GroupHealth

Individual and family plan application

Thank you for considering coverage through one of our individual and family plans. Coverage for these plans is provided by Group Health Cooperative or Group Health Options, Inc. ("Group Health" refers to both carriers, unless otherwise noted.)

To be considered for enrollment, please complete this application in black or blue ink only. This application and the necessary supporting documents must be **received by the 20th of the month,** or the first business day following if the 20th is a weekend or holiday, for coverage to begin the first of the following month. Incomplete or inaccurate information may delay the effective date of coverage.

Note that "producer" refers to a broker or agent. If you have any questions about this application or the process, please call us at 1-800-358-8815 or 206-448-4141.

Applicants must confirm that they meet the eligibility requirements by *checking the boxes below* and include the required documentation for processing. If you do not confirm that you meet these eligibility requirements there will be a delay in processing your application.

Send the application and supporting documents to:
Group Health individual and family sales
320 Westlake Ave N Suite 100
Seattle WA 98109-5233

ELIGIBILITY – RESIDENCE – ACKNOWLEDGEMENT REQUIRED

☐ Washington state is the principal residence for myself and my dependents and we reside within one of the following counties: Benton, Columbia, Franklin, Grays Harbor (98541, 98557, 98554, and 98568), Island, King, Kitsap, Kittitas, Lewis, Mason, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom, Whitman, or Yakima.

ELIGIBILITY – MEDICARE – ACKNOWLEDGEMENT REQUIRED

☐ You or your dependents are not eligible for Medicare*

Medicare eligible beneficiaries may not apply for individual and family coverage. If other family members still wish to enroll in an individual and family plan, they will need to designate a primary subscriber/applicant.

Medicare eligible beneficiaries may act as a Guarantor so their eligible dependents can apply for coverage. Eligible dependents are children under 18 or a dependent who is totally incapable of self-sustaining employment. Please indicate oldest dependent on the subscriber/applicant line and all remaining dependents on the dependent child lines. Guarantor MUST complete billing information under section 3.

If an applicant or dependent is over 65 and not Medicare eligible, a letter from the Social Security Administration attesting to noneligibility is required and must accompany this application.

* Medicare is a federally sponsored program designed for individuals over the age of 65, individuals with end-stage renal disease, or individuals that meet the criteria for disability as defined by the Social Security Administration. If you are unsure of your Medicare eligibility, please visit www.medicare.gov

ELIGIBILITY – DOCUMENTATION AND ACCOUNT STATUS – ACKNOWLEDGEMENT REQUIRED

☐ **Documentation:** I am enclosing all documentation as required. This includes applicable Medicare information and documentation outlined in Section 7, including a copy of the Standard Health Questionnaire for all persons listed on this application (unless exempt). Any missing information may delay processing of my application.

☐ **Signature:** This application has been signed by me and my spouse/domestic partner (if applicable).

☐ **Changing plans (if applicable)**: I have requested a plan change and my account is current and paid in full.

HOW DID YOU HEAR ABOUT US?

☐ Group Health employer plan	☐ Current Group Health I&F plan member	☐ Former/prior member	☐ Employer
☐ Producer (broker/agent)	☐ Word of mouth/referral	☐ ghc.org/MyGH	☐ Other Web site
☐ Facebook	☐ Twitter	☐ Television	☐ Radio
☐ Newspaper	☐ Direct Mail	☐ Seminar	☐ Other

SECTION 1. APPLICATION TYPE

☐ This is for new enrollment. I wish coverage to begin on the first day of ______________________ (month/year). I understand that my application must be received at Group Health by the 20th of the prior month.

☐ I am a current Group Health individual and family plan member and I am:
(please check the boxes below that apply)

Changes:

☐ Changing plans**

☐ Changing from dependent to subscriber

Adding eligible dependents (complete sections 2, 6, 7, and 8):

☐ Adding a newly adopted child Date of event:__________

☐ Adding a spouse/domestic partner

☐ Adding a dependent child

☐ Adding a newborn Date of birth:__________

** Changing from a Group Health Cooperative plan to a Group Health Options, Inc. plan will require completion of a new Standard Health Questionnaire. If you are changing from one Group Health Cooperative plan to another Group Health Cooperative plan, you may be required to complete a new Standard Health Questionnaire. Call Customer Service at 1-888-901-4636 for more information.

SECTION 2. SUBSCRIBER ADDRESS AND DEPENDENT INFORMATION

Group Health ID Number (if current or prior member)	Name: Last, first, middle initial	Sex M/F	Date of birth	Social Security # (REQUIRED)	Have tobacco products been used during the last 12 months?
	Applicant/subscriber				☐ Yes ☐ No
	Spouse/domestic partner				☐ Yes ☐ No
	Dependent child (under 25)				☐ Yes ☐ No
	Dependent child (under 25)				☐ Yes ☐ No
	Dependent child (under 25)				☐ Yes ☐ No
	Dependent child (under 25)				☐ Yes ☐ No

Street address (no P.O. Box)	City	State	ZIP	County
Mailing address	City	State	ZIP	Contact telephone number
E-mail address				

SECTION 3. BILLING INFORMATION

No payment is required at this time. You will be mailed a bill once you are approved for coverage. Information about automatic transfer from a checking or savings account will be included with your welcome letter and contract once you are enrolled.

Complete the following billing information:

☐ Send bill to subscriber address

☐ Send bill to a different address

Billing name ______________________

Address ______________________

City ______________________

State/ZIP ______________________

Billing phone ______________________

Billing E-mail ______________________

☐ Send bill to Guarantor (only if applicant is under age 18)

Guarantor name ______________________

Address ______________________

City ______________________

State/ZIP ______________________

Guarantor phone ______________________

Guarantor E-mail ______________________

SECTION 4. PLAN CHOICES

Check one box to indicate your health plan selection:

Group Health Cooperative:

☐ The Welcome **500** Plan – '09

☐ The Welcome **1750** Catastrophic Plan – '09*
(Annual deductible of $1,820 effective January 1, 2010)

☐ The Welcome **3500** Catastrophic Plan – '09*

Group Health Options, Inc.:

☐ The Balance **1000** Plan – '09

☐ The Balance **1500** Plan – '09

☐ The Balance **2500** Catastrophic Plan – '09*

☐ The Balance **5000** Catastrophic Plan – '09*

☐ HealthPays® Health Savings Account (HSA)
2000 Individual/**4000** Family Catastrophic Plan – '09*†

Note: Federal law places some limitations on HSA eligibility. Consult your tax advisor or materials available through the U.S. Treasury Dept. for this important information to make sure you're selecting the right HSA plan for your family.

* These plans provide catastrophic coverage. If you decide at a later date to switch to a plan that provides greater coverage, you may be asked to provide a new Standard Health Questionnaire. In addition, your prior catastrophic coverage may not meet creditable coverage requirements for pre-existing conditions.

† Children under age 18 cannot enroll as the primary applicant/subscriber.

☐ **Optional Dental:** I would like Washington Dental Service dental coverage for myself and all eligible dependents. The address of WDS is: 9706 Fourth Ave. N.E., Seattle, WA 98115-2157.

Note: If you waive dental coverage, you will not be able to reapply until your annual plan renewal.

SECTION 5. VOTING OPTIONS

☐ I would like Group Health Cooperative voting membership for myself and all eligible dependents.

SECTION 6. PRIOR OR CURRENT COVERAGE

If you have been covered within the last 63 days by a plan with equivalent or greater overall benefits than the plan you purchase, we will waive the pre-existing condition wait period or credit that coverage. If you had a 64-day-or-more break in coverage, no portability credit will be applied for pre-existing conditions.

The pre-existing condition wait period will be waived if you are an "eligible individual" under HIPAA. You qualify as an "eligible individual" if: you have 18 months or more of creditable coverage without a break of 63 full days or more before applying for coverage with Group Health; your most recent coverage was under a group health plan, governmental plan, or church plan (or under health insurance coverage offered in connection with such a plan); you are not eligible for a group health plan; you are not eligible for Medicare or Medicaid; you do not have other health insurance; you did not lose your most recent coverage because of nonpayment of premiums or fraud; and you elected and used up your available COBRA continuation coverage.

If you have/had previous coverage other than Group Health within the last 63 days, provide your Certificate of Creditable Coverage or other document showing your beginning and ending dates of coverage (when available) with this application so we may determine if a reduction of the wait period applies.

1. Name of carrier or insurance company: ____________________ Phone: (_______) ____________________
   (Any company, including Group Health Cooperative or Group Health Options, Inc.)
2. Names of all enrollees on current/previous coverage:
   ____
3. Date coverage began: ______________ Date coverage ended: ______________
4. Deductible amount per year: Individual ______________ Family ______________
5. Did/does your coverage include: ☐ Maternity ☐ Prescription drug ☐ Hospital only
6. Are you currently on or coming from COBRA: ☐ Yes ☐ No Began: ______________ Ended: ______________
7. What type of coverage are you coming from:
   ☐ Individual plan ☐ Group plan ☐ Federal plan (FEHBP/TriCare/Peace Corps Act)
   ☐ Healthy Options plan (DSHS) ☐ WSHIP ☐ College/school/short-term insurance
   ☐ Indian Health Service or tribal organization ☐ Basic Health plan ☐ State Children's Health Insurance Program (SCHIP)
   ☐ Medicaid ☐ State plan (PEBB)

SECTION 7. STANDARD HEALTH QUESTIONNAIRE EXEMPTIONS

Is an applicant exempt from health screening? If so, check the reason below. Note that a primary subscriber's exemption DOES NOT carry over to spouse or dependent(s). Otherwise, you must submit a Standard Health Questionnaire for everyone listed on this application. Refer to the Standard Health Questionnaire for more details.

☐ **Relocation:** Applicant has relocated within Washington in the past 90 days, and prior health plan is not available. *Include a copy of a utility bill in your name from the prior address dated within the last 90 days and a letter of verification from your prior carrier verifying that because you have moved, you no longer reside in their service area and they cannot provide health insurance at your new location.*

☐ **Exhausted COBRA / Employer went out of business while on COBRA:** Termination must be within 90-days of dated application. *Include letter from COBRA Administration verifying COBRA coverage has been exhausted or a letter from the employer/COBRA administrator indicating the employer has gone out of business and COBRA benefits are being discontinued. Certificate of Creditable Coverage is also required.*

☐ **Refused COBRA:** Applying for coverage within 90 days of COBRA qualifying event and was enrolled in group coverage for at least 24 continuous months prior to event and chose not to take COBRA. *Include a letter from your employer or COBRA Administrator that addresses your termination and Certificate of Creditable Coverage "COC."*

☐ **Terminated COBRA:** Applying for coverage within 90 days of terminating COBRA coverage and you had at least 24 months of continuous group coverage prior to termination (not applicable to BH applicants)? *Include a letter of verification from your employer addressing your termination of COBRA and a certificate of coverage for proof of 24 months of continuous group coverage.*

☐ **Employer exempt from COBRA:** Applying for coverage within 90 days of an event that would qualify for COBRA, had your employer not been exempt from COBRA, and you had at least 24 months of continuous group coverage prior to such event? *Include letter of verification of COBRA exemption from employer and Certificate of Creditable Coverage "COC."*

☐ **Provider cancellation:** Health care provider left network of your current individual plan within the last 90 days. *Include a letter of verification from the provider or carrier verifying service in the last 12 months and the date the provider left the network.*

☐ **Washington Basic Health plan (BH):** Applying for coverage within 90 days of termination of the BH plan and was enrolled for at least 24 continuous months. *Include a letter of verification from your carrier with dates of coverage for proof of your 24 months of eligibility from BHP, or a certificate of coverage.*

☐ **New child:** Addition of newborn or newly adopted child to an existing plan, within 60 days of event. *Include documentation indicating date of placement or birth.*

SECTION 8. ACKNOWLEDGEMENTS & SIGNATURES

This application becomes part of my Medical Coverage Agreement with Group Health. I understand that I have the right to examine and return the Medical Coverage Agreement within 10 days of receipt. I have read and agree to the Terms and Conditions included with this application and with the statements below.

☐ The signatures shown below allow me, my spouse/domestic partner, or my producer (Section 9) to release to Group Health information about any person listed on my individual and family plan application documents, including information from the Standard Health Questionnaire. I further understand that under the Health Insurance Portability and Accountability Act (HIPAA), Group Health may only be allowed to release limited information to me, my spouse/domestic partner, adult/minor children, or my producer.

☐ Group Health may collect, use, or disclose the Nonpublic Personal Information of persons listed on this application as required or permitted by law and to conduct routine business functions such as determining eligibility for enrollment, reviewing prior coverage for waiting periods, paying claims and, if appropriate, coordinating benefits, and fulfilling other legal obligations specified in my Group Health Medical Coverage Agreement.

☐ If my/our physical residential address changes to a different county in the Group Health service area, my premium rates may be subject to change.

I declare that, to the best of my knowledge, all information I have provided with this application 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 on behalf of myself or any family members, the Medical Coverage Agreement may be cancelled retroactively to its effective date. I further understand that it is a crime to knowingly provide false, incomplete, or misleading information for the purpose of fraudulently obtaining health coverage. Penalties may include imprisonment, fines, and denial of benefits.

Applicant/guarantor signature	**Date**
Spouse/domestic partner signature	**Date**

SECTION 9. PRODUCER INFORMATION (SECTION REQUIRED IF APPLICABLE)

Group Health sales representative or producer name	**Group Health producer ID number**
Company/house name (if applicable)	**Group Health house ID number**
Phone number	

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