Regence BlueCross BlueShield of Utah and
its non-insurer subsidiary, Regence ValueCare
and/or Regence HealthWise
Attn: Membership #4
P.O. Box 30270
Salt Lake City, Utah 84130-0270

APPLICATION FOR ENROLLMENT/WAIVER

Please print in black or blue ink in all **unshaded** areas. Incomplete and/or illegible information may result in delayed coverage. If an item is not applicable, write "N/A". The form must be signed and dated or it will be **returned**.

EMPLOYEE INFORMATION

Health Plan Option: *OR* **HSA Qualified Plan:**	**Network Option:**	**Dental:**	**Other:**		Health Group Number
☐ BlueEssentials ☐ Regence HSA Healthplan/ HSA High Deductible Plan ☐ BluePreferred ☐ BlueClassic Bank_______________	☐ BlueCross BlueShield ☐ ValueCare ☐ HealthWise (Not available on Regence HSA Healthplan)	☐ BCBS ☐ ValueCare	☐ Life ☐ Vision	☐ **Existing Enrollee** ☐ **New Enrollee** or **Transferring from** ____________________	

Employee Name (Last)	(First)	(M.I.)

Mailing Address

City	State	Zip Code (+ 4)	Social Security Number

Daytime Phone Number	Employer	Work Location (City/State)	Occupation

Hire Date (Mo/Day/Year)	Hours Per Week	Family Status:	Applying for:	
		☐ Single ☐ Married	☐ Self and Dependents ☐ Self only Number of eligible dependents ___________	☐ Owner ☐ Non-Management ☐ Salaried ☐ Retired ☐ Management ☐ Commissioned ☐ Hourly ☐ Union

Effective September 23, 2010, the Patient Protection and Affordable Care Act prohibits employers from discriminating in favor of highly compensated individuals as set forth in Internal Revenue Code section 105(h) and implementing regulations. Regence is unable to determine whether a plan discriminates in a way that violates the new law because it does not have access to information such as corporate structure, employee salaries, stock ownership, length of service, percentage of premiums paid by the employer, etc. Because the new law imposes fines on employers with discriminatory plans, Regence recommends that employers obtain tax and/or legal advice to ensure they comply with nondiscrimination requirements.

Effective Date	Membership Status	Adult Code	Family Members	Special Code	Medically Underwritten

ENROLLING MEMBERS

Relationship to Employee	Gender	Name(s) of Members to be covered (include last name if different from Employee) No nicknames: First Name	Middle Initial	Last Name	Social Security # for each member covered	Birthdate MM/DD/YYYY
Employee	☐ M ☐ F					
Spouse	☐ M ☐ F					
Dependent	☐ M ☐ F					
Dependent	☐ M ☐ F					
Dependent	☐ M ☐ F					
Dependent	☐ M ☐ F					
Dependent	☐ M ☐ F					
Dependent	☐ M ☐ F					

INSTRUCTIONS

WAIVING MEMBERS

- Complete this section for yourself (if waiving) and/or any of your eligible dependents for whom you are waiving coverage. You may not enroll dependents if you are waiving (except children subject to a Qualified Medical Child Support Order).
- If you decline enrollment in this plan for yourself and/or any of your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll the omitted individual(s) in this plan, provided that you request enrollment within 30 days after the other coverage of the individual(s) ends. ("Decline enrollment" includes omission of the individual from this application.) In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption (the Special Enrollment Period).
- Please complete type of insurance coverage for the employee and all eligible members who have other health insurance coverage by completing type of insurance [group, individual or other (Medicare, Medicaid, V.A., H.I.P., etc.)].
- All eligible family members must be listed in either Enrolling or Waiving Members section.

Name(s) of Member(s) Waiving Coverage (include last name if <u>different</u> from Employee) No nicknames, please.	Birthdate MM/DD/YYYY	Other Health Insurance: Yes	No	Type of Insurance: Group	Individual	Other (explain)	Insurance Carrier Name
Employee							
Spouse							
Children							

Complete and sign reverse side

APPLICATION FOR ENROLLMENT/WAIVER *continued*

CURRENT/PRIOR COVERAGE INFORMATION

Please indicate for EACH person listed on this application any health insurance coverage (including Medicare or Medicaid) in effect within 24 months prior to the proposed effective date of this coverage. Each person applying for coverage must be listed below. If no health insurance coverage was in effect within the past 24 months, please indicate NONE. Obtaining credit for previous coverage is subject to your eligibility under the Health Insurance Portability and Accountability Act (HIPAA) and, therefore, is not guaranteed by the completion of this application. Failure to complete all information and submit a "Certificate of Coverage" form withthis "Application For Enrollment/Waiver" will delay your ability to obtain credit for prior coverage to which you may be entitled.

MEDICARE If you or any family member listed on this application have Medicare, is coverage ☐ **PART A** ☐ **PART B** ☐ **PART D**, and please complete the following information:

Enrolling Individual	Effective Date	Medicare Number (please include alpha prefix)	Reason for Medicare Entitlement
	/ /		☐ Age ☐ Disability ☐ ESRD ☐ dual entitlement
	/ /		☐ Age ☐ Disability ☐ ESRD ☐ dual entitlement

Enrolling Individual's Name (Non-Medicare)	Insurance Carrier (Policy Number and Phone Number)	Dates of Coverage (Month/Day/Year)		When this application is approved, will the enrolling individual continue to be covered by this other health coverage?	Type of Coverage Check all that apply.
		From	To		
1.				☐ YES ☐ NO	☐ Group ☐ Individual ☐ Dental ☐ Medical
2.				☐ YES ☐ NO	☐ Group ☐ Individual ☐ Dental ☐ Medical
3.				☐ YES ☐ NO	☐ Group ☐ Individual ☐ Dental ☐ Medical
4.				☐ YES ☐ NO	☐ Group ☐ Individual ☐ Dental ☐ Medical
5.				☐ YES ☐ NO	☐ Group ☐ Individual ☐ Dental ☐ Medical
6.				☐ YES ☐ NO	☐ Group ☐ Individual ☐ Dental ☐ Medical
7.				☐ YES ☐ NO	☐ Group ☐ Individual ☐ Dental ☐ Medical
8.				☐ YES ☐ NO	☐ Group ☐ Individual ☐ Dental ☐ Medical

LIFE

BENEFICIARY DESIGNATION Please complete the following if your Group Life is administered by Highmark Life and Casualty (TransGeneral Life). Other forms are available for Regence Life and Health Insurance Company.

First Name	Last Name	Birthdate (mo/day/year)	Social Security Number	Relationship	Benefit %
Primary					%
Primary					%
Contingent					%
Contingent					%

Dependent Life ☐ YES ☐ NO

Life Group No. ____________________ Class ______________ Life Amount ________________

I authorize any source to release to Regence BlueCross BlueShield of Utah, its non-insurer subsidiary, Regence ValueCare, and/or Regence HealthWise (hereinafter referred to as "the Plan"), any medical, health, employment and/or insurance information requested for any enrolled member. I authorize payroll deduction of premiums as required. I agree to abide by the Plan's enrollment provisions. I understand that coverage cannot start until after I have served the waiting period agreed to by the employer as recorded on the Plan's records. I authorize my employer to act as my agent in all matters of administration of the group program, and acknowledge that my employer is in no way acting as agent for the Plan.

I acknowledge and understand that the issuer may request or disclose health information about me or my dependents (persons who are eligible for benefits coverage and are listed on the enrollment 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 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.

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

I acknowledge that I have had the opportunity to enroll, but do not wish to make application for those individual(s) listed in the WAIVING MEMBERS section above (or any eligible family member not listed). In waiving coverage, I am aware that waiving members (including myself, if I am waiving) may later enroll at my group's anniversary, unless qualified for a Special Enrollment Period (SEP). If I have waived enrollment for myself or any of my dependents (including my spouse) because of other health insurance or group health plan coverage, I may in the future be qualified for a Special Enrollment Period and be able to enroll the waived individuals in this plan, provided I request enrollment within 30 days after the other coverage of the individual(s) ends due to loss of eligibility or an employer's ceasing to contribute toward that other coverage. I may also enroll waived individuals within 30 days of receiving initial written notice of eligibility for premium assistance under Title 26, Chapter 18 of the Utah Code. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If I apply for life insurance, I understand that if I am not actively at work on the effective date of my coverage, my insurance will not begin until the day I return to work. For those coverages I have declined, I understand that if I choose to enroll at a later date, my cost may be higher and a health questionnaire may be required.

I understand that credit for prior coverage will be based upon the information contained in this application. If any information provided is false or incomplete, Regence BlueCross BlueShield of Utah, and/or its subsidiaries may without advance notice declare the contract null and void and cancel the coverage retroactive to its original effective date or impose the pre-existing condition waiting period and deny claims that are pre-existing.

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

Any matter in dispute between you and the Plan 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 Plan. The Plan 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 Plan. 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.

_______________________________________ _______________________

Employee's Signature Date