



UTAH INDIVIDUAL HEALTH INSURANCE APPLICATION

A. APPLICANT INFORMATION

Name (Last) _____ (First) _____ (MI) _____

Marital Status Legally Married Single Divorced Widowed Domestic Partner

Mailing Address _____ Apt. _____ City _____ State _____ Zip _____

Street Address _____ Apt. _____ City _____ State _____ Zip _____

Home (or other) Phone (_____) _____ Business Phone (_____) _____

Driver's License Number: _____ Email Address: _____

Does any listed proposed insured live, reside, work or attend school outside the state of Utah at any time during the year? Yes No If yes, % of time _____

Please check one of the following boxes: New Application Dependent Addition Re-apply

B. APPLICANT AND DEPENDENT INFORMATION (attach separate sheet if necessary)

In the section below, list yourself and all eligible family members to be included under the policy.

	Social Security # (for internal use only)	Name (Last, First, MI)	Date of Birth	Age	M/F	Weight	Height
Self						lbs.	
Spouse						lbs.	
Dependent						lbs.	
Dependent						lbs.	
Dependent						lbs.	
Dependent						lbs.	

Eligible family members include spouse, natural child, stepchild, adopted child, child placed for adoption, and child for whom you are appointed as legal guardian by the court. To be eligible for coverage, children must be under the age of 26, unmarried, and dependent upon you for 50 percent of their financial support. Financial dependency is not required for court-ordered child coverage. Any dependent not listed will not be considered for coverage.

C. CURRENT/PRIOR COVERAGE INFORMATION

Please indicate for EACH person listed on this application any health care coverage, including Medicare or Medicaid, in effect within 24 months prior to the proposed effective date of this policy. Each person applying for coverage must be listed below. If no health care coverage was in effect within the past 24 months, please indicate NONE. If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation that shows who is responsible for the dependent(s)' health care coverage so that the insurer can determine whose coverage is primary.

Enrolling Individual's Name (Non-Medicare)	Insurer (Including policyholder name, insurer name and phone number)	Date of Coverage Month/Day/Year		Will the individual continue this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Coverage (Check all that apply)
		From	To		
Self				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Spouse				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical

If you were previously insured on a group plan, have you exhausted your COBRA rights? Yes No NA If "Yes" Date Started _____ Date Ended _____

If COBRA was not an option for you, have you exhausted your Utah mini-COBRA rights? Yes No NA If "Yes" Date Started _____ Date Ended _____

Have you ever been or are you currently insured through HIPUtah? Yes No If "Yes" Date Started _____ Date Ended _____

Note: If you have had health care coverage within the last 63 days, your Pre-Existing Condition (PEC) waiting period limitation may be partially or completely waived. To determine if this applies to you, you must provide proof of prior coverage, such as a Certificate of Creditable Coverage from your previous insurer. Submission of prior coverage information does not automatically waive any PEC limitation. However, you will be subject to an automatic PEC Waiting Period of up to 12 months until we receive evidence of prior coverage.

D. EMPLOYMENT INFORMATION

Employer _____ Group Insurer _____ Job Title _____ Hrs/Week _____

Spouse's Employer _____ Spouse's Group Insurer _____ Spouse's Job Title _____ Hrs/Week _____

1. Is any employer reimbursing or paying for any portion of this policy? Yes No

2. Are you self-employed? Yes No If self employed, do you have any full or part-time employees? Yes No

E. HEALTH STATEMENT

IF ANY OF THE BELOW CONDITIONS OR QUESTIONS ARE CHECKED "YES" PROVIDE DETAILS IN SECTIONS G. & H. ON THE FOLLOWING PAGE.

The federal Genetic Information Nondiscrimination Act prohibits health insurers from requesting, requiring, purchasing, or collecting "genetic information" for underwriting purposes. "Genetic information" includes your genetic tests, the genetic tests of your family members, and the manifestation of a disease or disorder in family members not covered by the policy. Genetic information can also include requests for, or receipt of, genetic services, or participation in clinical research which includes genetic services. **Do not report genetic information on this form.** However, information about manifested diseases or conditions of anyone applying for coverage is not considered genetic information and is to be reported on this form, even if the disease or condition is caused by or associated with genetics.

EACH QUESTION MUST BE CHECKED "YES" OR "NO." This health statement must be complete or the application will be returned. Inaccurate health information may result in the policy being cancelled retroactively. It is your responsibility to notify the insurer of any change in health status while application is pending.								
Respond to the following questions:		YES	NO	Within the past 5 YEARS has any applicant been diagnosed with, treated for, or had any of the following (cont.):		YES	NO	
1	Pregnancy/Adoption: Are you, your spouse, or any dependent family member pregnant or financially responsible for an unborn child, or do you anticipate adopting a child in the next 12 months?			21	Female Reproductive Conditions/Disorders: Irregular bleeding, abnormal Pap smear/test, endometriosis, recurring pelvic pain, pelvic inflammatory disease, or any other disorder of the reproductive system?			
2	Pregnancy/Fertility Related Treatment: Are you, your spouse, or any dependent family member being treated for infertility, fertility evaluation or treatment (including medication), or miscarriage, complications related to pregnancy (including premature births)?			22	Digestive Conditions/Disorders: Ulcers, hernias, chronic diarrhea, diverticulitis, diverticulosis, irritable bowel syndrome, reflux, GERD, any other gallbladder or digestive disorder, hemorrhoids, polyps, or any other rectal disorder?			
3	Last Menstrual Period: Have you, your spouse or any dependent (whether or not proposed for insurance) missed her last menstrual period? If yes, provide date of last menstrual cycle on the following page.			23	Nervous, Mental and Behavioral: Mental health counseling, psychotherapy, depression, stress, anxiety, attention deficit hyperactivity disorder (ADHD), mental health disorder, or chemical imbalance that required consultation or medication?			
Within the past 12 MONTHS has any applicant:			YES	NO	Within the past 10 YEARS has any applicant been diagnosed with or treated for any of the following:			
4	Prescriptions/Medications/Immunizations: Been prescribed or taken any prescription or over-the-counter medications, drugs, or shots (including immunizations, birth control, etc.)?			24	Gout, arthritis, Rheumatoid arthritis, fibromyalgia, or scleroderma?			
5	Conditions Requiring Follow Up Medical Consult/Treatment: Do you, your spouse or any dependent family member have a condition for which hospitalization, tests, consultation, evaluation, surgery, or medication have been advised, but not completed?			25	Musculoskeletal Conditions/Disorders: Ankylosing spondylitis, neuropathy, osteogenesis imperfecta, osteoporosis, herniated and/or ruptured disc, spina bifida, kyphosis, scoliosis, spinal stenosis, spondylolisthesis, spondylosis, or other musculoskeletal disorder?			
6	Medical Consult/Treatment: Consulted or received treatment from a doctor, chiropractor, counselor, therapist, or other health care provider, including routine & wellness care?			26	Digestive Conditions/Disorders: Crohn's disease. Colitis, colostomy, ileostomy, or other digestive disorder?			
7	Conditions Requiring Initial Medical Consult/Treatment: Had a health condition, problem, disorder, or any other medical or mental health conditions not listed for which medical or mental health advice or treatment has not been sought ?			27	Alcohol or Drug Use/Abuse: been advised to reduce/limit alcohol use, or attended Alcoholics Anonymous (or similar program) for his/her own alcohol consumption, drug dependency, abuse, or misuse of prescribed or non-prescribed drugs such as opiates, stimulants, depressants, and/or hallucinogens?			
Within the past 5 YEARS has any applicant been diagnosed with, treated for, or had any of the following:			YES	NO	28	Eating Disorders/Obesity Treatment: including bulimia, anorexia, or obesity and any surgical services for obesity.		
8	Urinary, bladder, incontinence, kidney or liver conditions or disorders: Kidney stones, jaundice, nephritis, or any other disorder of the liver, kidneys, or pancreas?			29	Respiratory Conditions/Disorders: RSV, reactive airway disease, tuberculosis, asthma, sleep apnea, pleurisy, COPD, sarcoidosis, or emphysema?			
9	Neurological Disorders: Recurring headaches, migraines, head injury, epilepsy, seizures, convulsions, or other neurological disorder?			30	Tobacco use (chewing or smoking)? Quit Date: _____			
10	Metabolic and Endocrine Conditions/Disorders: Lupus, thyroid disorder, goiter, or any other lymph system disorder?			Has any applicant EVER been diagnosed with or treated for any of the following:			YES	NO
11	Eyes, ears, nose, sinus, or throat conditions/disorders or any other respiratory system disorder, including allergies or hay fever?			31	Birth Defects/Congenital Abnormalities: premature birth, development or learning disability, mental impairment, Down syndrome, or autism spectrum disorder?			
12	Skin Conditions/Disorders: Acne, psoriasis, eczema, growths (except warts), abnormal moles, abnormal birthmarks, or any other skin disorder?			32	Nervous, Mental and Behavioral: Bipolar affective disorder, manic depression, schizophrenia, chronic organic brain syndrome, or psychotic disorder?			
13	Breast Conditions/Disorders: Breast lumps, breast augmentation, or breast reduction?			33	Transplant or Implanted Device: Any organ or tissue transplant, pacemaker, or other implanted device?			
14	Heart Conditions/Disorders: Chest pain, high blood pressure, high cholesterol, irregular heart beat, or any other heart condition?			34	Heart and Circulatory Conditions/Disorders: Heart murmur, heart attack, bypass surgery, angioplasty/stent, blood clot, stroke, heart surgery, coronary artery disease, or congestive heart failure?			
15	Back, neck, bone, joint or spinal disorder: bone or joint disorders (including foot, knee, jaw, fracture, dislocation, or joint replacement)?			35	Brain/Nervous System Conditions/Disorders: Multiple sclerosis, muscular dystrophy, cerebral palsy, Lou Gehrig's disease (ALS), Parkinson's disease, Alzheimer's disease, or dementia?			
16	Blood Conditions/Disorders: Hemophilia, anemia, blood, or bleeding disorder?			36	Diabetes (type I or II), insulin resistance?			
17	Male Reproductive Conditions/Disorders: Impotence, prostate or testicular disorder, abnormal PSA, or other reproductive disorder?			37	Immune System Conditions/Disorders: Immune system diseases, human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), or AIDS related complex (ARC)?			
18	Circulatory System Conditions/Disorders: Varicose veins, or any other circulatory disorder?			38	Cancer/Tumors: (including skin cancer or melanoma) or tumors?			
19	Hospitalization/Surgery: Have you, your spouse, or any dependent family member been hospitalized or had surgery?			39	Urinary/Liver Conditions/Disorders: Cirrhosis, hepatitis, or renal failure?			
20	Sexually transmitted diseases?			OTHER MEDICAL INFORMATION			YES	NO
				40	Any medical condition or treatment that you are unsure of where it fits in above?			

I. ACKNOWLEDGMENT & SIGNATURE

I hereby apply to be enrolled with my listed dependents, if applicable, for coverage. When incorporated with the policy, this application will become part of the policy. Once fully signed and executed, insurer and I agree to terms set forth in the policy. In connection with both this application and any coverage that may be obtained, I am acting as agent and/or as natural guardian for my spouse and other dependents. I agree to act on behalf of myself and my dependents. I understand that coverage is dependent upon my satisfaction of applicable underwriting criteria. I also understand that no coverage will be in force until each person listed above is approved; that no benefits will be provided for any services which begin before the policy is effective; and that except as expressly provided in the policy, benefits will not extend beyond the termination of either my coverage or the policy.

CONSENT AT ENROLLMENT. I understand that no producer or insurer representative is allowed to permit me to answer any question inaccurately, untruthfully, or incompletely, and I represent that such did not occur. I understand that it is my continuing responsibility to report to the insurer changes in the eligibility of any applicants who become enrolled.

I understand that the data obtained by the use of this authorization will only be used to determine eligibility for coverage and for future benefit administration. I understand that my choice of health care providers whose services will be covered may be restricted by the policy, and I agree that coverage for any services that are obtained without or contrary to required preauthorization/precertification requirements in the policy may be denied. I understand the policy for which I am applying may limit or exclude certain conditions, regardless of whether or not they are pre-existing. I also understand that the policy may limit or exclude conditions for which a family member or I have received, or have been recommended to receive, any medical advice, diagnosis, care, or treatment during the six months immediately preceding the date I apply for coverage, according to the pre-existing conditions limitation provisions of the policy.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE. According to information furnished, you may intend to lapse or otherwise terminate existing accident and health insurance and replace it with a new policy. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (pre-existing conditions), may not be immediately or fully covered under the new plan. This could result in a denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present coverage.
2. You may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present coverage and replace it with a new policy, be certain to truthfully and completely answer all questions on the application concerning your medical/health history.
4. Failure to include all material medical information on an application may provide a basis for the insurer to deny any future claims and to refund your premium as though the policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

I hereby declare that to the best of my knowledge and belief, the information given on this application, including the health information on pages two and three of this application, is correctly recorded, true, and complete. I understand that material omissions or intentional misrepresentations regarding information provided on this application could cause an otherwise covered service to be denied and/or could void any coverage issued. **If I subsequently become aware of information different from that provided in this application, I agree to provide that additional information promptly to the insurer. A change of information prior to the effective date of the policy may void an offer to provide coverage.**

I understand there may not be participating providers in all specialty fields.

I understand that credit for prior coverage will be based upon the information contained in this application and/or proof of prior coverage, such as a Certificate of Creditable Coverage that I have obtained from my prior health care insurer(s) and provided to the insurer.

If any information provided is false or incomplete, the insurer may without advance notice pursue any remedies available under state or federal law, including but not limited to: declaring the policy null and void and canceling the policy retroactive to its original effective date; or imposing the pre-existing condition waiting period and denying claims that are pre-existing, subject to credit for prior coverage.

If the policy contains a voluntary arbitration provision: ANY MATTER IN DISPUTE BETWEEN YOU AND THE INSURER MAY BE SUBJECT TO ARBITRATION AS AN ALTERNATIVE TO COURT ACTION PURSUANT TO THE RULES OF THE AMERICAN ARBITRATION ASSOCIATION OR OTHER RECOGNIZED ARBITRATOR, A COPY OF WHICH IS AVAILABLE ON REQUEST FROM THE INSURER. THE INSURER SHALL BEAR THE COSTS OF ARBITRATION, FILING FEES, ADMINISTRATIVE FEES AND ARBITRATOR FEES. OTHER EXPENSES OF ARBITRATION, INCLUDING, BUT NOT LIMITED TO: ATTORNEY FEES, EXPENSES OF DISCOVERY, WITNESSES, STENOGRAPHER, TRANSLATORS, AND SIMILAR EXPENSES, WILL BE BORNE BY THE PARTY INCURRING THOSE EXPENSES. ANY DECISION REACHED BY ARBITRATION SHALL BE BINDING UPON BOTH YOU AND THE COMPANY. THE ARBITRATION AWARD MAY INCLUDE ATTORNEY'S FEES, IF ALLOWED BY STATE LAW, AND MAY BE ENTERED AS A JUDGMENT IN ANY COURT OF PROPER JURISDICTION.

I further certify that all information completed on this form is true, correct and complete and acknowledge the policy is subject to cancellation or other action permissible at law, if any completed information is found to be false or incorrect.

I attest that all information on this form is accurate. I have read the Acknowledgment of this document and agree to its terms. I have also completed an authorization to disclose protected health information, if such form accompanies this application.

Applicant Signature _____ Date _____

(A faxed signature shall be valid as an original signature.)

Spouse Signature _____ Date _____

(Required if applying for coverage. A faxed signature shall be valid as an original signature.)

Requested Effective Date _____ (Coverage is not in force until the insurer approves your application and determines the effective date.)

J. PRODUCER AGREEMENT AND COMPENSATION DISCLOSURE (If applicable)

I understand and agree that in acting as the producer for this applicant:

1. The application was completed by the applicant.
2. I am in possession of a valid license issued by the State of Utah that authorizes me to sell and service health insurance;
3. I have no authority to: a) make, alter, interpret, or discharge an application or policy in the name of a insurer; or b) waive any of the terms or conditions of the policy.
4. I have no authority to assign effective dates or to effect member changes.

Producer Name _____ License # _____ Agency _____ Phone (____) _____

Producer Signature _____ Date Signed _____

(A faxed signature shall be valid as an original signature.)

Producer Compensation Disclosure:

(Compensation includes commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options, gifts, prizes, or any other form of valuable consideration.)

I have received written disclosure that the producer will receive compensation from the insurer or a third party administrator for the placement of insurance, including the amount or type of compensation.

Applicant Signature _____ Date _____



Regence

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

Regence BlueCross BlueShield of Utah
2890 E. Cottonwood Parkway
Salt Lake City, Utah 84130-0270
Mail form to: PO Box 30270 MS:23
Salt Lake City, UT 84130-0270

Individual Application Cover Sheet (to be used with the Utah Individual Health Insurance Application)

SECTION 1 - GENERAL INFORMATION

Applicant's Name (please print) _____

Social Security Number _____

EFFECTIVE DATE: Upon approval, you will be eligible for an effective date of the first of the month following the date the completed application was received in our office, unless otherwise indicated. Incomplete applications may receive a later effective date.

Yes No I want to do my part for the environment and reduce waste. Please send my Explanation of Benefits (and when possible, other communications) electronically.

A complete application is needed to begin the underwriting process. Complete application includes:

- ◆ Individual Application Cover Sheet
- ◆ Utah Individual Health Insurance Application
- ◆ Authorization Form

SECTION 2 - PLAN SELECTION (Detailed benefit information can be found online at www.regence.com)

BASE PLANS (select ONE medical plan)

Evolve Core

- \$2,500 deductible per member (maximum of 2 deductibles per family)
- \$5,000 deductible per member (maximum of 2 deductibles per family)
- \$7,500 deductible per member (maximum of 2 deductibles per family)
- \$10,000 deductible per member (maximum of 2 deductibles per family)

Evolve Plus

- \$500 deductible per member (maximum of 2 deductibles per family)
- \$1,000 deductible per member (maximum of 2 deductibles per family)
- \$1,500 deductible per member (maximum of 2 deductibles per family) - NetCare Comparable low deductible plan
- \$2,500 deductible per member (maximum of 2 deductibles per family)
- \$4,000 deductible per member (maximum of 2 deductibles per family) - NetCare Comparable high deductible plan
- \$7,500 deductible per member (maximum of 2 deductibles per family)

Evolve HSA

- | | |
|---|--|
| <input type="checkbox"/> \$1,200 self-only deductible / 50% coinsurance (Utah Basic Health Care Plan) | <input type="checkbox"/> \$2,400 family deductible / 50% coinsurance |
| <input type="checkbox"/> \$1,200 self-only deductible / 80% coinsurance (Utah Basic Health Care Plan) | <input type="checkbox"/> \$2,400 family deductible / 80% coinsurance |
| <input type="checkbox"/> \$2,000 self-only deductible / 50% coinsurance | <input type="checkbox"/> \$4,000 family deductible / 50% coinsurance |
| <input type="checkbox"/> \$2,000 self-only deductible / 80% coinsurance | <input type="checkbox"/> \$4,000 family deductible / 80% coinsurance |
| <input type="checkbox"/> \$3,500 self-only deductible / 50% coinsurance | <input type="checkbox"/> \$7,000 family deductible / 50% coinsurance |
| <input type="checkbox"/> \$3,500 self-only deductible / 80% coinsurance | <input type="checkbox"/> \$7,000 family deductible / 80% coinsurance |

Evolve HSA 100

- \$5,000 self-only deductible
- \$10,000 family deductible

DENTAL OPTIONS (select ONE of the following dental options)

- 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)
- No Dental**

PROVIDER NETWORK (select ONE provider network)

- Participating** (Traditional)
- Preferred** (ValueCare)

SECTION 3 - PARENT OR GUARDIAN CONSENT (Complete only if applicant is under age 16 and will be the only insured)

Notice is hereby given that _____ Social Security Number _____ who is under the age of sixteen years is making application for individual health care coverage, with my full knowledge and consent. I request that you consider the child for such health care coverage. I accept full responsibility for the payment of monthly premium and the contents of the application attached hereto.

Signature _____

Date _____

Print Name _____

Relationship to Child _____

Phone Number _____



SECTION 4 – PREMIUM BILLING OPTIONS (if application is approved)

BILLING ADDRESS (complete only if billing should be sent to an address other than the Mailing Address listed on the application.)

Name		Relationship to Applicant
Address		City, State, ZIP Code

Please indicate which billing option you want to use. (If billing option is left blank, your policy will automatically default to Monthly Billing).

- Monthly Billing
- Quarterly Billing
- Surepay (monthly automatic bank deduction)

Note: If selecting Surepay, please fill out the information below.

SUREPAY is a simple and convenient way to keep your health coverage in force. If you select the SUREPAY option of paying for your Regence BlueCross BlueShield of Utah health insurance the payment will be deducted automatically on the draft date you choose below. This will provide several advantages to you:

- ◆ Your payment will always be made on time (if funds are available in your account).
- ◆ You won't have to worry about your coverage accidentally lapsing due to overlooked payments.
- ◆ Your monthly bank statement will show a withdrawal notation. This will serve as receipt of payment.
- ◆ Claims will be paid promptly due to your policy always being paid current.

GETTING STARTED IS EASY by mail or phone:

1. **Complete**, date and sign the Surepay Authorization information below.
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.*

SUREPAY AUTHORIZATION

Please indicate which day you want your payment made.

- 5th of the month** - will pay the current month's charges
- 15th of the month** - will pre-pay the next month's charges
- 25th of the month** - will pre-pay the next month's charges

AUTHORIZATION TO MY BANK

Checking Account Savings Account

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 BlueCross BlueShield of Utah, Salt Lake City, UT. 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	Transit/Routing Numbers	Account Number

Account Holder's Name (please print)

Account Holder's Authorized Signature(s) - as it appears on bank records

Date



SECTION 5 - MEDICARE

If you or any listed dependents have Medicare, please list family member's name and the Medicare Health Insurance Claim (HIC) number shown on his/her Medicare card:

SECTION 6 - ACKNOWLEDGEMENT

By signing the attached Individual Application, you understand and agree to the terms and conditions set forth on this cover sheet as well as the terms and conditions set forth on the attached application.

SECTION 7 - YOUR PRIVACY

For information about the use and disclosure of health information, including uses and disclosures required by law, please refer to the Regence Consumer Privacy Notice. A copy is available on our Web site at www.regence.com.

SECTION 8 - PRODUCER INFORMATION

FOR PRODUCER USE ONLY

Producer Name (please print or type)	Regence Producer Number
Producer's Street Address	Producer's E-Mail Address

PRODUCERS: Please also complete the **Producer Agreement and Compensation Disclosure** in Section J of the Utah Individual Health Insurance Application. Producers will not be compensated if this information is incomplete.



AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this form, you give any carrier identified on the cover sheet of this application the right to gather medical information about you and your dependents for whom you have legal authority to sign (e.g., a minor child). A carrier typically gathers both paper and electronic records. This information, for example, helps a carrier evaluate your application for enrollment and process your medical claims after enrollment.

A. Underwriting Authorization

I authorize any health plan and any health care provider (including any pharmacy) to disclose medical information about me to a carrier for purposes of determining my eligibility for health insurance coverage as requested in this application. The medical information I authorize to be disclosed includes any medical information related to my insurability except for any private genetic information about me or a blood relative of mine. (The law prohibits carriers from using private genetic information for underwriting purposes.)

B. General Acknowledgment

I acknowledge and understand that after enrollment the carrier will have the right to request or disclose health information about me or my dependents (persons who are eligible for benefits coverage and are listed 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 acknowledgment does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

C. Information for Applicant and Dependents

I understand the following information:

1. I may refuse to sign this Authorization, or I may revoke it if I have not been enrolled in a plan by sending my written request to the carrier; however, if I do so the carrier may refuse to enroll me and my revocation will not apply to any disclosure made by the Plan prior to my revocation;
2. A health care provider may not condition my treatment on signing this Authorization;
3. Another health plan may not condition payment, enrollment, or eligibility for benefits on my signing this Authorization;
4. I understand that the information the carrier receives because of this Authorization may be redisclosed and no longer protected by federal or state regulation. Items 5 and 6 of this section limit the potential for redisclosure of my information;
5. If enrollment does not occur the carrier may not use or disclose the information it receives because of this Authorization for any purpose other than underwriting, except as may be required by law. (If the carrier denies insurance coverage because of an individual's health condition, Utah law requires the carrier to tell the applicant specifically what this health condition is);
6. If enrollment does occur the carrier will only use information disclosed under this Authorization for purposes described in its notice of privacy practices;
7. This authorization will expire 90 days after it is signed if enrollment does not occur in the plan and 180 days after my coverage terminates if enrollment does occur;
8. If your application contains any material misstatements or omissions, Regence BCBSU may deny coverage, retro-actively terminate coverage, cancel coverage and/or take any other legal action available to us by law.

D. Identifying Signatures for Applicant and Dependents 18 years of age or older

For additional dependents over the age of 18, please attach a separate sheet of paper with Dependent Names, Date of Birth's, Signatures and Date Signed.

Applicant	Date of Birth	Signature*	Date Signed
Spouse	Date of Birth	Spouse's signature or representative with legal authority**	Date Signed
Dependent	Date of Birth	Dependent signature or representative with legal authority**	Date Signed
Dependent	Date of Birth	Dependent signature or representative with legal authority**	Date Signed
Dependent	Date of Birth	Dependent signature or representative with legal authority**	Date Signed
Dependent	Date of Birth	Dependent signature or representative with legal authority**	Date Signed

***If the main applicant's signature is completed by a legally authorized personal representative, please complete the following:**

Personal Representative's Name (please print) _____

Relationship to Individual _____ (if applicable, attach legal documentation)

**Generally, spouses and dependents 18 years of age or older must sign for themselves.