

Individual & Family plan application

Thank you for considering coverage through one of our Individual & Family plans. Coverage for these plans is provided by Group Health Cooperative or Group Health Options, Inc. ("Group Health" refers to both carriers, unless otherwise noted.)

To be considered for enrollment, please complete this application in black or blue ink only. This application and the necessary supporting documents must be **received by the 20th of the month** for coverage to begin the first of the following month. Incomplete or inaccurate information will delay the effective date of coverage.

Send the application and supporting documents to:

Group Health Individual & Family Plans
320 Westlake Ave N Suite 100
Seattle WA 98109-5233

If you have any questions about this application or the process, please call us at 1-800-358-8815 or 206-448-4141.

CHECKLIST

- Signature (required):** This application has been signed by myself and my spouse/domestic partner (if applicable).
- Payment (required):** The first month's premium payment is being made by including my credit card information on this application or enclosing a check or money order.
- Documentation (required, if applicable):** I am enclosing any and all documentation as required in Section 7, including a copy of the Standard Health Questionnaire for all persons listed on this application (unless exempt).
- Automatic transfer of funds (optional):** After the first month, I've requested premium payments be transferred from my banking institution and have enclosed the Transfer of Funds form.

ELIGIBILITY

Applicants must meet both of these requirements.

- Washington state is my principle residence. I am not eligible for Medicare.

HOW DID YOU HEAR ABOUT GROUP HEALTH?

- Group Health group plan Television Word of mouth Other: _____
- Web site Seminar Broker/agent
- Newspaper Direct mail Radio

SECTION 1. APPLICATION TYPE

This is for new enrollment. I wish coverage to begin on: _____

I am a current Individual & Family plan member and I am:

(please check the boxes below that apply)

Changes:

- Changing plans**
- Changing from dependent to subscriber

Adding eligible dependents (complete sections 2, 6, 7, and 8):

- Adding a newly adopted child Date of event: _____
- Adding a spouse/domestic partner
- Adding a dependent child
- Adding a newborn Date of birth: _____

Changing from a Group Health Cooperative plan to a Group Health Options, Inc. plan **will require completion of a new Standard Health Questionnaire. If you are changing from one Group Health Cooperative plan to another Group Health Cooperative plan, you **may** be required to complete a new Standard Health Questionnaire. Call Customer Service at 1-888-901-4636 for more information.

SECTION 2. ADDRESS AND BILLING INFORMATION

Group Health ID Number (if current or prior member)	Name: Last, first, middle initial	Sex M/F	Date of birth	Social Security # (REQUIRED)	Have tobacco products been used during the last 12 months?
	Applicant/subscriber				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Spouse/domestic partner				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Dependent child (under 25)				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Dependent child (under 25)				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Dependent child (under 25)				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Dependent child (under 25)				<input type="checkbox"/> Yes <input type="checkbox"/> No
Street address		City	State	ZIP	County
Mailing address		City	State	ZIP	Home telephone number
Guarantor/billing address		City	State	ZIP	E-mail address (optional)

SECTION 3. HOW TO PAY

Payment option:

- Monthly billing (by mail) Automatic Transfer of Funds (electronic)

First month's premium must be paid by credit card, check, or money order. We accept Visa, MasterCard, or Discover.

Card type Card # Expiration date Name on card (please print)

- Check or money order (must be included with application documents if not paying by credit card).
- Transfer of Funds from bank (optional). *First month's premium must be paid by credit card, check, or money order.*
— Please complete and send a Transfer of Funds form with this application.

Note: After your first premium payment, you will receive a monthly statement, unless you have arranged to have funds transferred from your financial institution.

SECTION 4. PLAN CHOICES

Check one box to indicate your health plan selection:

- Group Health Cooperative:** The Welcome **500** Plan – '08
 The Welcome **1750** Catastrophic Plan – '08*
 The Welcome **3500** Catastrophic Plan – '08*
- Group Health Options, Inc.:** The Balance **1000** Plan – '08
 The Balance **1500** Plan – '08
 The Balance **2500** Catastrophic Plan – '08*
 The Balance **5000** Catastrophic Plan – '08*
 HealthPays™ Health Savings Account (HSA)
2000 Individual/**4000** Family Catastrophic Plan – '08*†

Note: Federal law places some limitations on HSA eligibility. Consult your tax advisor or materials available through the U.S. Treasury Dept. for this important information to make sure you're selecting the right HSA plan for your family.

*These plans provide catastrophic coverage. If you decide at a later date to switch to a plan that provides greater coverage, you may be asked to provide a new Standard Health Questionnaire. In addition, your prior catastrophic coverage may not meet creditable coverage requirements for pre-existing conditions.

†Children under age 18 cannot enroll as the primary applicant.

SECTION 5. ADDITIONAL OPTIONS

- I would like Washington Dental Service dental coverage for myself and all eligible dependents. The address of WDS is:
9706 Fourth Ave. N.E., Seattle, WA 98115-2157.
- I would like Group Health Cooperative voting membership for myself and all eligible dependents.

SECTION 6. PRIOR OR CURRENT COVERAGE

Group Health's Individual & Family plans have a nine-month waiting period for pre-existing conditions. If you are coming from a noncatastrophic health plan with no more than a \$1,750 deductible and with maternity and prescription drug benefits, we will waive or credit that coverage. If you had a 64-day or more break in coverage, no pre-existing condition credit will be given. (If this applies, skip to Section 8.)

The pre-existing condition wait time will be waived if you qualify as a HIPAA Eligible Individual. You qualify as an HIPAA Eligible Individual if: you have 18 months or more of creditable coverage without a break of 63 full days or more before applying for coverage with Group Health; and your most recent coverage was under a group health plan, governmental plan, or church plan (or under health insurance coverage offered in connection with such a plan); and you are not eligible for a group health plan; and you are not eligible for Medicare or Medicaid; and you do not have other health insurance; and you did not lose your most recent coverage because of non-payment of premiums or fraud; and you accepted and used up your COBRA continuation coverage.

If you have/had previous coverage other than Group Health within the last 63 days, provide your Certificate of Creditable Coverage or other document showing your beginning and ending dates of coverage (when available) with this application so we may determine if credit can be given.

1. Name of insurance company: _____ Phone: (_____) _____
(Any company, including Group Health Cooperative or Group Health Options, Inc.)

2. Names of all enrollees on current/previous coverage: _____

3. Date coverage began: _____ Date coverage ended: _____

4. Deductible amount per year: Individual _____ Family _____

5. Did/does your coverage include: Maternity Prescription drug Hospital only

6. Are you currently on or coming from COBRA: Yes No Began: _____ Ended: _____

7. What type of coverage are you coming from:

- | | | |
|---|--|--|
| <input type="checkbox"/> Individual plan | <input type="checkbox"/> Group plan | <input type="checkbox"/> Federal plan (FEHBP/TriCare/Peace Corps Act) |
| <input type="checkbox"/> Healthy Options plan (DSHS) | <input type="checkbox"/> WSHIP | <input type="checkbox"/> College/school/short-term insurance |
| <input type="checkbox"/> Indian Health Service or tribal organization | <input type="checkbox"/> Basic Health plan | <input type="checkbox"/> State Children's Health Insurance Program (SCHIP) |

SECTION 7. STANDARD HEALTH QUESTIONNAIRE EXEMPTIONS

Are you exempt from health screening? If so, check your reason below. Otherwise, you must submit a Standard Health Questionnaire for everyone listed on this application.

- Relocation:** Applicant has relocated within Washington in the past 90 days, and prior health plan is not available. (Attach copy of recent utility bill.)
- COBRA:** COBRA coverage exhausted within 90-days of application. [Include a letter from COBRA Administration and Certificate of Creditable Coverage – “COC.”]
- COBRA termination:** Former employer went out of business while on COBRA; application dated within 90-day of termination. (Include a verification letter.)
- Provider cancellation:** Health care provider left network of our current individual plan within the last 90 days.
- Employer exempt from COBRA:** Applying for coverage within 90 days of termination of a group health plan (including church plans) that is exempt from offering COBRA coverage and was enrolled for at least 24 continuous months. (Include letter of verification from employer or COC.)
- Washington Basic Health plan:** Applying for coverage within 90 days of termination of the BH plan and was enrolled for at least 24 continuous months. (Include letter of verification from Basic Health.)
- New child:** Addition of newborn or newly adopted child to an existing plan, within 60 days of event.

SECTION 8. ACKNOWLEDGEMENTS & SIGNATURES

This application becomes part of my Medical Coverage Agreement with Group Health. I understand that I have the right to examine and return the Medical Coverage Agreement within 10 days of receipt. I have read and agree with the Terms and Conditions included with this application and the statements below.

- The signatures shown below allow me, my spouse/domestic partner, or my broker/agent (Section 9) to release to Group Health information about any person listed on my Individual & Family plan application documents, including information from the Standard Health Questionnaire. I further understand that under the Health Insurance Portability and Accountability Act (HIPAA), Group Health may only be allowed to release limited information to me, my spouse/domestic partner, adult/minor children, or my broker/agent.
- Group Health may collect, use, or disclose the Nonpublic Personal Information of persons listed on this application as required or permitted by law and to conduct routine business functions such as determining eligibility for enrollment, reviewing prior coverage for waiting periods, paying claims and, if appropriate, coordinating benefits, and fulfilling other legal obligations specified in my Group Health Medical Coverage Agreement.
- If my/our physical residential address changes to a different county in the Group Health service area, my premium rates may be subject to change.

I declare that, to the best of my knowledge, all information I have provided with this application 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 intentionally false or misleading statements on behalf of myself or any family members, the Medical Coverage Agreement may be cancelled. I further understand that it is a crime to knowingly provide false, incomplete, or misleading information for the purpose of fraudulently obtaining health coverage. Penalties may include imprisonment, fines, and denial of benefits.

Applicant/guarantor signature

Date

Spouse/domestic partner signature

Date

SECTION 9. BROKER INFORMATION

Group Health sales representative or broker or agent name

Phone number

Group Health broker/agent ID number

This information is valid for 36 months or until termination of this plan, whichever comes first.

It is a crime to knowingly provide false, incomplete, or misleading information for the purpose of fraudulently obtaining health coverage. Penalties may include imprisonment, fines and denial of benefits.