PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Alaska Individual Enrollment Application

Effective January 1, 2020

This application is for health care coverage purchased directly from Premera Blue Cross Blue Shield Alaska (Premera). **For timely and proper processing, please print your answers clearly in ink and make sure to submit the required documentation with your application. If a pencil is used, the application will be returned to you and could delay processing time.**

1. Enroll

Membership status

- ☐ I am a **new applicant**
- ☐ I am a **dependent moving to my own plan** as a subscriber (direct transfer)
- ☐ I am a **parent or legal guardian enrolling only my child(ren)**, and not myself. (Because you are the parent or legal guardian, please include your personal information under Applicant/Subscriber on page 2.)
- ☐ I am a **current member**. My subscriber ID# is: _____
  (see your ID card)

  As a **current member**, I want to:
  - ☐ add my spouse or domestic partner _____
    (marriage date/date of partnership)
  - ☐ add my newborn _____
    (date of birth)
    or my newly adopted/placed for adoption child(ren) _____
    (placement date)
  - ☐ add my dependent child(ren)
  - ☐ add my legal ward/guardianship/medical support order/foster child(ren)
  - ☐ change my plan

You're eligible to apply for a Premera plan if you are:

- A resident of and have a principal residence in the State of Alaska
- Not enrolled in federal Medicare A or B (including entitlement due to disability), or a Medicare Choice or Medicare Advantage plan
- Applying during an open enrollment period or when you have a qualifying event as described in Section 5

Eligible dependents who can enroll on your plan include your:

- Spouse or domestic partner
- Natural or legally adopted/placed child(ren), legal ward, or foster child(ren) under the age of 26 (Newborns or newly adopted/legally placed children under age 26 can apply as a subscriber or dependent outside an open enrollment period within the first 60 days of birth or placement.)

Enrollment eligibility (see Section 5)

- ☐ I am enrolling in the open enrollment period
- ☐ I am enrolling in a special enrollment period with required documentation included

If you checked special enrollment period, you must indicate your qualifying event in the Section 5 qualifying events table (page 5) and **submit required documentation**.

1. **Enroll** (continued)

Personal information

Applicant/Subscriber* Last Name, First Name, Middle Initial			Gender: ☐ M ☐ F I used tobacco in the last 6 months**: ☐ Y ☐ N
Social Security Number	Date of Birth		Email Address of Primary Applicant
Home Telephone Number	Work Telephone Number		Cell Telephone Number
Home Street Address (not a P.O. Box or business address) **required**			
City	State	ZIP	Borough
Mailing Street Address (if different from Home Address)			
City	State	ZIP	Borough
Billing Street Address (if different from Mailing Address)			
City	State	ZIP	Borough
Ethnicity (Optional)	(Check All That Apply) ☐ American Indian/Alaska Native ☐ Asian ☐ Black African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Hispanic/Latino ☐ Not Hispanic or Latino		Primary Language ☐ English ☐ Spanish ☐ Other_____ Secondary Language ☐ English ☐ Spanish ☐ Other_____

Legal Spouse or Domestic Partner* Last Name, First Name, Middle Initial			Gender: ☐ M ☐ F I used tobacco in the last 6 months**: ☐ Y ☐ N
Social Security Number	Date of Birth		Primary Telephone Number
Home Street Address (not a P.O. Box or business address) **required** (if different from subscriber)			
City	State	ZIP	Borough
Ethnicity (Optional)	(Check All That Apply) ☐ American Indian/Alaska Native ☐ Asian ☐ Black African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Hispanic/Latino ☐ Not Hispanic or Latino		Primary Language ☐ English ☐ Spanish ☐ Other_____ Secondary Language ☐ English ☐ Spanish ☐ Other_____

Dependent Child – under 26 only* Last Name, First Name, Middle Initial			Gender: ☐ M ☐ F I used tobacco in the last 6 months**: ☐ Y ☐ N
Social Security Number	Date of Birth		Primary Telephone Number
Home Street Address (not a P.O. Box or business address) **required** (if different from subscriber)			
City	State	ZIP	Borough
Ethnicity (Optional)	(Check All That Apply) ☐ American Indian/Alaska Native ☐ Asian ☐ Black African American		Primary Language ☐ English ☐ Spanish ☐ Other_____

	☐ Native Hawaiian/Pacific Islander ☐ White ☐ Hispanic/Latino ☐ Not Hispanic or Latino	Secondary Language ☐ English ☐ Spanish ☐ Other_____
Dependent Child – under 26 only* Last Name, First Name, Middle Initial		Gender: ☐ M ☐ F I used tobacco in the last 6 months**: ☐ Y ☐ N
Social Security Number	Date of Birth	Primary Telephone Number
Home Street Address (not a P.O. Box or business address) **required** (if different from subscriber)		
City	State / ZIP	Borough
Ethnicity (Optional)	(Check All That Apply) ☐ American Indian/Alaska Native ☐ Asian ☐ Black African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Hispanic/Latino ☐ Not Hispanic or Latino	Primary Language ☐ English ☐ Spanish ☐ Other_____ Secondary Language ☐ English ☐ Spanish ☐ Other_____

Dependent Child – under 26 only* Last Name, First Name, Middle Initial		Gender: ☐ M ☐ F I used tobacco in the last 6 months**: ☐ Y ☐ N
Social Security Number	Date of Birth	Primary Telephone Number
Home Street Address (not a P.O. Box or business address) **required** (if different from subscriber)		
City	State / ZIP	Borough
Ethnicity (Optional)	(Check All That Apply) ☐ American Indian/Alaska Native ☐ Asian ☐ Black African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Hispanic/Latino ☐ Not Hispanic or Latino	Primary Language ☐ English ☐ Spanish ☐ Other_____ Secondary Language ☐ English ☐ Spanish ☐ Other_____
Dependent Child – under 26 only* Last Name, First Name, Middle Initial		Gender: ☐ M ☐ F I used tobacco in the last 6 months**: ☐ Y ☐ N
Social Security Number	Date of Birth	Primary Telephone Number
Home Street Address (not a P.O. Box or business address) **required** (if different from subscriber)		
City	State / ZIP	Borough
Ethnicity (Optional)	(Check All That Apply) ☐ American Indian/Alaska Native ☐ Asian ☐ Black African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Hispanic/Latino ☐ Not Hispanic or Latino	Primary Language ☐ English ☐ Spanish ☐ Other_____ Secondary Language ☐ English ☐ Spanish ☐ Other_____

*Only the first 26 characters will be displayed on the ID card(s)

** "Tobacco use" means use of any tobacco product on average four or more times per week within the past 6 months. Tobacco use does not include religious or ceremonial use. E-cigarettes are not considered tobacco.

2. Select a Plan

Upon acceptance of your application and payment of the required subscription charges, the initial coverage for you and your enrolled dependents will become effective. Applications received by the 15th of the month will become effective on the first day of the following month.

- This date cannot be more than 60 days after the application is signed
- Direct transfers are only made on the first of each month
- Additional dependents can only be added on the first of each month
- Approval is only required for the Special Enrollment Period and based on submittal of required documentation.
- Special enrollment also requires that we receive the application within 60 days of the qualifying event(s) noted in Section 5

Health Plan

I want to enroll in the following Premera health plan (check only **one** option):

PPO Preferred Plans

☐ Preferred Gold 1500
☐ Preferred Silver 3500
☐ Preferred Bronze 6350

HSA Preferred Plan

☐ Preferred Bronze 5250 Individual HSA/ 10500 Family HSA

If you selected an **HSA** plan, please provide an option below.

☐ Yes, establish UMB Health Savings Account (Social Security number and primary applicant email must be provided in Section 1) For additional disclosures and information, view the UMB terms and conditions at https://hsa.umb.com/stellent/groups/public/documents/web_ content/006538.pdf.

UMB is a member of the FDIC and one of the largest independent banks in the U.S. since 1913. Terms and conditions of the personal funding account will be mailed with your HSA Healthcare Payment Visa Card. By enrolling in an HSA, I authorize the sharing of my information to establish a bank account.

☐ No, I will use my own bank

Dental/Vision/Hearing Plan

We offer a Dental/Vision/Hearing plan for all Alaska residents. If interested, please check the box below and we will send you additional information and an enrollment application.

☐ Yes, I would like additional information on your Dental/Vision/Hearing plan

3. Other Health/Dental Coverage

Do you have other health care or dental coverage that you intend to continue if you are accepted by Premera?

☐ Yes, health coverage (If you answered yes, we will coordinate benefits between plans.)

☐ Yes, dental coverage

☐ No (If you answered no, remember to cancel your current plan once accepted.)

4. Eligibility Verification

Open enrollment period (if applying during open enrollment, go to Section 6)

Individuals may apply for enrollment in a Premera plan during the open enrollment period defined by the state of Alaska. For open enrollment dates, see premera.com. The application must be postmarked or received electronically before the end of the open enrollment period.

Special enrollment period (You **must** check the box(es) below for the qualifying event(s) that apply to you and **include the required supporting documentation with your application**.)

Individuals can apply for enrollment outside of an open enrollment period if they qualify for a special enrollment period. To qualify for a special enrollment period, **you must experience a qualifying event**.

Qualifying events Application must be received within 60 days of the qualifying event (marriage, birth, placement, or custody).	**Submit a copy of the following document(s).** Supporting documents must be received within 60 days of the qualifying event.
☐ Gained or became a dependent due to marriage, birth, placement for adoption or adoption of the applicant for whom coverage is sought; for Qualified Health Plans (QHPs), also applies to children placed in foster care, legal wards, guardianship or medical support orders	Check the document you are submitting: ☐ Copy of marriage certificate or license ☐ Copy of birth certificate ☐ Copy of adoption papers ☐ Copy of foster care papers ☐ Copy of medical support order ☐ Copy of the court order appointing a guardian
☐ A permanent move	Must provide documentation to prove that you moved in the last 60 days and had prior health coverage. Utility bills from your prior address and new address within the last 60 days or U.S. Postal Service change of address confirmation or rental lease or mortgage and a letter verifying loss of coverage from your prior health plan, employer or COBRA coverage
☐ The loss of coverage as the result of divorce	Copy of divorce decree or annulment paper
☐ Loss of minimum essential coverage, including loss of employer sponsored insurance coverage; except for voluntary termination of health coverage, misrepresentation or fraud	• Letter from insurance coverage • Letter from employer • Letter about COBRA coverage Letters should list each applicant that experienced a loss of coverage and reason for termination
☐ Loss of coverage as the result of the death of an employee	Your COBRA offer letter or a letter from your employer indicating loss of coverage due to death of an employee
☐ The COBRA coverage period ends (usually after 18 months) or the individual has exceeded the lifetime limit in the plan and no other COBRA coverage is available Note: Voluntary termination of COBRA is not a qualifying event. If you terminate or stop paying for your COBRA, you must wait for the next Open Enrollment Period to apply	Letter from employer or COBRA administrator indicating loss of COBRA coverage due to individual exhausting the COBRA period or exceeding the lifetime limit in the plan and that no other COBRA coverage is available
☐ A loss of Medicaid or other public program providing health benefits	The letter from Medicaid or other program indicating ineligibility or loss of coverage
☐ Loss of coverage as a dependent due to age	Letter from employer or insurance health plan indicating loss of coverage due to age
☐ The loss of coverage under a Student Insurance plan (**involuntary or voluntary**)	Letter from the insurance health plan or school indicating loss of coverage
☐ Experience an exceptional circumstance that prevented enrollment in coverage	Attestation letter with description of exceptional circumstance
☐ Victims of domestic abuse/violence or spousal abandonment, and their dependents	Attestation letter

All documentation must have the full name of the person experiencing the qualifying event as well as the date of the event (or last day of coverage). All letters must be on official letterhead. Legal papers must have the official seal

Please Note: The ACA allows additional opportunity for special enrollment in the event of an error, misrepresentation, or inaction of an exchange or the Department of Health and Human Services, breach of contract by your prior health plan, or certain changes to your eligibility for advance payments of the premium tax credit or cost-sharing reductions.

5. Notice of Information Use and Disclosure

Type of information to be disclosed: I (We) authorize: any physician, health care provider, hospital, insurance or reinsurance company, pharmacy benefits manager, or third-party benefits administrator to disclose a copy of my (our) personal health information, including any and all diagnostic, procedural, treatment, claim, prescription, or other health-related information including records concerning alcohol and/or chemical dependency, reproductive health (including abortion), sexually transmitted diseases, HIV, AIDS, psychiatric disorders, and mental illness to Premera or its representatives as allowed by law.

Purpose of disclosure: I (We) understand that personal information will be used for evaluating enrollment in the health plan, determining eligibility for benefits, and paying claims. This information will not be used to make a decision on your eligibility for coverage.

Timeframe of release: Unless I revoke it, this release will remain valid for twenty-four (24) months from the date of my signature below.

Revocation of release: I understand that I may change my mind and revoke this release at any time. I will do this by letting Premera know of my decision. Any change will be effective five (5) business days after Premera receives my written notice at the address listed on this form. I understand that some or all of this information may already have been used by Premera to make decisions, which will not be affected by its revocation

Disclosure: Premera Blue Cross Blue Shield of Alaska may be required to redisclose this information to another party that is not subject to state and federal privacy rules

Effect of not authorizing: This authorization is a condition of your enrollment in our health plan or your eligibility for benefits. If you decide not to sign this authorization, we may decline to enroll you in our health plan or to give you benefits.

Please note: You or your authorized representative will receive a copy of this authorization.

6. Basic Terms of Enrollment

By signing this application, I understand and agree that:

1) This application is not an offer of coverage, and coverage does not begin until: (a) This application is received, reviewed, and accepted by Premera and an effective date of coverage is assigned; and (b) My complete and correct payment is received. Submission of this application does not guarantee I will receive coverage. This application becomes part of my contract and if the application is inconsistent with the plan, the plan will govern.
2) No benefits are available under this plan for services or supplies related to an inpatient confinement that began prior to the effective date of coverage.
3) (a) Persons listed on this application must be residents of the state of Alaska to apply for and maintain coverage under this plan; and (b) No one listed on this application is eligible for Medicare. "Resident" means a person who lives in Alaska and intends to remain in the state permanently or indefinitely. In no event will coverage be extended to a subscriber or dependent who resides in the state for the primary purpose of obtaining health care or health care coverage. The confinement of a person in a nursing home, hospital, or other medical institution shall not by itself be sufficient to qualify such person as a resident. We may require proof of residency from time to time. Examples of proof include, but shall not be limited to, a valid photo ID, utility bills, tax or financial records. All documents must show the street address of the individual's residence and not a post office box or business address. Only Premera may: (a) Make or modify the terms of the application or contract; or (b) Waive any of the Premera rights or requirements. I may receive benefits which are less than the amount billed by my provider when treatment is not received from a contracted provider.

   A person cannot apply with a business address as the home address.
4) I understand and agree that this coverage is issued as individual health coverage, is not sold or issued for use as a government or third-party sponsored health plan, and is not partially or fully paid for by third-party payers including employers, business accounts, providers, not-for-profit agencies, government agencies, or any other third-party payer, either directly or indirectly, except as required by law.

7. Signatures

I hereby apply for enrollment with Premera for myself and family members listed on this application for coverage under the individual contract indicated on this form. I understand I will have the right to examine and return the contract within 10 days of its delivery to me. I declare that:

a) I have read this form, I agree to its terms, and I have supplied all of the required information on this form.

b) I understand that a complete list of exclusions and limitations is detailed in the contract available online at **premera.com**. If there is a conflict, the terms of the contract prevail.

c) I declare that, to the best of my knowledge, all of the information on all forms necessary for enrollment is true and complete, and that all of the persons for whom I am requesting enrollment are eligible for coverage. I understand that, if I have made false, incomplete, or misleading statements or answers on behalf of myself or any family members, all entitlements to benefits are void and this contract may be canceled or modified retroactively to its effective date. I further understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Important! Signatures are required for all applications age 18 or older.

Signature of Primary Applicant (Parent/Legal Guardian) Subscriber must sign if adding spouse/domestic partner or child.	**Date of Signature**
X	

Signature of Spouse/Domestic Partner	**Date of Signature**
X	

Signature of Dependent Child age 18 or older	**Date of Signature**
X	

Signature of Dependent Child age 18 or older	**Date of Signature**
X	

Signature of Dependent Child age 18 or older	**Date of Signature**
X	

Signature of Dependent Child age 18 or older	**Date of Signature**
X	

If not the primary applicant, I am the: ☐ **Parent** ☐ **Holder of power of attorney** ☐ **Legal guardian**
(If you are not the legal guardian or holder of power of attorney for the applicant, attach legal documentation)

If you are applying for the first time and have questions, please contact your producer, or Individual Plan Sales at
888-334-0109.

If you are a current member with Premera Blue Cross Blue Shield of Alaska, please contact Customer Service at **800-508-4722.**

Mail completed applicant to:
Premera Blue Cross Blue Shield of Alaska
MS 295
PO Box 327
Seattle, WA 98111-0327

Sales: 888-334-0109
Customer Service: 800-508-4722
Fax: 425-918-5278
ApplicationServices@premera.com

(Applicants leave this blank.)

Producer Name	Kelly R. Shattuck / SGY, Inc.	**Premera Producer Number**	81128