

Employee: Please complete all sections (front & back) in black ink

BIAW Health Insurance Trust Employee / Subscriber Application

Select Plan: **Health plans underwritten by Regence BlueShield:** Enhanced Plan _____ Market Plan _____ Foundation Plan _____ HSA Plan _____ Selections Plan _____

EMPLOYEE SECTION:

Employee Legal Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

Marital Status: Married Single Date of Marriage: _____

Have Regence BlueShield or Group Health Options, Inc. assigned an alternate Identification number to you previously? Yes No If yes, please provide if available: _____

Please Note: List all eligible dependents to be insured, continue on another form if more space needed.

A Reason Must be Checked for Application:

Add Employee:

- New group
- New employee
- Open enrollment
- Loss of eligibility on another coverage

Add Dependent:

- Birth Marriage Adoption
- COBRA coverage exhausted
- Open enrollment
- Loss of eligibility on another coverage
- Add Domestic Partner / dependent(s)
(must attach proper documentation)

- Personal Care Provider change
- Change of Life Beneficiary
- Change of Address
- Name Change
- Change Medical Plan *

*** Plan election changes are allowed only during the Open Enrollment Period (April 1st of each year)**

Relationship	Name			Social Security Number or Individual tax payor ID number (ITIN)	Birth Date (mm/dd/yyyy)	Gender M/F	Personal Care Provider for Point of Service Plan only (First & Last Name)	PCP Rider #	Current Patient Y/N
	Last Name	First Name	M.I.						
Employee				- -	/ /				
Spouse				- -	/ /				
Child				- -	/ /				
Child				- -	/ /				
Child				- -	/ /				

If any dependent child(ren) being added is/are covered under another plan and the natural parents are divorced or separated, Washington State regulations require that we ask the following:

Name of parent with custody (if parents have dual custody, indicate): _____

If divorced, did the court establish financial responsibility for the child(ren)'s health care? Yes No (Please provide a copy of the divorce decree maintenance agreement outlining coverage specifications.)

If YES, please specify the name and address of the parent with responsibility: _____

Do you or any of your dependents applying for coverage have coverage (now, or within the past 6 months) with any health care plan? Yes No. Will coverage remain in effect? Yes No

IMPORTANT: If you or any of your dependents applying for coverage have coverage (now, or within the past 6 months) with any health care plan, you MUST complete the back of this form.

Completing the information on the back of this form will allow Regence BlueShield to credit any applicable waiting periods for preexisting conditions and process claims quickly and accurately.

BASIC LIFE INSURANCE BENEFICIARY: This section must be completed for all new employee enrollments. If no beneficiary is designated, benefits will be paid under the terms of the group insurance contract.

Beneficiary's Name: _____ Relationship: _____ Beneficiary's Birthdate: _____ Provided by: Regence Life & Health Insurance Company

Beneficiary's Address: _____ City/State/Zip: _____ Phone Number: _____ PO Box 1271, Portland, OR 97207

EMPLOYEE RELEASE AND AUTHORIZATION: I hereby verify that all of the information specified above is accurate and complete. By signing below, I have authorized the release of information, for myself and my dependents listed above, to Regence BlueShield.

EMPLOYEE'S SIGNATURE: _____ DATE: _____

EMPLOYER SECTION: The Employer section must be completed & signed by the Group's Contact Person as listed on the Employer Participation Agreement. If not fully completed, this form will be returned unprocessed.

Group Name: _____ Group Number: _____ Division Number: _____ Group Phone Number: _____ Intended Effective Date: _____

Employee Class (i.e. Hourly or Salaried): _____ Date of Hire: ___/___/___ Date of Rehire: ___/___/___ Date Changed from Part-time to Full-time: _____ Average Hours Worked Per Week: _____

SIGNATURE OF GROUP'S PRIMARY CONTACT PERSON: _____ Date: _____

This Section for Carrier Use Only – RIQ Code: _____ Rel ICN#: _____ Eff Date: _____
ACRW Loaded: _____ COB Loaded: _____ Date Completed: _____ Auditor Initials: _____ Plan Code: _____

Employee Section:

BIAW Health Insurance Trust Employee / Subscriber Application

Crediting of time covered under a previous insurance plan towards a new plan's pre-existing condition waiting period (i.e. Portability of coverage) is available under the BIAW Trust in accordance with State and Federal insurance regulations. All BIAW plans include a 3-month waiting period for Pre-Existing Conditions. In order for our carriers to determine if you or any of your dependents are eligible for portability of coverage in accordance with State and Federal laws, please provide a "Certificate of Creditable Coverage" from your prior health insurance carrier; or, complete the "Prior Coverage Information" section below. To obtain more information on waiting periods, pre-existing conditions and transplant related benefits, please contact your group administrator or benefits department.

PRIOR INSURANCE WITHIN THE PAST 6 MONTHS AND/OR CURRENT OTHER INSURANCE COVERAGE:

Prior or Other Insurance Company Name: _____ Prior or Other Insurance Company Phone #: _____

Prior or Other Insurance Company Full Address: _____

Policyholder's Name: _____ Policyholder's Birth Date: ___/___/___ (mm/dd/yyyy) Policy Holder's Member ID# or Social Security #: _____

Group Name & Policy #: _____ Effective Date of Coverage: ___/___/___ Intended Termination Date of Coverage: ___/___/___ Reason for Termination: _____

Persons covered by prior insurance (list names and date of birth for each): _____

Type of Coverage (please circle): Medical Pharmacy Dental Vision Medicare **Type of Policy (please circle):** Group Individual Medicaid Medicare Part A Medicare Part B Other: _____

If employee or dependents have Medicare, what was the begin date for Part A: _____ Part B: _____ Medicare HIC# with Alpha Suffix: _____

Name of Person covered by Medicare _____ Reason: Disability Over Age 65 End Stage Renal Disease

Contractual Effective Date and Eligibility: Applications for new employees must be received by the BIAW Trust within 15 days of the Contractual Effective Date. The Contractual Effective Date is based on the employee's date of hire and your company's established probationary period. Applications received after the Contractual Effective Date may delay an employee's eligibility date to the next BIAW Trust Open Enrollment period (April 1st of each year). New BIAW application forms are required to add dependents, including newborns and/or a new spouse (see Plan Booklets for details). Applicants should carefully review the program's "Waiting Periods Limitations". Review the plan benefit booklets or contact your company's administrator (or the BIAW Trust) to address any questions on these important provisions.

Eligible Dependents may include: A subscriber's legal spouse; domestic partner; a natural, adopted, stepchild or child of a qualified registered domestic partner provided that the child is: 1) unmarried; and 2) under the age of 25 (Incapacitated Children over Age 25). Application for newborn children must be received within 60 days of birth (newborn's social security number is not required to make application). Application to add a new spouse must be received within 31 days of the date of marriage. See benefit booklets for details regarding dependent eligibility.

HIPAA Special Enrollment Provisions: If you decline enrollment for yourself or your dependents (including your spouse) due to coverage through other health coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you submit a completed "Waiver of Insurance Form" within 30 days of your initial eligibility for this plan **and** you request enrollment within 30 days after your coverage ends. To qualify for this special enrollment, you or your dependents must have lost health insurance or other group health coverage because: 1) the health insurance was provided under COBRA, and the COBRA period was exhausted **-OR-** 2) the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage (including loss resulting from legal separation, divorce, death, termination of employment, or reduction in hours), **-OR-** 3) the coverage was non-COBRA coverage and employer contributions for the coverage were terminated. Under this provision, an employer's reduction (but not cessation) of contributions would **not** trigger a special enrollment right. In addition, if you require a new dependent as a result of marriage, birth, adoption or placement for adoption, you may also be able to enroll yourself and your dependents provided you request enrollment within 31 days after the marriage, and within 60 days after birth, adoption or placement for adoption.

Application Agreement: I have provided these answers as part of the application procedure required by Regence BlueShield to enroll in coverage and I certify that all information completed on this form is true, correct and complete. I understand that Regence BlueShield will rely on each answer in making coverage and rating determinations. If Regence BlueShield continues the Contract with the Group after untrue, incorrect, or incomplete information is found to have been provided, and if as a result of correcting false information the Group no longer qualifies for the Rate quoted, I understand that Regence BlueShield will have the right to adjust the rates to the appropriate level retroactive to the date the misrepresentation occurred, and the Group will be required to pay the Rate adjustment within 30 days of the date of notice by Regence BlueShield. 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. In addition, Regence BlueShield will have the right to collect any claims payments or other damages.

Release of Information: I acknowledge and understand my health plan 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) 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.

* For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Notice of Privacy Practices. A copy is available from our Website at www.epkbenefits.com or by phone at (800) 545-7011 or (425) 641-7762.

Coverage Provided by: Regence BlueShield
PO Box 21267 -- Seattle, WA 98111-3267