

Type of Enrollment	Change Request
Health Coverage (check one) <input type="checkbox"/> Self <input type="checkbox"/> Self and spouse <input type="checkbox"/> Self, spouse and children <input type="checkbox"/> Self + 1 child <input type="checkbox"/> Self + 2 or more children	Change current enrollment because of the following event: <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Birth <input type="checkbox"/> Involuntary loss of coverage <input type="checkbox"/> Death <input type="checkbox"/> Court order (copy of court order required) <input type="checkbox"/> Other _____ _____ Date event occurred ____ / ____ / ____ <div style="text-align: center;">mm dd yy</div>

Statement of Understanding

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

- No independent producer, agent or employee of the insurer, or of my employer can change any part of this application or waive the requirement that I answer all questions completely and accurately.
- The insurer may, at its discretion, request supplemental information from me, any family member listed on this application or any health care provider.
- On behalf of myself and all enrolled family members, I understand if the insurer discovers any intentional misrepresentation, omission or concealment of fact in obtaining coverage that was or would have been material to the insurer's acceptance of a risk, extension of coverage, provision of benefits or payment of any claim, the insurer may take action against my employer, including but not limited to increasing premiums.
- If this application is approved, coverage for myself and any eligible family members named on this application will begin on the date assigned by the insurer.
- 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 that is available at www.bcidaho.com.
- Preexisting condition waiting period: There are no benefits available under this policy for services, supplies, drugs or other charges that are provided within 12 months after an insured's enrollment date for any preexisting condition.

A preexisting condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the six months immediately preceding the enrollment date. A pregnancy existing on the enrollment date is not a preexisting condition under this policy. Genetic information shall not be considered as a preexisting condition in the absence of a diagnosis of the condition related to such information.

In certain circumstances, qualifying previous coverage will be credited toward the preexisting condition waiting period.

- 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, your current employer or Blue Cross of Idaho can assist you.
- My employer's master group policy is the document that sets forth all terms of my coverage, and no independent producer, agent or other person can change the terms of the master group policy, any of its amendments, or this application, except with an amendment issued expressly for that purpose and signed by an authorized officer of the insurer.
- I agree that a facsimile or photocopy of my signature will serve the same as an original.
- I understand that this application will become part of the contract between the insurer and my employer.
- **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.**

X _____
Applicant's Signature

Date

This application must be signed and dated.