

INDIVIDUAL REGENCE HEALTH SAVINGS ACCOUNT



P.O. Box 30270
Salt Lake City, Utah 84130-0270

APPLICATION

for Individuals and Family

Member Number

BAR _____

UMA _____

FBL _____

Other _____

FOR OFFICE USE ONLY

Group # _____

Eff. Date _____

PAYMENT PLAN:

SurePay Monthly Quarterly

Condition Specific Rider

Please follow instructions carefully. Inaccurate, incomplete, or illegible applications will be returned.

- MUST BE COMPLETED EXCLUSIVELY BY THE APPLICANT AND SIGNED AND DATED** on pg. 6.
- Complete ALL items. Print in **BLACK** or **BLUE** ink.

COVERAGE APPLIED FOR

REGENCE HEALTH SAVING ACCOUNT (HSA) QUALIFIED PLANS		STATUS	
Choose one		Choose one	
<input type="checkbox"/> \$1,500 Single	<input type="checkbox"/> \$3,000 Family	<input type="checkbox"/> (One Insured) Single	
<input type="checkbox"/> \$2,500 Single	<input type="checkbox"/> \$5,000 Family	<input type="checkbox"/> (Two Insured) Two-Party	
<input type="checkbox"/> \$3,500 Single	<input type="checkbox"/> \$7,000 Family	<input type="checkbox"/> (Three or more Insureds) Family	

GENERAL INFORMATION

COMPLETE THIS SECTION FOR APPLICANT AND SPOUSE (IF APPLICABLE)

APPLICANT			LAWFUL SPOUSE (Must be completed even if spouse is not applying)		
Last Name	First Name	Initial	Last Name	First Name	Initial
Mailing Address/Box No.			Mailing Address/Box No.		
City, State, ZIP			City, State, ZIP		
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed					
Home Phone () - ()		Work Phone ()	Home Phone () - ()		Work Phone ()
Email Address			Email Address		
Occupation		Hours Per Week	Occupation		Hours Per Week
Employer's Name		Location (City, State)	Employer's Name		Location (City, State)
# of Employees			# of Employees		
Name of employer's group health insurance company. (If none, write "none")			Name of employer's group health insurance company. (If none, write "none")		

INDIVIDUAL AND FAMILY INFORMATION — REQUIRED FOR ALL APPLICANTS

LIST THE FOLLOWING INFORMATION FOR ALL FAMILY MEMBERS APPLYING FOR COVERAGE

Family Members	First Name	Last Name	Sex	Relationship To Applicant*	Birthdate Mo/Day/Yr	Height Ft - In	Weight Lbs.	Social Security Number	Name of Current Physician	PEC
Applicant			<input type="checkbox"/> M <input type="checkbox"/> F	Applicant	/ /	-		- -		
Spouse			<input type="checkbox"/> M <input type="checkbox"/> F	Spouse	/ /	-		- -		
Unmarried children (under 26 – eldest first)			<input type="checkbox"/> M <input type="checkbox"/> F		/ /	-		- -		
			<input type="checkbox"/> M <input type="checkbox"/> F		/ /	-		- -		
			<input type="checkbox"/> M <input type="checkbox"/> F		/ /	-		- -		
			<input type="checkbox"/> M <input type="checkbox"/> F		/ /	-		- -		
			<input type="checkbox"/> M <input type="checkbox"/> F		/ /	-		- -		
			<input type="checkbox"/> M <input type="checkbox"/> F		/ /	-		- -		
			<input type="checkbox"/> M <input type="checkbox"/> F		/ /	-		- -		

HEALTH STATEMENT – (EACH CONDITION MUST BE CHECKED “YES” OR “NO”)

If complete health information is not received, this application will be returned. Inaccurate health information may result in your policy being cancelled retroactively.

Have you or any listed Family Members EVER experienced problems with, been diagnosed with, or been treated for any of the following:		Within the LAST FIVE YEARS (continued)		Complete the following questions for all immediate family members proposed for insurance.	
	Yes	No		Yes	No
1. AIDS/HIV positive	<input type="checkbox"/>	<input type="checkbox"/>	30. Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
2. Amputation	<input type="checkbox"/>	<input type="checkbox"/>	31. Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
3. Arteries/Veins	<input type="checkbox"/>	<input type="checkbox"/>	32. Asthma	<input type="checkbox"/>	<input type="checkbox"/>
4. Arthritis or Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	33. Bladder/Urinary Disorder	<input type="checkbox"/>	<input type="checkbox"/>
5. Autism	<input type="checkbox"/>	<input type="checkbox"/>	34. Bone/Joint	<input type="checkbox"/>	<input type="checkbox"/>
6. Back/Neck Surgery	<input type="checkbox"/>	<input type="checkbox"/>	35. Back, neck, or spinal problems, that required medical attention and/or interfered with normal daily activities?	<input type="checkbox"/>	<input type="checkbox"/>
7. Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>	36. Breast Disorder	<input type="checkbox"/>	<input type="checkbox"/>
8. Ankylosing spondylitis, neuropathy, osteogenesis imperfecta, osteoporosis, herniated and/or ruptured disc(s), spina bifida, kyphosis, scoliosis, spinal stenosis, spondylolisthesis, or spondylosis	<input type="checkbox"/>	<input type="checkbox"/>	37. Jaw Problems	<input type="checkbox"/>	<input type="checkbox"/>
9. Blood Disease or Problems	<input type="checkbox"/>	<input type="checkbox"/>	38. Depression/Chemical Imbalance	<input type="checkbox"/>	<input type="checkbox"/>
10. Bowel Disorder/Colitis	<input type="checkbox"/>	<input type="checkbox"/>	39. Digestive System	<input type="checkbox"/>	<input type="checkbox"/>
11. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	40. Drug Abuse/Addiction	<input type="checkbox"/>	<input type="checkbox"/>
12. Congenital Disorders/Defects	<input type="checkbox"/>	<input type="checkbox"/>	41. Eyes, Ears, Nose, Throat	<input type="checkbox"/>	<input type="checkbox"/>
13. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	42. Female or Menstrual Problems	<input type="checkbox"/>	<input type="checkbox"/>
14. Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	43. Foot Problems	<input type="checkbox"/>	<input type="checkbox"/>
15. Epilepsy, Seizure, or Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	44. Fracture or Dislocation	<input type="checkbox"/>	<input type="checkbox"/>
16. Heart Disease or Problems	<input type="checkbox"/>	<input type="checkbox"/>	45. Gall Bladder/Gall Stones	<input type="checkbox"/>	<input type="checkbox"/>
17. Liver Disorder/Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>	46. Glandular/Hormone System	<input type="checkbox"/>	<input type="checkbox"/>
18. Lung Disease/Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	47. Gout	<input type="checkbox"/>	<input type="checkbox"/>
19. Lupus	<input type="checkbox"/>	<input type="checkbox"/>	48. Hemorrhoids/Rectal Problems/Polyps	<input type="checkbox"/>	<input type="checkbox"/>
20. Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>	49. Hernia	<input type="checkbox"/>	<input type="checkbox"/>
21. Neurological Disease	<input type="checkbox"/>	<input type="checkbox"/>	50. High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
22. Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	51. Infertility	<input type="checkbox"/>	<input type="checkbox"/>
23. Polio (late effect)	<input type="checkbox"/>	<input type="checkbox"/>	52. Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
24. Suicide (attempted)	<input type="checkbox"/>	<input type="checkbox"/>	53. Kidney Disorder/Nephritis	<input type="checkbox"/>	<input type="checkbox"/>
25. Stroke/Brain	<input type="checkbox"/>	<input type="checkbox"/>	54. Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
26. Tumor or Growth (include location)	<input type="checkbox"/>	<input type="checkbox"/>	55. Knee Problems	<input type="checkbox"/>	<input type="checkbox"/>
Within the LAST FIVE YEARS have you or any listed Family Members experienced problems with, been diagnosed with, or been treated for any of the following:			56. Migraines/Headaches or Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No	57. Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
27. Abnormal Pap Test	<input type="checkbox"/>	<input type="checkbox"/>	58. Muscular/Nervous System	<input type="checkbox"/>	<input type="checkbox"/>
28. Abnormal PSA (Prostate Specific Antigen)	<input type="checkbox"/>	<input type="checkbox"/>	59. Pain (intractable or uncontrollable)	<input type="checkbox"/>	<input type="checkbox"/>
29. Accidental Injuries	<input type="checkbox"/>	<input type="checkbox"/>	60. Pregnancy (complications of)	<input type="checkbox"/>	<input type="checkbox"/>
			61. Premature Birth(s) (include gestational age & birth weight)	<input type="checkbox"/>	<input type="checkbox"/>
			62. Prostate Disorder/Male Organs/Impotence	<input type="checkbox"/>	<input type="checkbox"/>
			63. Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>
			64. Sinus Disorder	<input type="checkbox"/>	<input type="checkbox"/>
			65. Skin Disorder	<input type="checkbox"/>	<input type="checkbox"/>
			66. Stomach/Intestine Disorder	<input type="checkbox"/>	<input type="checkbox"/>
			67. Surgical Operation(s)	<input type="checkbox"/>	<input type="checkbox"/>
			68. Thyroid Disorder or Goiter	<input type="checkbox"/>	<input type="checkbox"/>
			69. Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
			70. Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>
			71. Do you or does any listed Family Member have any serious medical problems, or deformities not listed here?	<input type="checkbox"/>	<input type="checkbox"/>
			72. In the past 5 years have you or has any listed Family Member experienced any condition for which future consultation, treatment or surgery is contemplated or advised?	<input type="checkbox"/>	<input type="checkbox"/>
			73. Do you smoke now or have you smoked in the past? Does any listed Family Member smoke now or has smoked in the past? If “Yes,” please specify who smoked, for how long, and when the individual quit smoking (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>
			74. Have you or has any listed Family Member received any treatments or tests within the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
			75. Have you or has any listed Family Member received any medications, drugs or injections within the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
			76. Have you or has any listed Family Member consulted a physician in the last 12 months? Give date(s) and reason(s)	<input type="checkbox"/>	<input type="checkbox"/>
			Complete the following questions for all immediate family members whether or not proposed for insurance.		
				Yes	No
			77. Have you, your spouse or any eligible child (whether or not proposed for insurance) missed her last menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
			78. Are you, your spouse or any eligible child (whether or not proposed for insurance) currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
			79. Is anyone currently pregnant with your child, or your spouse’s child?	<input type="checkbox"/>	<input type="checkbox"/>

IF ANY OF THE ABOVE CONDITIONS OR QUESTIONS ARE CHECKED “YES,” PLEASE EXPLAIN IN THE SPACES PROVIDED ON THE FOLLOWING PAGE.
(Attach additional pages if necessary)

REQUIRED AND IMPORTANT INFORMATION. PLEASE ANSWER ALL QUESTIONS

IF ANSWER REQUIRES EXPLANATION OR ADDITIONAL INFORMATION, PLEASE PROVIDE INFORMATION, COMMENTS AND EXPLANATIONS BELOW.

Yes No

1. Are you, your spouse, and all eligible children applying for coverage? If no, please explain below.
2. Do you or any listed Family Member live, work, or attend school outside Utah?
If yes, please explain below, including percent of time spent outside Utah.
3. Have you or all listed Family Members resided in Utah for at least the 12 consecutive months immediately preceding the date of this application? If no, please explain below.
4. Are you or any listed Family Member covered or eligible for coverage under any of the following:
(a) public health insurance including, but not limited to, Medicare, Medicaid or the Utah Comprehensive Health Insurance Pool (HIP);
(b) private health insurance including, but not limited to, (i) Medicare Supplement, (ii) conversion coverage, (iii) continuation or extension under COBRA, or (iv) Mini COBRA;
(c) an association;
(d) individual/group health plan coverage?
If yes, please include name of health carrier and policy number below.
5. Are you or any listed Family Member **transferring** coverage from another Blue Cross or Blue Shield plan?
If yes, please list insurance carrier and dates of coverage below.
6. Have you or any listed Family Member been covered by any health insurance program within the past 63 days from the date of this application? If yes, please attach a "Certification of Coverage" form provided by your prior employer or insurer.
7. Within the past 93 days, have you or any listed Family Member been covered, under any health or medical insurance plan or arrangement? If yes, please explain below.
8. Within the past 93 days, have you or any listed Family Member been declined to be covered under any health or medical insurance plan or arrangement? If yes, please explain below
9. Does your employer or any employer of a listed Family Member offer Regence BlueCross BlueShield of Utah or Regence ValueCare group health insurance coverage? If yes, please explain below why you are not enrolling the Family Members in that coverage.
10. To the best of your knowledge has any insurance company (including Regence BlueCross BlueShield of Utah) refused, up-rated or restricted any health coverage on you or any of the listed Family Members?
If yes, please explain below. Please include insurance company's name, reason, and date.

Question #	First Name of Family Member	Relationship to Applicant	Additional Information, Comments and Explanations

CERTIFICATION, AUTHORIZATION and SIGNATURE

TO BE DISCLOSED TO REGENCE BLUE CROSS BLUE SHIELD OF UTAH (REGENCE BCBSU).
PLEASE COMPLETE AND RETURN THIS FORM WITH EACH APPLICATION.

CERTIFICATION OF COMPLETION AND CORRECTNESS

I, the undersigned, hereby make application for membership in Regence BCBSU, as specified above, hereinafter referred to as "the Plan." I understand that the services and benefits set forth in my contract with the Plan will be available only on or after the effective dates of said contract, as shall be determined by the enrollment regulations of the Plan.

I understand and agree that receipt of this application and/or my initial premium by an agent, employee or representative of Regence BCBSU in no way binds Regence BCBSU to cover any Family Members until and unless I receive written notice assigning the date coverage will start.

I understand and agree that if I am accepted for coverage, I will receive a Health Care Agreement which I will have ten days to review before acceptance. If the Health Care Agreement is not acceptable to me for any reason, I may return it to Regence BCBSU within the ten-day period and will receive a full refund of premiums paid.

Any matter in dispute between you and the Plan may be subject to arbitration as an alternative 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, stenographers, 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.

If you have a broker or agent, they may receive bonuses, commissions, administrative service fees, or other compensation, including non-cash compensation, from Regence BlueCross BlueShield of Utah. Incentives may be based on any of several factors, including the size of group business, the products you buy, your broker or agent's volume of business with Regence and the other services your agent or broker provides to you. These incentives may have an indirect impact on your rates. For more information, please contact your broker or agent.

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

INDIVIDUAL AUTHORIZATION FOR MY PROTECTED HEALTH INFORMATION

On behalf of ourselves and the family member(s) listed on the application, we authorize any physician, health-care provider, hospital, insurance or reinsurance company, or other insurance information exchange to disclose to Regence BCBSU or its representatives our health information (excluding health information relating to alcohol or chemical dependency, mental treatment, genetic testing, HIV treatment, or sexually transmitted diseases). We acknowledge and understand that this information will only be used for the purpose of determining enrollment in the health plan or eligibility for benefits. Health information may include claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records or hospital records (including nursing records and progress notes).

We understand that we are not legally obligated to sign this authorization. However, if Regence BCBSU is unable to obtain information necessary to process our application for coverage no further action will be taken with my application. Once my information is received, Regence BCBSU will continue to process my application.

We understand that we may cancel this authorization at any time by sending a written request to Regence BCBSU. Our cancellation of this authorization will not affect any action Regence BCBSU took before it received our request. If we do not revoke this authorization, it will automatically expire upon termination of our coverage with Regence BCBSU or 24 months from the date below, whichever comes first.

NAME OF APPLICANT (Please Print): _____

SIGNATURE: _____ DATE: _____

* If signed by a Personal Representative of the applicant, please complete the following:

✓ Personal Representative's Name: _____

✓ Relationship to Applicant: Parent Legal Guardian** Holder of Power of Attorney**

** Please attach legal documentation if you are the Legal Guardian or Holder of Power of Attorney.

SPOUSE'S NAME (Please Print): _____

SPOUSE'S SIGNATURE: _____ DATE: _____

THIS AUTHORIZATION MAY NOT BE USED FOR PSYCHOTHERAPY NOTES

(PSYCHOTHERAPY NOTES are notes recorded and separately maintained by a mental health professional documenting or analyzing the contents of conversation during a counseling session.)

NOTE: Careful consideration should be given before any existing health coverage is cancelled since your acceptance is not guaranteed and this program may have a waiting period for pre-existing conditions.

AGENT/AGENCY AGREEMENT

(This section to be completed by Insurance Agent when applicable.)

In order to receive proper credit for business written and to receive policy communications, please complete all applicable areas.

Agent/Agency Name _____ Utah License No. _____
Agent/Agency E-mail _____ Tax I.D. Number (if Agency) _____
Print Name of Agent _____ Business Address _____
Signature of Agent _____ City, State, ZIP _____
Date of Signature _____ Telephone Number _____
Regence BCBSU Appointment No. _____ FBL Agent No. (if applicable) _____

I understand and agree that in acting as Agent for this Applicant:

- a. **Application must be completed by the Applicant.**
- b. I am in possession of a valid license issued by the State of Utah authorizing me to sell and service life insurance and health care service contracts.
- c. I have no authority to: (1) make, alter, interpret, or discharge a contract in the name of **Regence BlueCross BlueShield of Utah** or (2) waive any of the terms or conditions of the contract.
- d. I have no authority to assign effective dates or to effect membership changes.
- e. Cancellation of this Health Care Agreement by either the subscriber or Regence BlueCross BlueShield of Utah will terminate this Agency Agreement.

THIS SECTION IS TO BE COMPLETED BY REGENCE BLUECROSS BLUESHIELD OF UTAH

Subscriber Name _____ Contract No. _____
Effective Date _____ Group No. _____
Agent No. _____

PAYING YOUR PREMIUMS

CHOOSE ONE OF THE FOLLOWING THREE OPTIONS
(Check appropriate box):

SUREPAY	MONTHLY BILL	QUARTERLY BILL
<input type="checkbox"/> Monthly Checking Account Deduction — Complete the “SUREPAY Authorization Form” on page 8	<input type="checkbox"/> Monthly Savings Account Deduction — Please see “ Special Note ” below — Complete the “SUREPAY Authorization Form” on page 8	<input type="checkbox"/> Every Month — Additional \$5 per month will be charged.
<input type="checkbox"/> Every 3 Months		

SPECIAL NOTE — SAVINGS ACCOUNT DEDUCTIONS:

Banks do not allow manual drafts on savings accounts. If you are authorizing withdrawals from your savings account, you will be billed until such time that scheduled deductions can start.

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 insurance, the premiums will be deducted automatically from your checking or savings account on or about the 5th day of the month.

This will provide several advantages to you:

- You will have no premium statements to keep up with and return.
- Your premiums will always be paid on time (if funds are available in your account).
- Postage expenses will be eliminated.
- You won't have to worry about your policy accidentally lapsing due to forgotten payments.
- Your monthly bank statement will show a withdrawal notation, which is your receipt of payment.

GETTING STARTED is as easy as 1-2-3

1. **COMPLETE**, date and sign the SUREPAY Authorization Form.
2. **FOR CHECKING ACCOUNT:** Attach a voided check (**not a deposit slip**) if funds are to be drawn monthly from your **checking** account. (Note: a checking account deposit slip does not contain the necessary routing numbers.)
FOR SAVINGS ACCOUNT: Attach a voided savings deposit slip if funds are to be drawn monthly from your **savings** account. Please verify with your financial institution that your name, account and routing numbers are **accurate** and included on the deposit slip.
3. **RETURN** this completed application and SUREPAY Authorization Form with your “voided” check or savings deposit slip in the envelope provided by Regence BlueCross BlueShield of Utah (or self-addressed envelope to SUREPAY Dept. #2, P.O. Box 30270, Salt Lake City, Utah 84130-0270).

Attach your “voided” check or savings account deposit slip here.
(Please do not attach a savings deposit slip for a checking account.)

Name O. Person
12345 Street
City, State 88888
24-242
2424
813

Pay to the Order of _____
Date _____

First Bank of Cash
2222 Commerce
City, State 88888
\$ Dollars

Memo _____
 |: 123123123 |: 12 31231 2 ||

SOME SUGGESTIONS

- **CHECKBOOK REMINDERS** — Since you will not be receiving a monthly premium notice, you should put a notation or some other reminder in your checkbook to remind you to deduct the premiums from your account balance each month. This will help you keep your account in balance and avoid overdraft problems.
- **IF YOU CHANGE YOUR BANK OR WISH TO CANCEL YOUR AUTOMATIC DEDUCTION**
 1. Do this at least 15 days before your next premium is due. We suggest you leave enough money in your old bank account to cover your premiums in case there is a delay in processing the change.
 2. Just send us a copy of your new “voided” check and a note explaining that you have changed banks.
- **ADDRESS CHANGES** — Please be sure to let us know when you change your address. We need your current address to notify you of rate, policy or procedure changes, and claims information.

**SUREPAY
Authorization Form**

- Checking Account**
- Savings Account**

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of Regence BlueCross BlueShield of Utah, Salt Lake City, Utah. I agree that your rights to each such check or electronic debit shall be the same as if it were a check drawn on you and signed by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such check. I 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.

Name of Applicant _____ SSN# _____ - _____ - _____
(please print)

Signature _____ Date _____
(as it appears on bank records)