St Luke's™ Health Plan

# Idaho Individual Application

**For Enrollment Outside of the Idaho Exchange**

Please type or print legibly in black ink and complete all applicable sections.

## Section 1: Enrollment Information (check all that apply)

1a. Are you: ☐ A new applicant ☐ Adding dependents ☐ Responsible party

1b. Do you have a current Idaho driver's license or Idaho identification card? ☐ Yes ☐ No

Idaho driver's license or identification card number _____ Expiration date_____

If you are unable to provide an Idaho driver's license or identification card number, to establish residency you must provide copies of two other forms of documentation that contain your name and residential address with this completed application.

Examples include home mortgage statement; lease or loan agreement; homeowner's, renter's, or car insurance policy (within the last 60 days). These documents must contain the applicant's name and residential address.

2. If you are enrolling outside of the annual open enrollment or adding dependents, what is the reason? *(documentation may be required)*

☐ Marriage ☐ Divorce ☐ Birth ☐ Adoption

☐ Involuntary loss of employer coverage ☐ Involuntary loss of individual coverage ☐ Involuntary loss of Medicaid

☐ Court order (copy of court order required) Other _____

Date of event (mm/dd/yyyy) _____

3. The primary applicant must be a resident of the state of Idaho on or before the effective date of and during the term of this policy to be eligible for coverage. Coverage under this policy will be terminated and this policy may be rescinded if the primary applicant was not a resident upon the effective date of the policy and/or failed to maintain residency in the state of Idaho.

Are you a resident of the state of Idaho? ☐ Yes ☐ No If yes: _____years _____months

4. Requested effective date *(Subject to approval): (mm/dd/yyyy)* _____

## Section 2: Select a Medical Plan

To view and print a Summary of Benefits and Coverage (SBC) for our standard individual health insurance plans, visit our website at **stlukeshealthplan.org.**

☐ Bronze HDHP (HSA compatible) ☐ Expanded Bronze - HSA Qualified ☐ Silver ☐ Gold

If you are selecting an HSA Qualified plan, do you want to open an HSA account (included with the plan)? ☐ Yes ☐ No

## Section 3: Applicant Information

| | | | |
|---|---|---|---|
| 1. Legal First Name, Middle Name, Last Name (and suffix, if applicable) | | | |
| 2. Street Address | | | |
| 3. City | 4. State | 5. Zip Code | 6. County |
| 7. Mailing Address (Street, Route, P.O. Box) (if different than street address) | | | |
| 8. City | 9. State | 10. Zip Code | 11. County |
| 17. Preferred Daytime Phone Number (with area code) | 18. Alternate Phone Number (with area code) | 19. Date of Birth (mm/dd/yyyy) | |
| 20. Which most closely describes your gender identity ☐ Male ☐ Female | 21. Social Security Number **(required)** | 22. Marital Status ☐ Single ☐ Married ☐ Other:_____ | 23. Email Address |

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## Section 4: Dependent Information

(List all eligible dependents you wish to enroll, including any child who is under the age of 26; or who is medically certified as disabled and dependent on parent for support (copy of certification required). If you have more dependents to include, make a copy of this page and attach.)

### Dependent 1

| 1. Legal First Name, Middle Name, Last Name (and suffix, if applicable) | | 2. Relationship ☐ Spouse ☐ Child ☐ Step-child ☐ Other_____ |
|---|---|---|
| 3. Gender ☐ Female ☐ Male | 4. Date of Birth (mm/dd/yyyy) | 5. Social Security Number **(required)** |
| 6. Does dependent 1 live at the same address as you? ☐ Yes ☐ No | | |

### Dependent 2

| 1. Legal First Name, Middle Name, Last Name (and suffix, if applicable) | | 2. Relationship ☐ Spouse ☐ Child ☐ Step-child ☐ Other_____ |
|---|---|---|
| 3. Gender ☐ Female ☐ Male | 4. Date of Birth (mm/dd/yyyy) | 5. Social Security Number **(required)** |
| 6. Does dependent 2 live at the same address as you? ☐ Yes ☐ No | | |

### Dependent 3

| 1. Legal First Name, Middle Name, Last Name (and suffix, if applicable) | | 2. Relationship ☐ Spouse ☐ Child ☐ Step-child ☐ Other_____ |
|---|---|---|
| 3. Gender ☐ Female ☐ Male | 4. Date of Birth (mm/dd/yyyy) | 5. Social Security Number **(required)** |
| 6. Does dependent 3 live at the same address as you? ☐ Yes ☐ No | | |

### Dependent 4

| 1. Legal First Name, Middle Name, Last Name (and suffix, if applicable) | | 2. Relationship ☐ Spouse ☐ Child ☐ Step-child ☐ Other_____ |
|---|---|---|
| 3. Gender ☐ Female ☐ Male | 4. Date of Birth (mm/dd/yyyy) | 5. Social Security Number **(required)** |
| 6. Does dependent 4 live at the same address as you? ☐ Yes ☐ No | | |

## Section 5: Other Information

1. Are you or any dependent listed on this application receiving Worker's Compensation payments or are now eligible to receive such payments? ☐ Yes ☐ No

If yes, give person's name, specific type and details: _____

_____

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## Section 6: Other Coverage Information

(Please complete the section below if you have other coverage that will remain in effect. If you have more policies to include, make a copy of this page and attach.)

If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation that shows who is responsible for the dependent(s)' health care insurance so that the insurance carrier can determine whose coverage is primary.

**Policy 1**

1. Other Insurance Carrier Information: Insurance Carrier Name, Policy Number, Phone Number

| 2. Policy Holder Name | | 3. Names of Covered Members | |
|---|---|---|---|
| 4. Types of Coverage (check all that apply)<br>☐ Group ☐ Medical<br>☐ Individual ☐ Dental<br>☐ Medicare ☐ Vision | 5. Coverage Start Date (mm/dd/yyyy) | 6. Is this coverage terminating?<br>☐ Yes (complete #7)<br>☐ No | 7. Coverage End Date (mm/dd/yyyy) |

**Policy 2**

1. Other Insurance Carrier Information: Insurance Carrier Name, Policy Number, Phone Number

| 2. Policy Holder Name | | 3. Names of Covered Members | |
|---|---|---|---|
| 4. Types of Coverage (check all that apply)<br>☐ Group ☐ Medical<br>☐ Individual ☐ Dental<br>☐ Medicare ☐ Vision | 5. Coverage Start Date (mm/dd/yyyy) | 6. Is this coverage terminating?<br>☐ Yes (complete #7)<br>☐ No | 7. Coverage End Date (mm/dd/yyyy) |

## Section 7: Electronic Communication Delivery Agreement

To provide you with a convenient and mobile avenue to access all of your health insurance documents and to reduce the use of paper, St. Luke's Health Plan sends communications to members through a secured member account through MyChart and provides notification by email to the email address you supply in your application when we post a new communication to your secure account.

Below is your agreement to receive electronic copies unless you indicate a preference to receive paper copies.

Unless I reject electronic distribution by checking the checkbox below, I consent by my signature on behalf of myself and any covered dependents to the electronic distribution of communications related to the coverage I have applied for, and agree that I consent to:

- Electronically receive any materials that are currently available electronically as well as those that become available in the future; printed and mailed copies will be sent to your mailing address prior to the availability of electronic copies.
- Electronically receive the following materials: explanation of benefits statements (EOBs); enrollment or effective date notices; acknowledgements of claims receipts; requests for additional information; and determinations on submitted claims, including adverse benefit determinations; legally required information and notifications, including but not limited to notices about the Women's Health and Cancer Rights Act, any federal or state rules and regulations, or privacy protection laws; information regarding complaints, appeals, or grievances; summaries of benefits and coverage (SBCs) and uniform glossaries of terms; benefit change notices; policy changes or updates; renewal information; discontinuation or termination notices; continuation of coverage rights; certificates of creditable coverage; billing notices or statements; and any health and wellness information I have requested or has been requested on my behalf by my employer.
- To receive a printed copy of any electronic notice, you can print a copy from your secure member account or call Customer Service at the number listed on the back of your member ID card.
- To easily change your communication preferences, log into your member account, select My Account from the top menu or visit your member preference center found at the footer of any email you receive.

☐

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## Section 8: Replacement of Existing Coverage

Will this policy replace any other accident and sickness insurance presently in force? ☐ Yes ☐ No

If YES, please read, sign and date the following notice.

**Notice to Applicant Regarding Replacement of Accident and Sickness Insurance**

According to this application, you intend to allow to lapse or otherwise terminate existing accident and sickness insurance and replace it with a program to be issued by St. Luke's Health Plan. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the health care coverage available to you under the new program.

1. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present program. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
2. If, after due consideration, you still wish to terminate your present program and replace it with new coverage, please be certain to completely and accurately answer all questions on this application. Failure to include all information on an application may provide a basis for the company to deny any future claims and to refund your premiums as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

☐ I confirm that a copy of "Notice to Applicant Regarding Replacement of Accident and Sickness Insurance" was furnished to me.

## Section 9: Initial Payment

Submit payment by check or money order, payable to St. Luke's Health Plan.
Mailing to **St. Luke's Health at P.O. Box 736221, Chicago, IL 60673-6221**

## Section 10: 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 in Idaho.

- You are not covered under another group health plan
- Your most recent coverage was not canceled 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 coverage or continuation coverage ends. Act promptly to protect your rights.

## Section 11: The Effect of Non-Payment

If your coverage is terminated for non-payment, you may be required to pay your past due balance prior to reenrolling in a new health insurance policy with St. Luke's Health Plan in the future.

## Section 12: Affirmation

I affirm the answers in this "Idaho Individual Application" are complete and correct. I am providing these answers as part of the application procedure required by this insurance carrier to enroll in its insurance coverage. I understand that the insurance carrier will rely on each answer in making its determination to extend coverage and to determine the type of coverage offered. I understand if I have made any misstatement or omission in this application, the insurance carrier may take any action available by law, including but not limited to, retroactive adjustment of premiums or claims. Further, I understand that any fraud or intentional misrepresentation of material fact in my completion of this application is cause for retroactive termination of coverage by the insurance carrier and/ or other action available by law. I will promptly inform the insurance carrier in writing if anything happens before my coverage takes effect that makes an answer on this application incomplete or incorrect. Following receipt of a fully-executed application, coverage will be in force as of the effective date determined by the insurance carrier under applicable law.

**DISCRIMINATION IS AGAINST THE LAW**

St. Luke's Health Plan does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

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## Section 13: Statement of Understanding

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

- No independent producer, agent or employee of the insurance carrier can change any part of this application or waive the requirement that I answer all questions completely and accurately.
- The insurance carrier may terminate or rescind an insured's coverage for any intentional misrepresentation, omission of fact by, concerning, or on behalf of any insured that was or would have been material to the insurance carrier's acceptance of a risk, extension of coverage, provision of benefits or payment of any claim.
- If this application is approved, coverage for me and any eligible persons named on this application will begin on the effective date assigned by the insurance carrier.
- I understand that this application will become part of the contract between the insurance carrier and me.
- 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.

## Section 14: Parental Or Guardian Consent To Application

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

| Print Name | Date (mm/dd/yyyy) |
|---|---|
| Address (if different than Dependent) | |

## Section 15: Acknowledgment

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 application) 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 acknowledgment does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

**Signature of Applicant** _____ **Signature Date** (mm/dd/yyyy) _____

**Signature of Spouse** _____ **Signature Date** (mm/dd/yyyy) _____

*(if applying for coverage)*

**Signature of Responsible Party** _____ **Signature Date** (mm/dd/yyyy) _____

*(if applying for dependent-only coverage)*

## Section 16: Independent Producer (Agent) Information

**Agent's Name** _____ **ID Number** _____

**Signature of Agent** _____ **Date** (mm/dd/yyyy) _____

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