

Questions? Call us at CDA Insurance LLC at 800.884.2343

Tips for completing the application:

1. Please read everything carefully and answer all questions honestly. This document becomes part of your health insurance contract.
2. Please complete all sections to the best of your ability. Remember to fill out the Washington Standard Health Statement. **One statement per person applying for coverage.** This may not be required, please refer to the Standard Health Questionnaire for who is exempt from completing the questionnaire. Please pay special attention to the Health History Section.

Prior Insurance?

Yes: Please make a photocopy of your health insurance card(s) or contact your insurance carrier and request a "Certificate of Credible Coverage." Include this with your application.

No: If your application is approved, when the policy is sent to you, there will be a form that will need to be a 9 month waiting period on pre-existing conditions. There is a 12 month waiting period for Transplants.

Payment: No payment is due at the time of application. You will be mailed a bill once you are approved.

Final check list before mailing:

- All sections completed including the Washington State Standard Health Questionnaire (if required)?
- Copy of your Certificate of Credible Coverage (to waive the pre-existing conditions clause)
- Proof of Residency (Valid Washington Drivers License or ID card, Voter registration card or current utility bill in your name, including address)
- Signed and Dated

Send Completed Application to:

CDA Insurance LLC
PO Box 26540
Eugene, Oregon 97402

GroupHealth Washington Application

Individual and family plan application (For coverage effective on or after July 1, 2011)

Thank you for considering us for your individual and family coverage.

To be considered for enrollment:

- Complete this application in black or blue ink only.
- Read the application carefully and answer all applicable sections completely.
- Confirm that you meet all the eligibility requirements called out throughout this application by checking the appropriate boxes. Not doing so will delay the processing of your application.
- Send this completed application and supporting documents to arrive at our offices by the 20th of the month, or the first business day following the 20th if it's a weekend or holiday, for coverage to begin the first of the following month.
- Send the application and supporting documents to:
Group Health individual and family sales
320 Westlake Ave N, Suite 100
Seattle, WA 98109-5233
- Call us at **1-800-358-8815** or **206-448-4141** if you have any questions about this application or the process.

ELIGIBILITY – RESIDENCE – ACKNOWLEDGEMENT REQUIRED

- Washington state is the principal residence for myself and my dependents and we reside within one of the following counties: Benton, Columbia, Franklin, Grays Harbor (98541, 98557, 98559, and 98568), Island, King, Kitsap, Kittitas, Lewis, Mason, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom, Whitman, or Yakima.

ELIGIBILITY – MEDICARE – ACKNOWLEDGEMENT REQUIRED

- You or your dependents are not eligible for Medicare.

Medicare-eligible beneficiaries may not apply for individual and family coverage. Medicare is a federally sponsored program designed for individuals over the age of 65, individuals with end-stage renal disease, or individuals that meet the criteria for disability as defined by the Social Security Administration. If you are unsure of your Medicare eligibility, please visit **www.medicare.gov**

If an applicant or dependent is over 65 and not Medicare eligible, a letter from the Social Security Administration attesting to noneligibility is required and must accompany this application. If other family members still wish to enroll in an individual and family plan, they will need to designate a primary subscriber/applicant.

Medicare-eligible beneficiaries may act as a guarantor so their eligible dependents can apply for coverage. Eligible dependents are children under 18 or a dependent who is totally incapable of self-sustaining employment. Please indicate oldest dependent on the subscriber/applicant line and all remaining dependents on the dependent child lines. Guarantor **MUST** complete billing information in Section 3.

SECTION 1. APPLICATION TYPE

Pick **one** of these two options:

I/we are new applicants.

I/we wish coverage to begin on the first day of _____.
(month/year)

OR

I'm a current Group Health individual and family plan member and my member ID is _____, and I am (please check the boxes below that apply):

Adding eligible dependents:

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

Requesting changes:

- Changing plans.*
- Changing from dependent to subscriber.

NOTE:

If you are requesting a plan change, your account must be current and paid in full.

Changing plans during annual renewal from May 1–June 30, 2011 for coverage effective July 1, 2011.

To change plans during annual renewal, complete Sections 2, 3, 4, 5, 9, 10 (if applicable), and 11. Current subscribers will not be required to complete a Standard Health Questionnaire during the renewal period. Section 7 is not applicable. Changing plans requires re-election of dental coverage in Section 5.

*Changing plans between Group Health Cooperative/Group Health Options, Inc. will require completion of a new Standard Health Questionnaire. You can find this online at **ghc.org**. If you are changing from a higher deductible plan to a lower one within the same group, you **may** be required to complete a new Standard Health Questionnaire. Call Customer Service at **1-888-901-4636** for more information.

SECTION 2. SUBSCRIBER & ADDRESS INFORMATION

Name: Last, first, middle initial	Sex M/F	Date of birth	Social Security number (REQUIRED)	Have tobacco or nicotine 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 26)*				N/A
Dependent child (under 26)*				N/A
Dependent child (under 26)*				N/A
Dependent child (under 26)*				N/A
Street address (no P.O. Box)	City	State	ZIP	County
Mailing address	City	State	ZIP	Contact phone number
E-mail address				

*Applicants under 19 years of age are subject to special guidelines for enrollment. See the instruction sheet affecting applicants under age 19.

FOR INTERNAL USE ONLY
DATE APPLICATION WAS RECEIVED:

SECTION 3. BILLING INFORMATION

No payment is required at this time. You will be mailed a bill once you are approved for coverage. Information about automatic funds transfer from a checking or savings account will be included with your welcome letter once you are enrolled.

Choose **one** of the following three billing options and fill in the billing information (if applicable).

1 – Send bill to: subscriber address.

OR

<input type="checkbox"/> 2 – Send bill to: different address below.	<input type="checkbox"/> 3 – Send bill to: guarantor at the address below.* (This option is only available if the applicant is under age 18.)
Billing name	Guarantor billing name
Address	Address
City	City
State/ZIP	State/ZIP
Billing phone number	Guarantor billing phone number
Billing e-mail	Guarantor billing e-mail

*If a third party is paying premiums on behalf of the applicant, the third party is required to either set up a monthly electronic funds transfer or, if receiving a paper bill, submit one check per subscriber policy.

SECTION 4. PLAN CHOICES

Check **one** box to indicate your health plan selection:

Group Health Cooperative: <input type="checkbox"/> The Welcome 750 Plan – '11 <input type="checkbox"/> The Welcome 2000 Catastrophic Plan – '11* <input type="checkbox"/> The Welcome 3500 Catastrophic Plan – '11*	Group Health Options, Inc.: <input type="checkbox"/> The Balance 1750 Plan – '11 <input type="checkbox"/> The Balance 2500 Catastrophic Plan – '11* <input type="checkbox"/> The Balance 5000 Catastrophic Plan – '11*
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Group Health Cooperative: <input type="checkbox"/> HealthPays® Health Savings Account (HSA) 2000 Individual/ 4000 Family Catastrophic Plan – 11* Do you want a banking arrangement with HealthEquity? <input type="checkbox"/> Yes <input type="checkbox"/> No	Group Health Options, Inc.: <input type="checkbox"/> HealthPays® Health Savings Account (HSA) 2750 Individual/ 5500 Family Catastrophic Plan – '11* Do you want a banking arrangement with HealthEquity? <input type="checkbox"/> Yes <input type="checkbox"/> No
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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, your prior catastrophic coverage may not meet creditable coverage requirements for pre-existing conditions.

SECTION 5. OPTIONAL DENTAL COVERAGE

Choose **one** box below to indicate whether you'd like to elect, waive, or terminate optional dental coverage through Washington Dental Service, which is located at 9706 Fourth Ave. N.E., Seattle, WA 98115-2157.

- I would like dental coverage for myself and all eligible dependents.
 - Check here if you are enrolling a dependent under age 3.
- I am a new applicant and would like to waive dental coverage for myself and all eligible dependents.*
- I am a current member and I wish to terminate the existing dental coverage for myself and all eligible dependents.*

*If you waive or terminate dental coverage, you will not be able to reapply until the annual plan renewal in July.

SECTION 6. PRIOR OR CURRENT COVERAGE

Your contract contains coverage exclusions for Pre-Existing Conditions (PEC). These exclusions could be fully or partially waived based on prior or current coverage. Review this section carefully and complete the information requested for both you and your dependents to assure proper processing of your claims.

Name (first and last)	Current or previous carrier (include phone number)	COBRA	Date coverage began (mm/dd/yy)	Date coverage ended (mm/dd/yy)
		Yes <input type="checkbox"/> No <input type="checkbox"/>		
		Yes <input type="checkbox"/> No <input type="checkbox"/>		
		Yes <input type="checkbox"/> No <input type="checkbox"/>		
		Yes <input type="checkbox"/> No <input type="checkbox"/>		
		Yes <input type="checkbox"/> No <input type="checkbox"/>		
		Yes <input type="checkbox"/> No <input type="checkbox"/>		

Deductible amount per year: Individual _____ Family _____

Out-of-pocket limit per year: Individual _____ Family _____

Did/does your coverage include:

- Maternity Prescription drug Hospital only

What type of coverage are you coming from:

- Individual plan College/school/short-term insurance
 Group plan Indian Health Service or tribal organization
 Federal plan (FEHBP/TriCare/Peace Corps Act) State Children's Health Insurance Program (SCHIP)
 Healthy Options plan (DSHS) Basic Health plan
 WSHIP Medicaid
 State plan (PEBB)

The pre-existing condition wait period will be waived if you are an "eligible individual" under HIPAA. You qualify as an "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; your most recent coverage was under an employer health plan, governmental plan, or church plan (or under health insurance coverage offered in connection with such a plan); you are not eligible for an employer health plan; you are not eligible for Medicare or Medicaid; you do not have other health insurance; you did not lose your most recent coverage because of nonpayment of premiums or fraud; and you elected and used up your available COBRA continuation coverage.

The pre-existing condition wait period may not be applied to applicants under the age of 19 per federal law.

- Crediting PEC:** I am including a Certificate of Creditable Coverage which shows the beginning and ending dates of prior coverage in order to have my pre-existing condition wait period credited.

SECTION 7. STANDARD HEALTH QUESTIONNAIRE EXEMPTIONS

Is an applicant or dependent exempt from health screening? If so, check the reason below.

Note that a primary subscriber's exemption DOES NOT carry over to spouse or dependent(s). Otherwise, you must submit a Standard Health Questionnaire for all individuals listed on this application who are not exempt. Refer to the Standard Health Questionnaire for more details.

- Relocation:** Applicant has relocated within Washington in the past 90 days, and prior health plan is not available. **Include:** a copy of a utility bill in your name from the prior address dated within the last 90 days and a letter of verification from your prior carrier verifying that because you have moved, you no longer reside in their service area and they cannot provide health insurance at your new location.
- Exhausted COBRA / Employer went out of business while on COBRA:** Termination must be within 90 days of dated application. **Include:** letter from COBRA Administration verifying COBRA coverage has been exhausted or a letter from the employer/COBRA administrator indicating the employer has gone out of business and COBRA benefits are being discontinued. Certificate of Creditable Coverage is also required.
- Refused COBRA:** Applying for coverage within 90 days of COBRA qualifying event* and was enrolled in group coverage for at least 24 continuous months prior to event and chose not to take COBRA. **Include:** a COBRA offer letter.
- Terminated COBRA:** Applying for coverage within 90 days of voluntarily terminating COBRA coverage and you had at least 24 months of continuous group coverage prior to cancellation (not applicable to Basic Health applicants). **Include:** a most recent COBRA billing statement and a certificate of coverage for proof of 24 months of continuous group coverage.
- Employer exempt from COBRA:** Applying for coverage within 90 days of an event that would qualify for COBRA, had your employer not been exempt from COBRA, and you had at least 24 months of continuous group coverage prior to such event? **Include:** letter of verification of COBRA exemption from employer and Certificate of Creditable Coverage.
- Provider cancellation:** Health care provider left network of your current individual plan within the last 90 days. **Include:** a letter of verification from the provider or carrier verifying service in the last 12 months and the date the provider left the network.
- Washington Basic Health plan (BH):** Applying for coverage within 90 days of termination of the BH plan and was enrolled for at least 24 continuous months. **Include:** a letter of verification from your carrier with dates of coverage for proof of your 24 months of eligibility from the BH plan, or a certificate of coverage.
- New child:** Addition of newborn or newly adopted child to an existing plan, within 60 days of event. **Include:** documentation indicating date of placement or birth.
- Group plan terminated because employer went out of business:** Applying for coverage 90 days before or after employer discontinued group coverage due to business closure and you had 24 months of continuous group coverage immediately prior to this event. Effective date for individual plan must fall on or within 90 days after the date group coverage was discontinued. **Include:** a letter from your employer/ administrator indicating the employer has gone out of business and benefits are being discontinued. A Certificate of Creditable Coverage showing 24 continuous months of coverage is also required.

*For a listing of COBRA qualifying events, visit www.dol.gov/ebsa/faqs/faq_consumer_cobra.html

SECTION 8. TERMS AND CONDITIONS

1. **Acceptance of application:** Group Health's acceptance of you and your dependents 19 years of age or older for coverage is based upon your score(s) determined by the Washington State Health Insurance Pool (WSHIP) Standard Health Questionnaire unless an exemption under the law applies. In order to process your application for one of our individual and family plans, we must receive the application signed by you and your spouse/domestic partner, signed questionnaire(s) for each family member over the age of 18, and any Certificates of Creditable Coverage (if available).
2. **Dependent children:** Each eligible child (under 26) will be charged the child rate, except as noted in number 3 of these terms and conditions. Dependents aged 19–26 may be enrolled at any time of year. Dependents under the age of 19 must be enrolled during selected open enrollment periods, unless they experience a qualifying event which makes them eligible for special enrollment. See number 4 for a list of qualifying events.
3. **Adults applying as a Guarantor (dependent-only coverage):** Financial guarantors are only required for children under the age of 18. As a Guarantor, you hereby agree to accept the financial and contractual responsibilities for all dependents listed on the application. A Guarantor may enroll only dependent children who are under the age of 18 and dependents who are totally incapable of self-sustaining employment as described in number 2, above. For dependent-only coverage, the oldest/only child (noted as Applicant/Subscriber on the application) is charged the lowest adult age rate, while all additional children are charged the child rate.
4. **Special enrollment for individuals under age 19:** All individuals under the age of 19 may apply for coverage during an open enrollment period only. If an individual under the age of 19 wishes to apply for coverage outside of an open enrollment period, either as a subscriber, a dependent-only, or as a dependent of a subscriber, they may do so only if they experience a qualifying event which makes them eligible for special enrollment. More detail on qualifying events can be found in the Special Instructions for Under Age 19 Applicants sheet that accompanies this application. The five qualifying events are listed below:
 - A) a loss of employer-sponsored coverage.
 - B) a loss of eligibility under Medicaid or another public program providing health benefits.
 - C) a loss of coverage as a result of the dissolution of a marriage.
 - D) a change in residence and the health plan under which the individual was covered does not provide coverage in that service area.
 - E) the addition of a newborn or newly adopted child.
5. **Coverage effective date:** The effective date of your application is based upon Group Health's receipt of your completed application documents as noted in number 1. All application documents must be received in the individual and family sales department at Group Health.
 - For application documents received on or before the 20th of the month, coverage will begin on the first day of the following month. (Example: If your application is received on or before Oct. 20, then enrollment is effective Nov. 1.)
 - For application documents received on the 21st through the end of the month, coverage will begin on the first of the month following the first full month after receipt. (Example: If your application is received Oct. 21–31, then your coverage begins Dec. 1.)

SECTION 8. TERMS AND CONDITIONS *continued*

6. **Premium payments:** Premium payments are due on a calendar month basis on or before the first day of each month, subject to a grace period of 10 days. Payment can be set up through monthly billing, paid by check or money order, or as monthly automatic withdrawal from a checking or savings account. Premium amounts are subject to change upon 30 days written notice, which will be sent to the Contract Holder's residential address unless there is a designated billing address provided on your application.
7. **Revoking coverage:** Failure to answer questions fully and correctly on your application documents may result in Group Health's refusal to extend coverage, cancellation of coverage, or rescission of coverage for you and/or your family members.
8. **Applicant's financial liability:** a) Pre-enrollment Services: If any hospital or medical service is rendered to you and/or your dependent(s) prior to your effective date of coverage, you will be responsible for paying for those services. These noncovered services will be billed to you at full schedule rates. Regardless of whether you and/or your dependents become a member, you will be responsible for payment of such charges; b) Prior Authorizations: Upon termination from any Group Health individual and family plan, all prior authorizations for health care coverage for the terminated individual(s) will no longer be valid, and you will be financially liable for any additional services obtained.
9. **Pre-existing conditions:** These plans include a nine-month pre-existing condition wait period that excludes coverage for any condition for which there has been any diagnosis, treatment (including prescribed drugs), or medical advice within the six-month period prior to the effective date of coverage. Section 6 of this application form will help us determine whether you have Creditable Coverage, which would allow Group Health to waive any pre-existing condition wait period(s) for you and/or your dependent(s). The pre-existing condition wait period does not apply to individuals who are under the age of 19, however, enrollment restrictions apply. Please see number 4 for details.
10. **Portability (Creditable Coverage):** If you have been covered within the last 63 days by a plan with equivalent or greater overall benefits than the plan you purchase, we will waive pre-existing conditions or credit that coverage. If you had a 64-day-or-more break in coverage, no portability credit will be applied for pre-existing conditions.
11. **Adding dependents:** Subject to your plan's terms, you may add eligible dependents over the age of 18 to your plan at a later date. Health screening may be required for these dependents prior to their enrollment, so please review the WSHIP Standard Health Questionnaire to determine whether or not the eligible dependents meet one of the exceptions. To add dependents under age 19, certain restrictions apply. Please see number 4 for details.

SECTION 9. ACKNOWLEDGEMENTS & SIGNATURES

I acknowledge that:

- This application becomes part of my Medical Coverage Agreement with Group Health.
- I have the right to examine and return the Medical Coverage Agreement within 10 days of receipt.
- Potential changes due to state or federal mandates, effective in January, may alter the benefits or rates of my current plan.
- Regardless of my enrollment date, my plan rate will renew July 1st.
- 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 have read and agree to the Terms and Conditions (Section 8) included with this application.
- The signatures shown below allow me, my spouse/domestic partner, or my producer (Section 10) to release to Group Health information about any person listed on my individual and family plan application documents, including information from the Standard Health Questionnaire.
- Under the Health Insurance Portability and Accountability Act (HIPAA), Group Health, without my authorization, may only release limited information to the selection of a plan to me, my spouse/domestic partner, adult/minor children, or my producer.
- 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.

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 retroactively to its effective date. 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

- Documentation:** I am enclosing all documentation as required. This includes applicable Medicare information and a copy of the Standard Health Questionnaire for all persons listed on this application, or documentation outlined in Section 7 if exempt. Any missing information may delay processing of my application.
- Signature:** This application has been signed by me and my spouse/domestic partner (if applicable).

SECTION 10. PRODUCER INFORMATION (SECTION REQUIRED IF APPLICABLE)

Dann Loewenthal

Group Health sales representative or producer name

B6082

Group Health producer ID number

Company/house name (if applicable)

H1769

Group Health house ID number

800.884.2343

Phone number

SECTION 11. VOTING OPTIONS

I would like Group Health Cooperative voting membership for myself and all eligible dependents.

HOW DID YOU HEAR ABOUT US?

- | | |
|---|--|
| <input type="checkbox"/> Group Health employer plan | <input type="checkbox"/> Former/prior member |
| <input checked="" type="checkbox"/> Producer (broker/agent) | <input type="checkbox"/> ghc.org/MyGroupHealth for Members |
| <input type="checkbox"/> Facebook | <input type="checkbox"/> Television |
| <input type="checkbox"/> Newspaper | <input type="checkbox"/> Seminar |
| <input type="checkbox"/> Current Group Health individual and family plan member | <input type="checkbox"/> Employer |
| <input type="checkbox"/> Word of mouth/referral | <input type="checkbox"/> Other website |
| <input type="checkbox"/> Twitter | <input type="checkbox"/> Radio |
| <input type="checkbox"/> Direct Mail | <input type="checkbox"/> Other _____ |



ghc.org