

APPLICATION FOR INDIVIDUAL COVERAGE



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.)

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

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

PREFERRED PLANS — Deductible Options:				
Catastrophic*		Comprehensive	HSA Catastrophic*	HSA Comprehensive
Asuris ClaritySM 50	Asuris Core PlanSM	Asuris ClaritySM 70	Asuris HSA Healthplan	Asuris HSA Healthplan Comprehensive
<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000	<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$3,000	<input type="checkbox"/> \$2,500 Member/ \$5,000 Family <input type="checkbox"/> \$3,500 Member/ \$7,000 Family	<input type="checkbox"/> \$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.)

<input type="checkbox"/> Monthly	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Semiannually	<input type="checkbox"/> Annually	<input type="checkbox"/> 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					
<input type="checkbox"/> Spouse <input type="checkbox"/> Registered Domestic Partner <input type="checkbox"/> Non-Registered Domestic Partner*					
Street Address			City	State	ZIP Code
Mailing Address			City	State	ZIP Code
Billing Address (if different)			City	State	ZIP Code
					County
					Home Telephone Number
					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 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.