

APPLICATION FOR CONVERSION COVERAGE



PO Box 91130
Seattle, WA 98111
1 (888) 344-5587

MAIL APPLICATION TO:

PO Box 1107
1602 21st Ave. MS LD2N
Lewiston, ID 83501

All answers must be complete and accurate. Omissions or incomplete answers require the return of your application and result in delays. Application must be made within 31 days of termination of your prior group coverage.

SECTION 1. TYPE OF APPLICATION (Check one.)

- Converting from Asuris Northwest Health Group Coverage Adding Dependent(s). (Dependent(s) may be added only to your current plan. **Skip to Section 4**)

SECTION 2. TYPE OF COVERAGE Deductible Option (select one)

- Plan 1 - \$500 Plan 2 - \$1,000 Plan 3 - \$500

SECTION 3. PAYMENT TYPE

- Monthly Quarterly Semi-Annually Annually Automatic Bank Withdrawal
Complete the enclosed Subscriber Agreement for PreAuthorized Bill Payment (monthly only).

SECTION 4. MEMBER INFORMATION (Please list subscriber, then spouse/eligible domestic partner and/or 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.**

Name (Last, First, Middle Initial)	Social Security Number	Sex	Birth Date
Subscriber			
<input type="checkbox"/> Spouse <input type="checkbox"/> Registered Domestic Partner <input type="checkbox"/> Non-Registered Domestic Partner*			
Home Address (including full Street Address, City, State, ZIP code)			PO Box (if applicable)
Billing Address (if different than home or mailing address)		County	
Home Telephone Number		Email Address (optional)	
*Non-Registered Domestic Partners must submit an Affidavit of Domestic Partnership.			
Name and Health Insurance Claim Number of anyone listed on this form that is covered by Medicare.			

SECTION 5. OTHER COVERAGE INFORMATION

- Are you or any dependents applying for coverage eligible for, or covered on any group, individual, or self-insured plan?
 Yes No If yes, please indicate the plan and the member's name:

- If you are adding a dependent for coverage, have they had medical coverage within the last three months? Yes No
If you answered no, you may skip the Prior Coverage Information section of this application.
If you answered yes, please continue below. If you need additional space, use the blank lines provided on page 3 of this application.

ASURIS NORTHWEST HEALTH USE ONLY

Date Application Substantially Complete	Effective Date	Package Number	Producer Number

SECTION 6. PRIOR COVERAGE INFORMATION Please provide a copy of your Certificate of Coverage from your current or former carrier, if available. Please note: If your prior coverage was with an Asuris Northwest Health group plan, it is not necessary to include a copy of your Certificate of Coverage.

Asuris Northwest Health Conversion Plans contain a three-month preexisting condition exclusion clause. This clause excludes coverage for a limited time period for you and your dependents' conditions for which medical advice was given or treatment provided by a health care provider within three months from the date we received your completed application. In certain circumstances, we will waive or credit this waiting period based on current or prior coverage. Please call us if you have any questions about this exclusion clause.

Policyholder's Name	Policyholder's Birth Date	Name(s) of Person(s) Covered	
Date Coverage Began	Date Coverage Ended or is Ending		Name of Plan Under Which You Were Covered
Insurance Company or Prior Carrier's Name	Company Telephone Number		Policy Number/ID Number

Policyholder's Name	Policyholder's Birth Date	Name(s) of Person(s) Covered	
Date Coverage Began	Date Coverage Ended or is Ending		Name of Plan Under Which You Were Covered
Insurance Company or Prior Carrier's Name	Company Telephone Number		Policy Number/ID Number

SECTION 7. APPLICATION AGREEMENT

I hereby apply for myself and/or for any spouse or eligible domestic partner/Dependent(s) listed on this application for coverage under the Conversion Contract indicated on this form or currently in effect if adding Dependent(s). Contracts are offered through Asuris Northwest Health (the Company), and I agree with the terms of the Contract. I certify that my listed Dependents and I meet the eligibility requirements set forth in the summary of benefits and/or the Conversion Plan Contract. 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 also 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 three-month waiting period for preexisting conditions as defined in the Contract.

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 on this form 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.

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 (888) 344-5587.

SECTION 9. SIGNATURE AND DATE

APPLICANT 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)

APPLICANT SPOUSE/ELIGIBLE DOMESTIC PARTNER SIGNATURE: _____ (If applying)

DATE: _____

Dependent Signature: _____ (If age 18 or over) **Dependent Signature:** _____ (If age 18 or over)

PRODUCER INFORMATION

IF APPLICATION IS BEING MADE THROUGH A PRODUCER, HE/SHE MUST COMPLETE THE INFORMATION REQUESTED 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 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.

CHECKLIST

Thank you for selecting Asuris Northwest Health Conversion Plans. To ensure timely processing of your application please review this checklist. All answers on this application must be complete and accurate.

- ✓ Did you indicate the Plan you are selecting? (Not required when adding dependent(s) to current coverage.)
- ✓ If you chose automatic bank withdrawal, did you complete the enclosed **Subscriber Agreement For Preauthorized Bill Payment** and include a voided check? Please pay your paper billing until you are notified that your electronic funds transfer has been initiated. (Not required when adding dependent(s) to current coverage.)
- ✓ Did you complete the **Prior Coverage Information section**? Please provide us with documentation of current or prior coverage, such as a Certificate of Coverage or similar document in accordance with federal law, for you and/or your dependent(s), unless current or prior coverage was with Asuris Northwest Health.
- ✓ Please read the **Application Agreement** and the **Release of Information** sections. **Remember to sign and date this application.**

ADDITIONAL INFORMATION
