

# Transfer Application (To be used for current Blue Cross of Idaho enrollees)

You are eligible to apply for individual program coverage **unless**: (1) part or all of the premium will be paid by an employer, either directly or indirectly through wage adjustments or other means of reimbursement; or (2) the health coverage is to be treated as part of a plan or program under Internal Revenue Code Section 106 (contributions by employer to accident and health plans), Section 125 (cafeteria plans) or Section 162 (trade or business expenses, except special rules for health insurance costs of self-employed individuals).

**Will any portion of the health coverage premium be paid by an employer, either directly or indirectly through wage adjustments or other means of reimbursement, or is the health coverage to be treated as part of a plan or program under Internal Revenue Code Section 106, 125 or 162?**  Yes  No If your answer is yes, you are not eligible for individual coverage. If your answer is no, you may proceed with this Transfer Application.

Are you a Federally Eligible Individual as defined on the back of this application?  Yes  No If yes, you may apply for any of the preferred programs or the High Risk Pool (HRP) programs. If no, please complete and submit an Idaho Individual Application for a premium quote for one of the preferred programs.

**Complete every section in ink. Incomplete information will delay the processing and effective date of this application.**



Requested Effective Date _____
Current Blue Cross of Idaho Identification Number _____

## Applicant Information (Employee)

Your Name (first, initial, last)	Social Security No. _____	Date of Birth _____	Age _____	Height _____	Weight _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address	City, State, Zip Code _____		County _____	Email Address _____		
Name of Employer	Your Business Phone _____	Your Home Phone _____	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Your Occupation	Idaho resident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how long? _____		Current/Last Physician _____			

## Family Member Information

List family members you wish to enroll including any unmarried child who is under age 21; or who is under age 25 and a full-time student and financially dependent upon you; or who is medically certified as disabled and dependent upon you for support (copy of certification required).

Family Member's Name (first, initial, last)	Relationship to Applicant (spouse, child, stepchild, etc.)	Date of Birth (mm/dd/yy)	Age	Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female
Family Member's Name (first, initial, last)		_____/_____/____	Age _____	Height _____	Weight _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Family Member's Name (first, initial, last)		_____/_____/____	Age _____	Height _____	Weight _____	<input type="checkbox"/> Male <input type="checkbox"/> Female

## Program Information

### Preferred Programs

Creditable under Medicare Part D*	Non-creditable under Medicare Part D**		No drug coverage; Medicare Part D does not apply
<input type="checkbox"/> Personal Blue® 1000 <input type="checkbox"/> Personal Blue® 2000	<input type="checkbox"/> BlueCare® PPO 1000 <input type="checkbox"/> BlueCare® PPO 2000 <input type="checkbox"/> BlueCare® PPO 5000 <input type="checkbox"/> Supplemental Accident for BlueCare® PPO  <input type="checkbox"/> Essential Blue <sup>sm</sup> PLUS PPO 1000*** <input type="checkbox"/> Essential Blue <sup>sm</sup> PLUS PPO 2000*** <input type="checkbox"/> Essential Blue <sup>sm</sup> PLUS PPO 3000*** <input type="checkbox"/> Essential Blue <sup>sm</sup> PLUS PPO 5000***	<input type="checkbox"/> HSA Blue <sup>sm</sup> PPO Single (\$2,000/80%) <input type="checkbox"/> HSA Blue <sup>sm</sup> PPO Single (\$3,000/80%) <input type="checkbox"/> HSA Blue <sup>sm</sup> PPO Single (\$2,000/90%) <input type="checkbox"/> HSA Blue <sup>sm</sup> PPO Single (\$3,000/90%) <input type="checkbox"/> HSA Blue <sup>sm</sup> PPO Single (\$5,000/100%)  <input type="checkbox"/> HSA Blue <sup>sm</sup> PPO Family (\$4,000/80%) <input type="checkbox"/> HSA Blue <sup>sm</sup> PPO Family (\$6,000/80%) <input type="checkbox"/> HSA Blue <sup>sm</sup> PPO Family (\$4,000/90%) <input type="checkbox"/> HSA Blue <sup>sm</sup> PPO Family (\$6,000/90%) <input type="checkbox"/> HSA Blue <sup>sm</sup> PPO Family (\$10,000/100%)  <input type="checkbox"/> Personal Blue® 3000 <input type="checkbox"/> Personal Blue® 5000  <input type="checkbox"/> Latitude <sup>sm</sup>	<input type="checkbox"/> Essential Blue <sup>sm</sup> BASIC PPO 1000*** <input type="checkbox"/> Essential Blue <sup>sm</sup> BASIC PPO 2000*** <input type="checkbox"/> Essential Blue <sup>sm</sup> BASIC PPO 3000*** <input type="checkbox"/> Essential Blue <sup>sm</sup> BASIC PPO 5000***

\* Creditable prescription drug coverage is that which, on average, is expected to pay out as much as the standard Medicare prescription drug coverage.  
\*\* Non-creditable prescription drug coverage is that which, on average, is not expected to pay out as much as the standard Medicare prescription drug coverage.  
\*\*\* Essential Blue is a Limited Benefit Health Plan. Benefits are not intended to cover all medical expenses.  
The terms "creditable" and "non-creditable" apply to Medicare Part D and are not related to preexisting condition qualifications.

### High Risk Pool (HRP) Programs

<b>Non-creditable under Medicare Part D**</b> <input type="checkbox"/> Idaho Basic <input type="checkbox"/> Idaho Standard <input type="checkbox"/> Idaho HSA	<b>You are eligible to apply if:</b> <ul style="list-style-type: none"><li>• you do not qualify for a preferred program because of an existing health condition</li><li>• your premium for a preferred program would exceed the premium for an HRP program, or</li><li>• you are a federally qualified individual as defined on page 3 of the Idaho individual Application</li></ul>
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### Payment Options

Automatic monthly bank withdrawal (authorization form will be sent to you – \$2.00 monthly service fee will apply until authorization is received)  
 Monthly-direct (payment must include \$2.00 monthly service fee)

### Non-smoker Certification

I am applying for non-smoker certification and neither I, nor any of my family members, nor any other persons residing in my household have smoked tobacco during the 12 months immediately preceding the date of this application.

**X** \_\_\_\_\_  
Applicant's Signature Date

### Health Statement

**If the answer to any of the following questions is YES, please give the details. Include the patient's name, and where applicable, the nature of the health condition and reason for the consultation, the advice and results, and the physician's name and dates of the consultation.**

Have you or any family members listed on this application:  
Suffered from, or now suffer from, any chronic or recurring ailments, illnesses, conditions, or other departures from good health, regardless of whether a physician or other health care provider was consulted?  
 YES  NO If yes, give details.

Received a prescription for medication from a physician or used any prescribed medication during the last 12 months?  YES  NO  
If yes, give details (type or name, dosage, strength and duration).

Ever been diagnosed with a serious health condition not included in any previous questions?  YES  NO If yes, give details.

Ever had or been told he or she had, or been counseled or treated for any of the following: alcohol/drug addiction, cancer, heart condition, diabetes, digestive disorder, immune disorder, renal/kidney disease, stroke, mental or nervous disorder, or respiratory disorder?  YES  NO If yes, give details.

Are you, your spouse, or any eligible dependent child, whether or not listed on this application, now pregnant?  YES  NO If yes, give details.

**Name and Relationship**

Been advised to have any surgical operation(s) or diagnostic testing that has not yet been performed?  YES  NO If yes, give details.

### Statement of Understanding Acknowledgement

**If selecting the Essential Blue Policy: The Essential Blue policy provides limited benefits. Review your policy carefully.**

I acknowledge that I have read the Statement of Understanding on the reverse side. By signing this application, I represent that all my answers are complete and accurate, and that I understand and agree to the conditions set forth:

**X** \_\_\_\_\_  
Applicant's Signature (Parent or Guardian's signature if applicant is under age 18) Date

\_\_\_\_\_ Date  
Spouse's Signature (If listed on the application)

Independent Producer's Name \_\_\_\_\_ BCI# \_\_\_\_\_

Program #	Enrollee ID	Eff. Date	Cr. Days/End Date	Class	Plan
Reason Code	Risk	Smoker	Bill Mode	Pmt Received	Receipt ID
					Auditor

**Parental or Guardian Consent to Application**

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

X \_\_\_\_\_  
Signature Date Print Name Relationship

**Statement of Understanding**

- No Independent Producer, agent or employee of Blue Cross of Idaho can change any part of this application or waive the requirement that I answer all questions completely and accurately, nor can any such person change the terms of the policy, except by endorsement issued expressly for that purpose over the signature or facsimile signature of the President of Blue Cross of Idaho.
- Blue Cross of Idaho may deny benefits or terminate or rescind my policy retroactive to its effective date for any misrepresentation, omission, or concealment of fact by, concerning, or on behalf of any persons listed on this application that was or would have been material to Blue Cross of Idaho's acceptance of a risk, extension of coverage, provision of benefits, or payment of any claim.
- Blue Cross of Idaho may review this application and, at its discretion, request supplemental information from me, any family member listed on this application, or any health care providers before deciding whether to approve or reject the application.
- If this application is not approved for the program applied for, any payment submitted with this application will be refunded. Upon the refund of the payment, Blue Cross of Idaho will have no further obligations to me or any family member listed on this application.
- If this application is approved, coverage for myself and any eligible family members named on this application will begin on the date assigned by Blue Cross of Idaho. I understand a copy of the application will be attached to my policy. I approve the inclusion of any needed alterations to the application as long as I have been consulted by a duly authorized employee of Blue Cross of Idaho or a licensed and duly appointed Independent Producer representing me and I have had an opportunity to review the application that will be attached to my policy.
- I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage 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. For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Blue Cross of Idaho Notice of Privacy Practices at [www.bcidaho.com](http://www.bcidaho.com).
- I have been advised that if I am declined coverage under the plan I am applying for, I may be eligible for my choice of the High Risk Basic, Standard, Catastrophic A, Catastrophic B or Idaho HSA plans. I have also been advised that I may be eligible for one of the High Risk Basic, Standard, Catastrophic A, Catastrophic B or Idaho HSA plans if Blue Cross of Idaho refuses to issue a health benefit plan providing coverage substantially similar to coverage offered under an equivalent High Risk Pool plan except at a rate exceeding the rate of the High Risk Pool plan.
- If you have had group or individual health coverage or a government health care program for at least 12 months, you are entitled to receive a Certificate of Creditable Coverage from your previous employer or insurance company. This document will state the effective date of prior coverage and the termination date of coverage for you and any covered dependents. Your previous employer or insurance company will furnish you this certificate upon request. If you need assistance in obtaining a certificate, Blue Cross of Idaho can assist you.
- I understand that this application will become part of any agreement or policy that Blue Cross of Idaho issues.
- I affirm that I have reviewed all the answers given on this application and, regardless of whether an Independent Producer or other person has filled out the answers for me and on my behalf, I verify the answers accurately reflect all the information given by me.

**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:

- You have at least 18 months of continuous creditable coverage without any break in coverage greater than 63 days
- Your most recent coverage was under a group health plan, a governmental plan or a church plan (or health insurance offered in connection with such a plan)
- 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 health coverage or continuation coverage ends. Act promptly to protect your rights.

**Medicare Part D Creditable / Non-creditable**

Blue Cross of Idaho's individual products are categorized as "creditable" or "non-creditable" for purposes of Medicare Part D. If you are a person nearing age 65 or an individual under 65 who is entitled to Medicare, the creditable/non-creditable information is important to you.

When you become eligible for Medicare, you can enroll in Medicare Part D. If you do not sign up when first eligible, you may generally enroll between November 15 and December 31 of each year.

If you do not sign up when first eligible and/or if you go 63 days or longer without prescription drug coverage that is creditable (at least as good as the standard Medicare prescription drug coverage), you may have to pay a higher monthly premium.

- The higher premium is based on the number of months you did not have creditable coverage.
- The penalty is 1% per month without creditable coverage. For instance, if you went 19 months without creditable coverage and then signed up for Medicare Part D, your premium would be 19% higher than the premium rate at the time you sign up.

**Creditable** prescription drug coverage is that which, on average, is expected to pay out as much as the standard Medicare prescription drug coverage.

**Non-creditable** prescription drug coverage is that which, on average, is not expected to pay out as much as the standard Medicare prescription drug coverage.

– FOR INDEPENDENT PRODUCER'S USE ONLY –

**Independent Producer Certification**

1. Who actually completed this application?  Independent Producer  Applicant  Other

If Independent Producer or Other, please explain: \_\_\_\_\_

2. Were you present at the time the application was filled out?  YES  NO

If NO, please explain: \_\_\_\_\_

3. Are you aware of any medical information relating to the applicant or any family member that has not been disclosed on this application?

YES  NO

If YES, please explain: \_\_\_\_\_

4. Was money collected from applicant?  YES  NO Amount \$ \_\_\_\_\_

I have explained the eligibility provisions to the applicant. I have not made any representations about benefits, conditions, or limitations of the policy except through written material furnished by Blue Cross of Idaho. I hereby certify that the information supplied to me by the applicant has been completely and accurately recorded.

Independent Producer's Printed Name Independent Producer's Signature Date Blue Cross of Idaho No.

Type of Company Appointment  Personal  Agency (name) \_\_\_\_\_

Business Phone Home Phone

If a Blue Cross staff member has signed for the I.P., please sign here: \_\_\_\_\_