IDAHO INDIVIDUAL APPLICATION

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

SECTION 1—ENROLLMENT INFORMATION

Are you: ☐ a new applicant ☐ adding dependents	Are you a resident of the state of Idaho? ☐ Yes ☐ No If yes: _________ years _________ months	REQUESTED EFFECTIVE DATE *(subject to insurance carrier approval)*

SECTION 2—APPLICANT INFORMATION

FIRST NAME		LAST NAME	MIDDLE INITIAL
STREET ADDRESS		CITY, STATE, ZIP CODE	
MAILING ADDRESS *(Street, Route, P.O. Box) (if different than street address)*		CITY, STATE, ZIP CODE	
BILLING ADDRESS *(if different than mailing address)*		CITY, STATE, ZIP CODE	
PREFERRED PHONE NUMBER	ALTERNATE PHONE NUMBER	E-MAIL ADDRESS	

MARITAL STATUS	DATE OF BIRTH	AGE	GENDER	WEIGHT	HEIGHT	SOCIAL SECURITY NUMBER
☐ Single ☐ Married ☐ Divorced ☐ Other *(explain)*_______________________________			☐ Male ☐ Female			

SECTION 3—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). ***Refer to Section 8.h. for dependent eligibility requirements for High Risk Pool plans.*** **Use extra paper if necessary.**

DEPENDENT'S NAMES (first, initial, last)	RELATIONSHIP TO APPLICANT (spouse, child, etc.)	DATE OF BIRTH *(mm/dd/yy)*	AGE	GENDER	WEIGHT	HEIGHT	SOCIAL SECURITY NUMBER
				☐ Male ☐ Female			
				☐ Male ☐ Female			
				☐ Male ☐ Female			
				☐ Male ☐ Female			
				☐ Male ☐ Female			
				☐ Male ☐ Female			

SECTION 4— CURRENT/PRIOR COVERAGE (For proper crediting of preexisting condition waiting periods AND Coordination of Benefits, please complete the section below.) Use extra paper if necessary.

If any person listed on this application has been covered during the 12 months prior to the requested effective date of this application, with a 63-day or less break in coverage, please complete the following information. Please provide a ***Certificate of Creditable Coverage*** from your prior insurance carrier or other appropriate documents to establish prior creditable coverage. 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 **(please use additional paper if needed)**.

To reduce the 12-month exclusion period by your creditable coverage, you should give your new insurance carrier a copy of any ***Certificates of Creditable Coverage*** you have. If you do not have a certificate, but you do have prior health coverage, you should work with your prior plan or insurer to obtain evidence of coverage. Please contact your new insurance carrier if you need help demonstrating creditable coverage.

If you have cancelled state of Idaho individual High Risk Pool mandated plan coverage within the past 12 months, you may not be eligible for coverage unless you are a federally defined eligible individual. Please read the *Notice of Federal Eligibility* on the bottom of page 3 of this application.

Other Insurance Carrier Information: Insurance Carrier Name, Policy Number, Phone Number	Policyholder Name	Names of Covered Members: Self and Dependent(s)	Coverage Start Date *(mm/dd/yy)*	Coverage End Date *(mm/dd/yy)*	Type of Coverage	Will this coverage continue?
					☐ Group ☐ HRP ☐ Indiv ☐ COBRA	☐ Yes ☐ No
					☐ Group ☐ HRP ☐ Indiv ☐ COBRA	☐ Yes ☐ No
					☐ Group ☐ HRP ☐ Indiv ☐ COBRA	☐ Yes ☐ No
					☐ Group ☐ HRP ☐ Indiv ☐ COBRA	☐ Yes ☐ No
					☐ Group ☐ HRP ☐ Indiv ☐ COBRA	☐ Yes ☐ No
					☐ Group ☐ HRP ☐ Indiv ☐ COBRA	☐ Yes ☐ No

List applicants eligible for coverage under any other plan (group, Medicare, Medicaid, etc.) and type of plan eligibility: ___________________________________

____

COMPLETE THE REMAINDER OF THE APPLICATION ONLY IF YOU ARE APPLYING FOR COVERAGE.

SECTION 5A—HEALTH STATEMENT

Please answer each question completely and accurately. Each medical question set forth below applies to each person you listed on this application for whom you wish to obtain coverage, and they apply to both past and present symptoms, conditions, diseases, illnesses, accidental injuries, or deformities ("health conditions"). Coverage under the individual policy will not commence until the application is approved by the insurer's Underwriting Department. No independent producer, agent, or any other person can waive its requirements or is authorized to set forth anything less than a complete and accurate response to each of the questions. The insurer shall not be bound by any attempted waiver of complete answers to the questions set forth below. **If you learn at any time before the policy is effective that any answer on this application is incomplete or inaccurate or is no longer complete and accurate, you must advise the insurer.**

Answer the questions below YES or NO. Each of the questions must be answered, even if the answer is NO. **Answer a question YES, if you or any dependent(s) for whom you want to obtain coverage, for which medical advice, diagnosis, care or treatment was recommended or received for a health condition or event specified in that question. IF YOU ANSWER YES TO ANY QUESTION BELOW, PLEASE COMPLETE SECTION 5B.**

RESPOND to the following questions, for everyone applying for coverage: Yes No

1. Are you, your spouse or any eligible dependent family member listed on this application, now pregnant? . . . . ❒ ❒
   If Yes, due date ____________________________
   Do you anticipate complications?. . . . . ❒ ❒
   Prior/anticipated multiple births?. . . . . ❒ ❒
2. **Pregnancy/Fertility Related Treatment:** Are you, your spouse, or any eligible dependent family member being treated for infertility, fertility evaluation or treatment (including medication)?. . . . . ❒ ❒

WITHIN the past 12 MONTHS has any applicant: Yes No

3. Used any medication or drug?. . . . . ❒ ❒

WITHIN the past 5 YEARS has any applicant been diagnosed with or treated for any of the following: Yes No

4. **Urinary, bladder, incontinence, kidney or liver conditions or disorders?** Kidney stones, jaundice, nephritis, or any other disorder of the liver, kidneys, or pancreas?. . . . . ❒ ❒
5. **Neurological disorders:** Recurring headaches, migraines, head injury, epilepsy, seizures, or convulsions or other neurological disorder?. . . . . ❒ ❒
6. **Metabolic and endocrine conditions or disorders:** Lupus, thyroid disorder, goiter, or any other lymph system disorder . . . . ❒ ❒
7. **Eyes, ears, nose, sinus, or throat conditions or disorders** or any other respiratory system disorder including allergies or hay fever?. . . ❒ ❒
8. **Skin conditions or disorders:** Acne, psoriasis, eczema, growths (except warts), cysts, abnormal moles or birthmarks, any other skin disorder?. . . . . ❒ ❒
9. **Breast conditions or disorders:** breast lumps, fibrocystic breast disease, breast augmentation, or breast reduction? . . . . ❒ ❒
10. **Heart conditions or disorders:** Chest pain, high blood pressure, high cholesterol, irregular heartbeat, or any other heart condition?. . . ❒ ❒
11. **Male reproductive conditions or disorders:** Impotence, prostate or testicular disorder, or abnormal PSA or other reproductive disorder?. . . . . ❒ ❒
12. **Circulatory system conditions or disorders:** Varicose veins, or any other circulatory disorder?. . . . . ❒ ❒
13. **Sexually transmitted diseases?**. . . . . ❒ ❒
14. **Female reproductive conditions or disorders:** Irregular bleeding, abnormal Pap smear/test, endometriosis, recurring pelvic pain, or pelvic inflammatory disease or any other disorder of the reproductive system?. . . . . ❒ ❒
15. **Nervous, mental and behavioral:** Mental health counseling, psychotherapy, depression, stress, anxiety, attention deficit hyperactivity disorder (ADHD), mental health disorder, or chemical imbalance that required consultation or medication?. . . . . ❒ ❒

WITHIN the past 10 YEARS has any applicant been diagnosed with or treated for any of the following: Yes No

16. **Arthritis or rheumatism?**. . . . . ❒ ❒
    ❒ Osteoarthritis ❒ Rheumatoid ❒ Other __________________
    If Yes, joints affected: ___________________________________
17. **Musculoskeletal conditions or disorders:** Ankylosing spondylitis, neuropathy, osteogenesis imperfecta, osteoporosis, herniated and/or ruptured disc, spina bifida, kyphosis, scoliosis, spinal stenosis, or spondylosis or other musculoskeletal disorders?. . . . . ❒ ❒

WITHIN the past 10 YEARS has any applicant been diagnosed with or treated for any of the following (continued): Yes No

18. **Digestive conditions or disorders:** Ulcers, hernias, chronic diarrhea, diverticulitis, irritable bowel syndrome, reflux, GERD, hemorrhoids, polyps, Crohn's disease, colitis, colostomy or ileostomy, or any other gallbladder, digestive or rectal disorders?. . . . . ❒ ❒
19. **Alcohol or Drug Use/Abuse:** Alcoholism, drinking problem, convicted of DUI/DWI, drug dependency, abuse, or misuse of prescribed or non-prescribed drugs such as opiates, stimulants, depressants, and/or hallucinogens?. . . . . ❒ ❒
20. **Eating disorders/obesity treatment:** including bulimia, anorexia, or obesity and any surgical services for obesity?. . . . . ❒ ❒
21. **Back, neck, bone, joint or spinal disorders:** bone infection, bone or joint disorders (including foot, knee, jaw, fracture, dislocation or joint replacement)? . . . . ❒ ❒
22. **Blood conditions or disorders:** Hemophilia, anemia, blood or bleeding disorder?. . . . . ❒ ❒

HAS any applicant EVER been diagnosed with or treated for any of the following: Yes No

23. **Respiratory conditions or disorders:** Respiratory Syncytial Virus (RSV), reactive airway disease, tuberculosis, asthma, chronic bronchitis, sleep apnea, pleurisy, COPD, sarcoidosis, or emphysema? . . . . ❒ ❒
24. **Transplant or implanted device:** Any organ or tissue transplant, pacemaker or other implanted device?. . . . . ❒ ❒
25. **Nervous, mental and behavioral:** Bipolar affective disorder, manic depression, schizophrenia, chronic organic brain syndrome, attempted suicide, or psychotic disorder?. . . . . ❒ ❒
26. **Birth defect/congenital abnormalities:** premature birth, development or learning disability, mental impairment, Down syndrome, autism spectrum disorder or physical deformities?. . . . . . ❒ ❒
27. **Heart and circulatory conditions or disorders:** Heart murmur, heart attack, bypass surgery, angioplasty/stent, blood clot, stroke, heart surgery, coronary artery disease, or congestive heart failure? . . . . ❒ ❒
28. **Brain/nervous system conditions or disorders:** Multiple sclerosis, polio, stroke, paralysis, muscular dystrophy, cerebral palsy, Lou Gehrig's disease (ALS), Parkinson's disease, Alzheimer's disease, or dementia?. . . . . ❒ ❒
29. **Diabetes or insulin resistance?**. . . . . ❒ ❒
    If you have diabetes, is it: ❒ Type 1 ❒ Type 2
30. **Immune system conditions or disorders:** Immune system diseases, human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), or AIDS related complex (ARC)?. . . . . ❒ ❒
31. **Cancer (including skin cancer or melanoma) or tumors?**. . . . . . . ❒ ❒
32. **Hospitalization/Surgery:** Has anyone listed on this application been hospitalized or had surgery? . . . . ❒ ❒
33. **Any medical conditions not mentioned in the previous questions?** . . . . ❒ ❒
    If Yes, list: ____
    ____

OTHER MEDICAL INFORMATION Yes No

34. **Do you have a family doctor?**. . . . . ❒ ❒
    If Yes, list name: ______________________________________

SECTION 5B—HEALTH STATEMENT (If you answered Yes to any question in Section 5A, please complete the information in this section. Use extra paper if necessary.)

Question #	Person Affected		Name of Disease, Symptom or Condition	Type of Treatment	Complete Recovery? (Y/N)
	Date of Onset (mm/yy)	Last Treated (mm/yy)	Name of Physician and/or Hospital	Medication Name	Frequency/Last Date Taken
Question #	Person Affected		Name of Disease, Symptom or Condition	Type of Treatment	Complete Recovery? (Y/N)
	Date of Onset (mm/yy)	Last Treated (mm/yy)	Name of Physician and/or Hospital	Medication Name	Frequency/Last Date Taken
Question #	Person Affected		Name of Disease, Symptom or Condition	Type of Treatment	Complete Recovery? (Y/N)
	Date of Onset (mm/yy)	Last Treated (mm/yy)	Name of Physician and/or Hospital	Medication Name	Frequency/Last Date Taken
Question #	Person Affected		Name of Disease, Symptom or Condition	Type of Treatment	Complete Recovery? (Y/N)
	Date of Onset (mm/yy)	Last Treated (mm/yy)	Name of Physician and/or Hospital	Medication Name	Frequency/Last Date Taken

List any medications or drugs (that are not listed in previous sections) taken by all applicants within the past 12 months. Use extra paper if necessary.

Patient's Name	Type or Name of Drug	Dosage or Frequency of Use	Date Last Taken or Ongoing	Condition Requiring Medication	Physician's Name

35. Are you or any of your dependents listed on this application currently disabled? ☐ Yes ☐ No
    Name of disabled person______________________________ Physician's Name and Phone ____
    Date of Disability ___________________________________ Physician's Address ____
    Nature of Disability ____

36. Has any person listed on this application used a tobacco product during the past 12 months? ☐ Yes ☐ No
    If Yes, list name(s) ____ Quit date(s) ________________

37. Has surgery, diagnostic testing, medical treatment or follow-up visit been advised (but not yet performed) ☐ Yes ☐ No
    for anyone on this application? **If Yes**, list person's name and details? ____
    ____

38. Has any named person incurred medical expenses or claims exceeding $10,000 in the past 24 months? ☐ Yes ☐ No
    If Yes, give person's name and details: ____
    ____

39. Are you or any dependent listed on this application covered on Medicare or have received Social Security Disability or Workers' Compensation payments or are now eligible to receive such payments? ☐ Yes ☐ No
    If Yes, give person's name, specific type and details: ____
    ____

40. Has any insurance carrier refused, restricted (including waiver or condition), or rated any health coverage for you or any dependents listed on this application? ☐ Yes ☐ No
    If YES, please explain (list applicant's name, medical condition and whether refusal, waiver, or restriction) ___________________________
    ____
    Name of Insurance Carrier ____ Date of refusal, etc. ___________________________
    (Please attach a copy of refusal letter, if applicable)

SECTION 6—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 have at least 12 months of continuous creditable coverage without any break in coverage greater than 63 days
- Your most recent coverage was under a group health plan, a governmental plan or a church plan (or health insurance offered in connection with such a plan)
- You are not covered under another group health plan
- Your most recent coverage was not cancelled 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 7—AFFIRMATION

I affirm the answers given 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 this application contains any material misstatements or omissions, the insurance carrier may, within the first 24 months of coverage, deny coverage retroactively and/or take any other legal action available by law. I will promptly inform the insurance carrier in writing if anything happens before my coverage takes effect that makes any answer in this application incomplete or incorrect. I understand that a twelve month waiting period for coverage of preexisting conditions may apply. I understand and agree no coverage shall be in force until approved by the insurance carrier. If approved, coverage will be in force as of the effective date determined by the insurance carrier.

SECTION 8—STATEMENT OF UNDERSTANDING

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

a. 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.
b. The insurance carrier may terminate or rescind an insured's coverage for any 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.
c. 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.
d. I understand that this application will become part of the contract between the insurance carrier and me.
e. 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.
f. The following preexisting condition exclusion applies to NON-HIGH RISK POOL (HRP) PLANS:
   For individuals enrolled in a grandfathered policy effective prior to January 1, 2014, the following preexisting condition exclusion will be applied:

   > "A preexisting condition is (i) a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the effective date of coverage; (ii) a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage; or (iii) a pregnancy existing on the effective date of coverage."

   This exclusion may last up to 12 months from your first day of coverage; however, the exclusion period will be reduced by the number of days of your prior "creditable coverage." Most prior health coverage is considered creditable coverage and can be used to reduce the preexisting condition exclusion period if you have not experienced a break in coverage of 63 days or more.

   This preexisting condition exclusion **does not** apply to a child who is enrolled in the plan within 60 days after birth, adoption or placement for adoption.

   The preexisting condition exclusion defined above **will not** be applied to individuals under the age of 19 years who are enrolled in a non-grandfathered plan, beginning with renewals on or after September 23, 2010, as provided in the federal Patient Protection and Affordable Care Act (PPACA).
g. The following preexisting condition exclusion applies to HIGH RISK POOL (HRP) PLANS:

   > A preexisting condition is a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the effective date of coverage; a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage; or a pregnancy existing on the effective date of coverage.

   This exclusion may last up to 12 months from your first day of coverage or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is considered creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days.
h. If enrolling in a High Risk Pool plan, eligible dependents include any unmarried child who is under the age of 25 and more than ½ financially dependent on parent for support; or who is medically certified as disabled and dependent on parent for support (copy of certification required).

I understand that if I am declined coverage under the plan I am applying for, that I may be eligible for my choice of the state of Idaho individual High Risk Pool mandated plans. I also understand that I may be eligible for one of the state of Idaho individual High Risk Pool mandated plans, if my insurance carrier refuses to issue a health benefit plan providing coverage substantially similar to coverage offered under an equivalent High Risk Pool plan except at a rate exceeding the rate of the High Risk Pool plan.

SECTION 9—ACKNOWLEDGEMENT

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

Signature of Applicant____ Date ______________________

Signature of Spouse ____ Date ______________________
(if applying for coverage)

SECTION 10—PARENTAL OR GUARDIAN CONSENT TO APPLICATION

I, the undersigned, 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.

Signature	Print Name	Date *(mm/dd/yy)*

SECTION 11—AGENT INFORMATION

Agent's Name ____ ID No. ______________________

Signature of Agent ____ Date ______________________