PacificSource Health Plans
Individual and Family Policy Direct Application

Thank you for choosing PacificSource! You may also apply online at **PacificSource.com/find-a-plan**.

1. What you'll need to complete this application:

- A blue or black pen.
- Information, such as your old ID card, from any insurance company that currently or recently covered you or your family.
- A copy of any documentation you may need to show legal guardianship. If you are part of a domestic partnership, attach an Affidavit of Domestic Partnership (found on our website under For Employers > Forms and Materials > Administrative Forms).

The name of your primary care physician for all family members applying.

Choose a plan and a deductible (check one):

	SmartAlliance Network*	BrightIdea Network*	SmartHealth Network*
Balance	☐ Balance Silver 2500	☐ Balance Silver 2500	☐ Balance Silver 2500
	☐ Balance Silver 1500	☐ Balance Silver 1500	☐ Balance Silver 1500
	☐ Balance Bronze 6350	☐ Balance Bronze 6350	☐ Balance Bronze 6350
Value	☐ Value Silver 3600	☐ Value Silver 3600	☐ Value Silver 3600
	☐ Value Silver 3000	☐ Value Silver 3000	☐ Value Silver 3000
	☐ Value Bronze 6250	☐ Value Bronze 6250	☐ Value Bronze 6250
	☐ Value Bronze 3000	☐ Value Bronze 3000	☐ Value Bronze 3000

*Not all SmartAlliance, BrightIdea, or SmartHealth plans are available in all counties. For plan availability, please visit PacificSource.com/find-an-individual-plan and view Browse Plans, or refer to our Oregon Individual and Family Plan Guide.

If this policy does not provide coverage for the Essential Health Pediatric Dental benefits in accordance with Federal and State regulations, please indicate the name of the carrier in the section below so that we can be reasonably assured that you have obtained the coverage through another carrier for you and your dependents that are covered under this policy.

Please indicate the name of the carrier that will be providing the Essential Health Pediatric Benefit: _____

Please be aware that if you do not provide PacificSource with Essential Health Pediatric Dental information for your pediatric dental eligible dependants, PacificSource will be required to issue a Stand Alone Dental Plan to you and your eligible dependants.

PacificSource HEALTH PLANS

2. Enrolling Myself and My Family

***Race/Ethnicity** (choose the code that each family member would most closely identify with): **A**-American Indian/Alaska Native, **B**-Asian, **C**-Black/African American, **D**-Hispanic/Latino, **E**-Native Hawaiian/Other Pacific Islander, **F**-White/Caucasian

Name (First, MI, Last)	Race/ Ethnicity*	Primary Care Physician (Name/Address)
Myself:		
Email (Would you like to receive your information electronically?):		
Name (First, MI, Last)	**Race/ Ethnicity***	**Date of Birth (MM-DD-YYYY)**
My spouse or domestic partner:		
My dependent child:		
My dependent child:		
My dependent child:		
My dependent child:		
My dependent child:		
My dependent child:		

Attach additional pages if needed. ☐ I have attached ___ page(s).

Need help? ***If you have questions about any part of this application, we'd be happy to help. You can reach an Individual Sales Representative at (855)333-1559.***

3. How Do You Prefer to Pay?

☐ Send me a paper bill by mail each month. (Continue to section 10.)

☐ Through automatic withdrawal from my bank account (EFT)

We authorize and direct PacificSource Health Plans to withdraw funds as follows:

Amount of monthly withdrawal: $_____ Withdrawals will occur on the 5th of each month.

Select one: ☐ Begin transfers on the next available date ☐ Delay transfers until_____(month)

Bank information:

Bank name: _____ Account number: _____

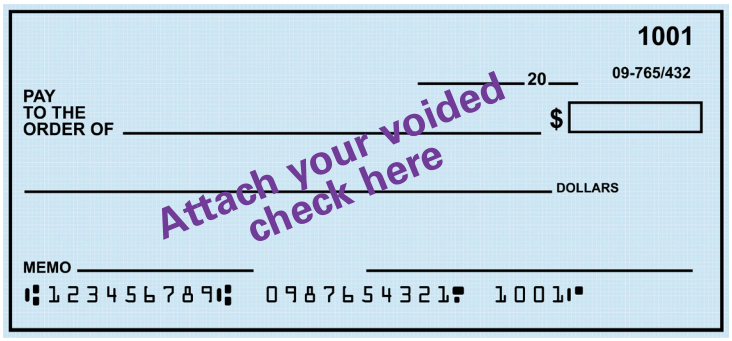
Account Type: ☐ Checking—attach a voided check ☐ Savings—attach a voided savings withdrawal slip

This authorization will remain in effect until termination by either party. If the individual policy premium changes due to a rate increase, alternate plan selection, or age change of the policyholder, this authorization will automatically be amended to authorize withdrawal of an amount equal to the new premium.

Policyholder's Name (please print)	Signature of Bank Account Holder
Policyholder's ID	Date

Important details about the automatic withdrawal of your monthly premiums:

- New accounts take 30 days to set up. If your policy is accepted and coverage starts sooner than your automatic withdrawal is set up, you may need to pay by check until the funds transfer is in place.
- Transfers occur on the 5th of each month. If the 5th falls on a weekend or a holiday, the transfer will occur on the next business day.
- Transfers will be made for the premium balance due.



Send your signed, completed application and attachments to us by:

Mail: PacificSource Health Plans
408 E Parkcenter Boulevard, Suite 100
Boise, ID 83706

Fax: (208) 342-4508

Email: idahoindividual@pacificsource.com

4. Certify, Authorize, and Sign

Be sure to sign and date the application on the following page. Your spouse's or domestic partner's signature is also required (if applicable) as is the signature of any child over the age of 18.

Certification of Completeness and Correctness

I affirm that the answers given in this application are complete and correct. I am providing these answers as part of the application procedure required by PacificSource to enroll in their insurance coverage. I understand that if this application contains any intentional misrepresentation of material fact or fraud, PacificSource may modify or cancel the contract, and/or take any other legal action available to it by law. I will promptly inform PacificSource in writing if anything happens before my coverage takes effect that makes the information I have provided on this application incomplete or incorrect. I understand and agree that no coverage will be in force until accepted by PacificSource. If accepted, coverage will be in force as of the effective date determined by PacificSource. A representative of PacificSource may contact me to clarify answers on this application. Representations made by the applicant are deemed to be representations made on behalf of each person covered under this policy. However, changes to the application will not be effective until approved in writing by the applicant. An application received by PacificSource requiring alterations will be modified by amendment and sent to the applicant for signature. As the applicant, I understand I have the right to inspect the information in my file.

I (We) have reviewed and I (we) understand this authorization and the "Certification of Correctness" above.

Applicant/responsible party/guardian Signature _____ Date _____

Spouse's/Domestic Partner's Signature (if applying for coverage) _____ Date _____

Signature of child age 18 or older (if applying for coverage) _____ Date _____

Signature of child age 18 or older (if applying for coverage) _____ Date _____

This application must be signed and dated. All fields must be completed for this authorization to be valid. If accepted, PacificSource will provide the policyholder with a copy of this completed form with the policy.

Required if applicant is a minor:

Signature of (check one) _____ Date _____ Printed Name of Parent or Guardian _____

☐ Parent ☐ Guardian

5. Are You Ready to Submit?

- ☐ Are all sections filled in completely?
- ☐ Have you attached any requested paperwork (such as guardianship documentation, Certificate of Coverage, etc.)?
- ☐ Have you selected a payment option and attached a voided check if needed?
- ☐ Did you select a policy effective date on page 2?

6. Submit

Send your signed, completed application and attachments to us by:

Mail: PacificSource Health Plans
408 E Parkcenter Boulevard, Suite 100
Boise, ID 83706

Fax: (208) 342-4508

Email: idahoindividual@pacificsource.com

Thank you for your application!

IDAHO INDIVIDUAL APPLICATION
FOR ENROLLMENT OUTSIDE OF THE IDAHO EXCHANGE

Please type or print legibly in black ink and complete all applicable sections.

SECTION 1 ENROLLMENT INFORMATION (check all that apply)

1. Are you: ☐ a new applicant ☐ adding dependents ☐ enrolling during the annual open enrollment
2. If you are enrolling ***outside*** of the annual open enrollment or adding dependents, what is the reason *(documentation may be required)*? ☐ marriage ☐ divorce ☐ birth ☐ adoption ☐ involuntary loss of ***employer*** coverage ☐ involuntary loss of ***individual*** coverage ☐ involuntary loss of Medicaid ☐ court order *(copy of court order required)* ☐ other _____
   Date of event _____ *mm/dd/yyyy*
3. Are you a resident of the state of Idaho? ☐ Yes ☐ No If yes: _____ years _____ months
4. Requested effective date *(subject to approval)*: _____ *mm/dd/yyyy*

SECTION 2 APPLICANT INFORMATION

1. **Legal** first name, middle name, last name *(and suffix, if applicable)*			
2. Street Address			
3. City	4. State	5. Zip Code	6. County
7. Mailing Address *(Street, Route, P.O. Box) (if different than street address)*			
8. City	9. State	10. Zip Code	11. County
12. Billing Address *(if different than mailing address)*			
13. City	14. State	15. Zip Code	16. County
17. Preferred **Daytime** Phone Number	18. Alternate Phone Number		19. Date of Birth *(mm/dd/yyyy)*
20. Gender ☐ Male ☐ Female	21. Social Security Number **(required)**	22. Marital Status ☐ Single ☐ Married ☐ Other _____	
23. Email address			

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SECTION 3 — DEPENDENT INFORMATION (List all eligible dependents you wish to enroll, including any child who is under the age of 26; or who is medically certified as disabled and dependent on parent for support (copy of certification required). If you have more dependents to include, make a copy of this page and attach.)

Dependent 1

1. **Legal** first name, middle name, last name *(and suffix, if applicable)*

2. Relationship
   ☐ **legal** spouse ☐ child
   ☐ step-child
   ☐ Other _____

3. Gender
   ☐ Male ☐ Female

4. Date of Birth *(mm/dd/yyyy)*

5. Social Security Number **(required)**

6. Does dependent 1 live at the same address as you? ☐ Yes ☐ No

Dependent 2

1. **Legal** first name, middle name, last name *(and suffix, if applicable)*

2. Relationship
   ☐ **legal** spouse ☐ child
   ☐ step-child
   ☐ Other _____

3. Gender
   ☐ Male ☐ Female

4. Date of Birth *(mm/dd/yyyy)*

5. Social Security Number **(required)**

6. Does dependent 2 live at the same address as you? ☐ Yes ☐ No

Dependent 3

1. **Legal** first name, middle name, last name *(and suffix, if applicable)*

2. Relationship
   ☐ **legal** spouse ☐ child
   ☐ step-child
   ☐ Other _____

3. Gender
   ☐ Male ☐ Female

4. Date of Birth *(mm/dd/yyyy)*

5. Social Security Number **(required)**

6. Does dependent 3 live at the same address as you? ☐ Yes ☐ No

Dependent 4

1. **Legal** first name, middle name, last name *(and suffix, if applicable)*

2. Relationship
   ☐ **legal** spouse ☐ child
   ☐ step-child
   ☐ Other _____

3. Gender
   ☐ Male ☐ Female

4. Date of Birth *(mm/dd/yyyy)*

5. Social Security Number **(required)**

6. Does dependent 4 live at the same address as you? ☐ Yes ☐ No

SECTION 4 — OTHER INFORMATION

1. Are you or any dependent listed on this application receiving Worker's Compensation payments or are now eligible to receive such payments? ☐ Yes ☐ No

   If yes, give person's name, specific type and details: _____

   _____

2. Has any person listed on this application used a tobacco product on average four or more times a week within no longer than the past six months (anyone age 18 or older)? ☐ No ☐ Yes **If yes**, list names below:

   1. _____ 3. _____
   2. _____ 4. _____

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SECTION 5 — OTHER COVERAGE INFORMATION *(Please complete the section below if you have other coverage that will remain in effect. If you have more policies to include, make a copy of this page and attach.)*

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 insurance so that the insurance carrier can determine whose coverage is primary.

Policy 1

1. Other Insurance Carrier Information: Insurance Carrier Name, Policy Number, Phone Number

2. Policy Holder Name		3. Names of Covered Members	
4. Types of Coverage *(check all that apply)* ☐ Group ☐ COBRA ☐ Individual ☐ HRP ☐ Medicare ☐ Medicaid ☐ Other _____	5. Coverage Start Date *mm/dd/yyyy*	6. Is this coverage terminating? ☐ Yes (complete #7) ☐ No	7. Coverage End Date *mm/dd/yyyy*

Policy 2

1. Other Insurance Carrier Information: Insurance Carrier Name, Policy Number, Phone Number

2. Policy Holder Name		3. Names of Covered Members	
4. Types of Coverage *(check all that apply)* ☐ Group ☐ COBRA ☐ Individual ☐ HRP ☐ Medicare ☐ Medicaid ☐ Other _____	5. Coverage Start Date *mm/dd/yyyy*	6. Is this coverage terminating? ☐ Yes (answer #7) ☐ No	7. Coverage End Date *mm/dd/yyyy*

SECTION 6 — FEDERALLY ELIGIBLE INDIVIDUAL INFORMATION

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), guaranteed availability of individual coverage means that if you are HIPAA eligible, you cannot be denied the right to buy individual coverage. In addition, a preexisting condition exclusion cannot be applied to your coverage.

You are HIPAA eligible, also called an "eligible individual," if **ALL** of the following are true at the time you apply for individual coverage in Idaho.

- You are not covered under another group health plan
- Your most recent coverage was not cancelled because you did not pay your premiums or because you committed fraud
- You are not currently eligible for Medicare or Medicaid

If you are HIPAA eligible, you will lose your right to get individual coverage without an exclusion unless you submit an application for individual coverage within 63 days after the day your group coverage or continuation coverage ends. Act promptly to protect your rights.

SECTION 7 — AFFIRMATION

I affirm the answers in this "Idaho Individual Application" are complete and correct. I am providing these answers as part of the application procedure required by this insurance carrier to enroll in its insurance coverage. I understand that the insurance carrier will rely on each answer in making its determination to extend coverage and to determine the type of coverage offered. I understand if I have made any misstatement or omission in this application, the insurance carrier may take any action available by law, including but not limited to, retroactive adjustment of premiums or claims. Further, I understand that any fraud or intentional misrepresentation of material fact in my completion of this application is cause for retroactive termination of coverage by the insurance carrier and/or other action available at law. I will promptly inform the insurance carrier in writing if anything happens before my coverage takes effect that makes an answer on this application incomplete or incorrect. Following receipt of a fully-executed application, coverage will be in force as of the effective date determined by the insurance carrier under applicable law.

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SECTION 8 STATEMENT OF UNDERSTANDING

By signing this application, I represent that all my answers are complete and accurate to the best of my knowledge and belief and that I understand and agree to the following conditions:

- No independent producer, agent or employee of the insurance carrier can change any part of this application or waive the requirement that I answer all questions completely and accurately.
- The insurance carrier may terminate or rescind an insured's coverage for any intentional misrepresentation, omission of fact by, concerning, or on behalf of any insured that was or would have been material to the insurance carrier's acceptance of a risk, extension of coverage, provision of benefits or payment of any claim.
- If this application is approved, coverage for me and any eligible persons named on this application will begin on the effective date assigned by the insurance carrier.
- I understand that this application will become part of the contract between the insurance carrier and me.
- I affirm that I have reviewed all answers given on this application and, regardless of whether an independent producer or other person has filled out the answers for me, I verify that the answers are true and complete.

SECTION 9 PREEXISTING CONDITION WAITING PERIOD (OVER 19 YEARS OF AGE)

NOTICE OF PREEXISTING CONDITION LANGUAGE: I understand that until the first plan year beginning January 1, 2014 or later, a waiting period for preexisting conditions may apply. This means if you have a medical condition before coming to our plan, you might have to wait a specified period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a six-month period. Generally, the six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period began. This preexisting condition exclusion does not apply to pregnancy nor to individuals under the age of 19 years beginning upon the policy renewal on or after September 23, 2010, as provided in the Patient Protection and Affordable Care Act (PPACA).

This exclusion may last up to 12 months from your first day of coverage, or if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is considered creditable coverage and can be used to reduce the preexisting condition exclusion if you have experienced a break in coverage of at least 63 days. To reduce the 12-month exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

SECTION 10 PARENTAL OR GUARDIAN CONSENT TO APPLICATION

By completing this section and signing this application, I represent that the person listed as the applicant on this application is under 18 years of age and is making application for health coverage with my full knowledge and consent. I hereby accept full responsibility for the payment of premiums and the answers and information provided in this application.

Print Name | Date *(mm/dd/yyyy)*

Address *(if different than dependent)*

SECTION 11 ACKNOWLEDGEMENT

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.

Signature of Applicant _____ Date _____ *mm/dd/yyyy*

Signature of Spouse _____ Date _____ *mm/dd/yyyy*
(if applying for coverage)

SECTION 12 INDEPENDENT PRODUCER (AGENT) INFORMATION

Agent's Name _____ ID No. _____

Signature of Agent _____ Date _____ *mm/dd/yyyy*

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