Washington Individual Enrollment Application

Effective June 10, 2010

LIFEWISE
HEALTH PLAN OF WASHINGTON

Please print your answers clearly in ink so we can process your application quickly.

You can become a LifeWise member if you are:

- A resident of and have a principal residence in Washington state; and
- Not entitled to Medicare, either because you're 65 or older, or due to a disability.

65 or Older?

If you're 65 or older and not eligible for Medicare, attach a "Not Eligible for Medicare" document from the Social Security Administration.

1 I'm filling out this application because I am…

☐ a new applicant

☐ a current member adding: (select a box below)

☐ my spouse: ______________________ (marriage date)

☐ my domestic partner

☐ a child(ren): ☐ Newborn

☐ Adopted: ______________________ (date of placement)

☐ changing my plan.

My subscriber ID# is: ______________________ (see your ID card)

Enrolling Children?

Be sure to complete a separate application for each child if there is not an adult applicant or subscriber (18 or older) on the same plan.

Changing Plans?

If you're changing plans, your new plan will take effect on the first of the following month.

2 Date my coverage should begin

I want this plan to begin on the ☐ 1st **or** ☐ 15th of ______________________ (enter month) (no more than 60 days after the application is signed)

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 25 only (Last, First, Middle Initial)	Social Security Number (optional)		Gender: ☐ M ☐ F
	Date of Birth / /		
Dependent Child—under 25 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 health plan

I want to enroll in the…	…and I want this deductible: (check only one box)
WiseSimplicity plan	☐ $10,000*
WiseEssentials Rx plan	☐ $1,850* ☐ $2,500* ☐ $3,500*
WiseEssentials Copay plan	☐ $5,000* ☐ $7,500*
WiseChoices Prime plan	☐ $1,500 ☐ $3,000*
WiseSavings plan	☐ $1,820* (Individual) ☐ $3,640* (Family) ☐ $3,000* (Individual) ☐ $6,000* (Family)

* This is a catastrophic plan. 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.

Choose Only One

Check only **one plan deductible box** per application. If you want a family member to be on a different plan or deductible, complete a separate enrollment application.

5 Paying for my health plan (select one)

☐ 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 LifeWise 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		
Bank Routing Number (see picture below)	Account Number (see picture below)	☐ Checking ☐ Savings

Your Name
123 Main Street
Anytown, USA 12345
0001
DATE
PAY TO THE ORDER OF $
DOLLARS
Notes
Attach your voided check HERE
⑆123456789⑆ 987654321O⑈ 0001

Bank Routing Number   Account Number

Remember

An employer may not sponsor or pay for your Individual Health Plan.

Don't Pay Now

Don't send payment with this application. You'll receive a bill once your application is accepted if you selected monthly paper bills. You can also pay by credit card after your first month's payment.

Routing Number

We can't set up automatic withdrawals with bank routing numbers that begin with a "5." If your routing number begins with a "5," call your bank to get the correct bank routing number.

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 January 1st pays for coverage in January.)
- 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 LifeWise that it should be cancelled. To ensure prompt cancellation, I must notify LifeWise 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)?

Each applicant 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.

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

Important!

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

- ☐ **Relocation:** I changed residences from one part of Washington to another and my previous health plan doesn't cover my new area of residence. (Please include a photocopy of a utility bill in your name that shows your prior address with a date no earlier than 90 days prior to the date of this application.)
- ☐ **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 LifeWise network.
- ☐ **COBRA:** In the past 90 days of the date of this application:
  - I have either exhausted or terminated my COBRA continuation coverage; or
  - I have experienced a COBRA qualifying event and I am choosing not to elect COBRA.
- ☐ **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.
- ☐ **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.
- ☐ **Newborn/newly-adopted child addition:** I'm adding my newborn or newly-adopted child to my existing LifeWise plan, within 60 days of the birth or adoption.
- ☐ **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.

Need additional copies of the Standard Health Questionnaire? You can download a copy from the "Forms" section on **lifewisewa.com**, call LifeWise Customer Service at 1-800-592-6804 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 LifeWise?

☐ Yes ☐ No (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. For more information on eligibility to get waiting periods waived, please see Section 11.

Prior Coverage?

Remember to attach your Certificate of Coverage or other documentation 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 #
Names of All Enrollees on Prior Coverage		
Type of Coverage ☐ Individual ☐ Group/Employer ☐ Healthy Options ☐ Basic Health Plan ☐ WSHIP	Date Coverage Began / /	Date Coverage Ended / /

8 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 LifeWise 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: 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.
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 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. LifeWise 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 LifeWise may: a) Make or modify the terms of the application or contract; or b) Waive any of the LifeWise rights or requirements.
8) I understand and agree that this coverage is issued as individual health coverage, is not sold or issued for use as an employer-sponsored health plan, and is not partially or fully paid for by my employer either directly or indirectly.

9 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, 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.

☐ **Yes** ☐ **No** — If one or more family members are 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).

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 over age 18 X	Date of Signature / /
Signature of Dependent Child over age 18 X	Date of Signature / /

Important!

Signatures are required for all applicants over the age of 18.

10 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.

Did I remember to:

- ☐ Choose an effective date in Section 2?
- ☐ Indicate in Section 3 whether my spouse/domestic partner or I use tobacco? This will ensure I pay the correct rate.
- ☐ Select only one deductible option in Section 4?
- ☐ Complete a Standard Health Questionnaire for each applicant 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 coverage 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?
- ☐ Get all applicants over the age of 18 to sign this application in Section 9?

Thank you!

Mail completed application to:

LifeWise Health Plan of Washington
PO Box 91120, MS 295
Seattle, WA 98111-9220

1-800-592-6804 • lifewisewa.com

If you want to enroll additional dependents and ran out of space in Section 3, please add your other dependents below:

Dependent Child—under 25 only (Last, First, Middle Initial)	Social Security Number (optional)	Gender: ☐ M ☐ F
	Date of Birth / /	
Dependent Child—under 25 only (Last, First, Middle Initial)	Social Security Number (optional)	Gender: ☐ M ☐ F
	Date of Birth / /	
Dependent Child—under 25 only (Last, First, Middle Initial)	Social Security Number (optional)	Gender: ☐ M ☐ F
	Date of Birth / /	

11 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.

12 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 LifeWise 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 LifeWise know of my decision. Any change will be effective five (5) business days after LifeWise 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 LifeWise to make decisions, which will not be affected by its revocation.

Redisclosure: LifeWise Health Plan of Washington 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.

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	
Producer Name	LifeWise Producer Number
Producer Address	
Producer Telephone Number ( )	Producer E-mail Address
Producer Signature X	Date / /

Please Note: Producers who do not have a current appointment with LifeWise are not authorized to offer LifeWise products.