is applying for individual coverage within 90 days of termination of conversion coverage.*

❒ **Addition of:** newborn or newly adopted child to an existing LifeWise plan, within 60 days of birth or adoption.

** Include a copy of your Certificate of Coverage or other supporting evidence. (Complete Section 10.)*

*** Include a letter from the small group employer indicating the type and length of prior coverage.*

## SECTION 8 – NOTICE OF INFORMATION USE AND DISCLOSURE

When you apply for
information about your
address, telephone number, and Social Security Number. This information may come from health-care providers, insurance companies (including members of our corporate family) or other sources.

We may collect, use, or disclose your PPI to conduct routine business functions, such as:

- Determining your eligibility for enrollment, credit for waiting periods, benefits;
- Paying claims and coordinating benefits with other insurers;
- Conducting case and care management, and quality reviews;
- Fulfilling other legal obligations specified in our contract with you; and,
- We may also collect or disclose PPI as required or permitted by law.

If a disclosure of PPI is
signed authorization.
which the authorization is valid. You may revoke this authorization.

## SECTION 9 – BASIC TERMS of ENROLLMENT

1) I understand and agree that coverage does not begin until:
   a) This application is received, reviewed, and accepted by LifeWise and an effective date of coverage is assigned; and
   b) My complete and correct payment is received.
2) I also understand and agree that:
   a) This application becomes a part of my Contract.
   b) This application summarizes certain key terms of the Contract; to the extent that the application is inconsistent with the Contract, the Contract will govern.
   c) Terms and conditions of enrollment are described in the Contract.
   d) **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: NEWBORN AND ADOPTIVE CHILDREN ENROLLED AFTER THE SUBSCRIBER'S EFFECTIVE DATE OF COVERAGE AS LONG AS ADDED WITHIN 60 DAYS OF THE BIRTH OR PLACEMENT; 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 HEALTH CARE COVERAGE.**
   e) **I ALSO 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.**
   **f) The benefits under this Contract will be subject to coordination of benefits with other plans.**
3) **I also understand that acceptance for coverage is dependent on the following:**
   **a) Persons listed on this application must be residents of the state of Washington in order to apply for and maintain coverage under this Contract. "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 health care 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. We 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.
   b) No one listed on this application is 65 years of age or older and eligible for Medicare on the date coverage would begin.
4) I also understand that no benefits are available under this Contract 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.
5) I also understand and agree that only LifeWise may:
   a) Make or modify the terms of the application or Contract; or
   b) Waive any of the LifeWise rights or requirements.
6) I understand that the benefits under this plan may vary based on the contracting status of the provider, and that the number of contracted providers varies in different geographic locations. In some cases, I may receive benefits that are substantially less than the amount billed by the provider when treatment is not received from a contracted provider.
7) I understand that this application is not an offer of coverage from LifeWise and that submission of this application does not guarantee I will receive coverage.
8) I understand and agree that this coverage is issued as individual health coverage, and is not sold or issued for use as an employer-sponsored health plan

## SECTION 10 – PRIOR or CURRENT COVERAGE

If you have prior creditable coverage, we will waive or credit the nine-month waiting period. To help us determine if you qualify for shortening the pre-existing condition waiting period, please complete the following. Application must be received within 63 days of prior coverage ending for consideration of waiting period credit.

***Attach your Certificate of Coverage from your current or prior carrier.***

If you do not have a Certificate of Coverage, you may provide other documentation which demonstrates prior coverage beginning and ending dates.

**This documentation may be sent in separate from the application, but should be provided within 60 days of the effective date.**

Name of carrier (insurance company): _____ Phone #: (_____) _____

Name of subscriber (contract holder) and ID#: _____

Names of all enrollees on prior coverage: _____

**Date coverage began:** _____/_____/_____ **Date coverage ended:** _____/_____/_____

Deductible amount: $_____ per individual per year. Deductible amount: $_____ per 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

Do you intend to continue this other coverage if you are accepted by LifeWise? ❒ Yes ❒ No (If no, remember to contact your insurance company to cancel, including our corporate affiliates.)

## SECTION 11 – SIGNATURES

I hereby apply for enrollment with LifeWise 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, 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 have read and agree to all the Basic Terms of Enrollment listed in Section 9.
d) I have read the Notice of Information Use and Disclosure.
e) In applying for enrollment as indicated on this application, 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 intentionally false or misleading statements or answers on behalf of myself or any family members, that all entitlements to benefits are void and this Contract may be cancelled or modified retroactively to its effective date.

**If one or more family members is not accepted for coverage, I authorize LifeWise to enroll those who are eligible in the plan I have selected (not applicable to HSA plans if this would result in changing family coverage to individual coverage).**

❒ Yes ❒ No

X _____ / / X _____ / /

**Signature of Primary Applicant**

**Approved applications postmarked or received by the 5th 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 20th day of the month will be effective on the first day of the following month.**

**To select a later effective date, please indicate here (no more than 60 days after the receipt day, and must be the 1st or 15th of the month):** _____/_____/_____.

### DO NOT SEND PAYMENT WITH THIS APPLICATION.

**Completion of this section BY THE AGENT** is required if the agent wishes to be considered as agent of record for applicant. All agent information must be provided below to ensure credit/commission for the application.

Agency Name ( If applicable): Insurance Northwest

Agent Name (Please Print): Kelly Peterson, MBA

Agent Address: 1445 W. Rose, Suite One, Walla Walla, WA 99362

Agent Telephone Number: (509) 522-0234 Agent E-mail Address: kellypeterson@insurancenorthwest.com

Agent Signature: _____ LifeWise Agent Number: 63300