Application for the Addition of Family Members to an Individual or Group Conversion Plan

(Grandfathered)

P.O. Box 91120, MS 295
Seattle, WA 98111-9220
lifewisewa.com

LifeWise

Please read all accompanying material before completing this application. **All questions must have complete and accurate answers**. Omissions or incomplete answers will result in the return of your application and may cause a delay in the effective date of your coverage. Please **PRINT**, sign and date in ink.

To be eligible for coverage, applicants:

- Must be a resident of Washington state. We may require proof of residency.
- Must not be entitled to Medicare (including entitlement due to disability)
- If over 65 years of age and not eligible for Medicare, attach a "not eligible for Medicare document" from the Social Security Administration.

SECTION 1: EFFECTIVE DATE

Application must be received within 60 days of the event (marriage, birth, placement, custody), to be effective the date of the event.

Approved applications postmarked or received by the last day of the month will be effective on the first day of the following month. To select a later effective date, please indicate here (no more than 60 days after the signature date): _____ /01/_____

SECTION 2: SUBSCRIBER INFORMATION

Last name (of current subscriber) First Middle Initial	Member Identification number (see your ID card)	
Home address (required): Street, city, state, ZIP (not P.O. Box)	County	Home number ( )
Mailing address (if different from home address): Street, city, state, ZIP	County	Work number ( )
Billing address (if different from mailing address): Street, city, state, ZIP	County	Cell number ( )

SECTION 3: DEPENDENTS TO BE ADDED

☐ **Legal Spouse** or ☐ **Domestic Partner Name** (Last, First, Middle Initial)	Social Security Number	Gender: ☐ M ☐ F	**I used tobacco in the last 6 months: ☐ Yes ☐ No
	Date of Birth / /	Date of Marriage* / /	
Dependent Child Name—Under 26 only (Last, First, Middle Initial)	Social Security Number	Gender: ☐ M ☐ F	**I used tobacco in the last 6 months: ☐ Yes ☐ No
	Date of Birth / /	Date of Placement/Custody	
Dependent Child Name—Under 26 only (Last, First, Middle Initial)	Social Security Number	Gender: ☐ M ☐ F	**I used tobacco in the last 6 months: ☐ Yes ☐ No
	Date of Birth / /	Date of Placement/Custody	

** "Tobacco use" means use of any tobacco product on average four or more times per week within the past 6 months. Tobacco use does not include religious or ceremonial use.

*** For adoption, attach a copy of the placement/adoption agreement. For dependents that court orders for legal wards, guardianship or Medical Child Support, attach a copy of the court order.

Coverage of a dependent child will not be terminated while the child is and continues to be both (1) incapable of self-sustaining employment by reason of developmental or physical disability and (2) chiefly dependent upon the subscriber for support and maintenance.

SECTION 4: HEALTH OUESTIONAIRE

Notice To All Applicants: It is important for you to accurately complete this health questionnaire for all dependents listed. Have you or any family member listed on this application ever experienced symptoms, been advised of, diagnosed with, received treatment or had treatment recommended for any of the following conditions? Provide details on page 3 to any item answered "yes."

Please check each item either Yes or No	Yes	No
1. **Alcohol or Drug Abuse/ Dependence**		
a. Alcohol / Chemical/ Drug/ DUI	Y	N
2. **Autoimmune Disorder**		
a. Lupus/ Scleroderma / Mixed	Y	N
3. **Bleeding/ Blood/ Circulatory Disorders**		
a. Anemia/ Bleeding/ Hypercoagulation	Y	N
b. Blood Disorder (TCP, etc.) / Leukemia	Y	N
c. Aneurysm/ Impaired Circulation	Y	N
d. High Cholesterol, Triglycerides	Y	N
e. Hypertension (Last:_____/____)	Y	N
f. Phlebitis/ Clots / Raynaud's/ PVD	Y	N
4. **Congenital Conditions**		
a. Congenital Disorder/ Birth Defects	Y	N
5. **Ear/ Nose/ Throat/ Eye**		
a. Ear Infections (# _____ past yr.) / Tubes	Y	N
b. Nasal Malformation/ Deviated Septum	Y	N
c. Nasal Polyps/ Sinusitis/ Tonsillitis	Y	N
d. Crossed Eyes/ Strabismus	Y	N
e. Retina/ Macular: Detach, Degeneration	Y	N
f. Cataract(s)/ Lens Implants/ Glaucoma	Y	N
6. **Gastrointestinal Conditions**		
a. Swallowing Problems/ GERD/ Reflux	Y	N
b. Ulcers/ Chronic Abd. Pain/ Gallbladder	Y	N
c. Diverticulitis/ Hemorrhoids/ IBS	Y	N
d. Ulcerative Colitis/ Crohn's/ Colitis	Y	N
e. Hernia (Specify type)/ Polyps	Y	N
f. Weight gain or loss > 10 lbs. within 1 yr.	Y	N
7. **Glandular or Hormonal Disorders**		
a. Diabetes/ Elevated Blood Sugar	Y	N
b. Goiter/ Nodule/ Thyroid: Hyper/ Hypo	Y	N
c. Adrenal/ Pituitary Condition	Y	N
8. **Heart Condition**		
a. Angina/ Chest Pain/ Heart Attack	Y	N
b. Arterio-Antherosclerosis/ Coronary Artery Disease/ Congestive Failure	Y	N
c. Heart Murmur/ Arrhythmia/ Pacemaker	Y	N
d. Valve Disorder (Specify type, cause)	Y	N
9. **Immune Disorders**		
a. AIDS/ AIDS Related Complex/ HIV	Y	N
10. **Kidney/ Bladder Conditions**		
a. Bladder: Infections/ Incontinence	Y	N
b. Kidney Infections/ Kidney Stones	Y	N
c. Kidney Failure/ Nephritis	Y	N
11. **Liver Conditions**		
a. Hepatitis A/ B/ C Other	Y	N
b. Cirrhosis/ Liver Failure	Y	N

Please check each item either Yes or No	Yes	No
12. **Musculoskeletal Conditions**		
a. Chronic Back or Neck Pain/ Strain	Y	N
b. Disc Problems/ Bone spurs	Y	N
c. Arthritis/ Rheumatoid/ Osteoporosis	Y	N
d. Fibromyalgia/ Chronic Fatigue	Y	N
e. Muscular Dystrophy/ Polio Residuals	Y	N
f. Tendon/ Joint: Inflammation/ Gout/ Carpal Tunnel/ Replacement (Specify site)	Y	N
g. Food Disorder/ Bunions/ Hammertoe	Y	N
h. Fractures (Specify site, hardware present)	Y	N
i. Gait Abnormality/ Loss of Limb(s)	Y	N
j. Chronic Pain/ Decreased Motion	Y	N
13. **Mental Health Disorders**		
a. Schizophrenia/ Bipolar/ Psychosis	Y	N
b. Depression/ Anxiety/ Suicide Attempt	Y	N
c. Anorexia/ Bulimia	Y	N
d. Attention Deficit Hyperactivity Disorder	Y	N
14. **Neurological Conditions**		
a. Brain Injury/ Seizures/ Cerebral Palsy	Y	N
b. Stroke/ TIA/ Paralysis	Y	N
c. Headaches (Recurrent or migraine)	Y	N
d. MS/ Alzheimer's/ Huntington's/ ALS/ Parkinson's	Y	N
e. Meningitis/ Encephalitis	Y	N
f. Developmental delay (Specify type, cause)	Y	N
15. **Organ**		
a. Transplant (Previous or pending)	Y	N
b. Critical Organ Cyst/ Tumor (i.e., brain)	Y	N
c. Cancer (Specify type, location, extent)	Y	N
16. **Reproductive System Conditions**		
a. Menstrual Irregularity/ Pregnant	Y	N
b. Breast Disorder/ Fibrocystic/ Implant	Y	N
c. Abnormal Pap Smear/ Dysplasia	Y	N
d. Endometrial/ Uterine/ Cervix Disorders	Y	N
e. Ovarian/ Testicular: Cyst/ Torsion	Y	N
f. Prostate Problems/ Sexual Dysfunction	Y	N
17. **Respiratory Conditions**		
a. Allergies/ Asthma/ Sleep Apnea	Y	N
b. Chronic Bronchitis/ Pneumonia/ TB	Y	N
c. Lung Clot/ Collapsed Lung	Y	N
d. Chronic Obstructive Lung Disease	Y	N
18. **Sexually Transmitted Disease**		
a. Genital Herpes/ HPV/ Other	Y	N
19. **Skin Conditions**		
a. Burns/ Scars/ Acne/ Ulcers (Specify site)	Y	N
20. **Specify other condition(s) not listed above:**		
a.		
b.		

Notice to Applicants For Non-Grandfathered Plans (Individual Plans purchased after March 23, 2010): Applicants under age 19 will not be denied coverage due to a health condition.

21. If you have answered "yes" to ANY of the previous questions or have experienced any other health issues, complete this question. Instructions: Include complete details including site, cause, and extent of condition. Attach additional sheet if needed. You may wish to submit copies of relevant medical records to expedite the process (at your own expense).

#	Name	Dates	Describe Condition	Provider	Current Status	Follow Up
		Start Mo Yr End Mo Yr	Diagnosis Treatment	Practitioner Hospital Days	Condition Present? ☐ Yes, persists OR O No, resolved	Future Care? ☐ Yes, future surgery or treatment O No, resolved (Describe type, reason):
		Start Mo Yr End Mo Yr	Diagnosis Treatment	Practitioner Hospital Days	Condition Present? ☐ Yes, persists OR O No, resolved	Future Care? ☐ Yes, future surgery or treatment O No, resolved (Describe type, reason):
		Start Mo Yr End Mo Yr	Diagnosis Treatment	Practitioner Hospital Days	Condition Present? ☐ Yes, persists OR O No, resolved	Future Care? ☐ Yes, future surgery or treatment O No, resolved (Describe type, reason):
		Start Mo Yr End Mo Yr	Diagnosis Treatment	Practitioner Hospital Days	Condition Present? ☐ Yes, persists OR O No, resolved	Future Care? ☐ Yes, future surgery or treatment O No, resolved (Describe type, reason):

22. ☐ Yes O No **Has anyone listed on this application taken medications within the past year?** If yes:

Name	Medication (name, dose, duration)	Prescriber	Diagnosis

23. ☐ Yes O No **Has any insurance company refused or restricted any insurance coverage for you or any person listed on this application?** If yes, explain:

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24. □ Yes O No **Has any other future surgery, diagnostic testing or medical treatment been recommended or discussed for any person listed on this application?** If yes, explain:

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25. □ Yes O No **Is any family member applying for coverage currently pregnant?** If yes, explain:

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26. □ Yes O No **Is any person on this application, including male applicants and dependent males or females, responsible for a current pregnancy?** If yes, explain:

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27. **Please list the date of last menstrual cycle for every female applicant age 13 and over**:

SECTION 5: HEALTH INFORMATION

To identify applicants who may benefit from our health management programs, please complete the following questions.
Note: Do not list individuals who will not be enrolled for coverage.

A. □ Yes O No Do you or any dependents have a disability, chronic health conditions (i.e. diabetes, heart condition, etc.), or been advised in the last 12 months that hospitalization, surgery or treatment is needed or pending?

NAME	REASON

SECTION 6: PRIOR OR CURRENT COVERAGE (use for adding dependents only)

If you have prior creditable coverage:

□ Yes O No Do you intent to continue this other coverage if you are accepted by LifeWise? (If no, remember to contact your insurance company to cancel, including our corporate affiliates.)

SECTION 7: NOTICE OF INFORMATION USE AND DISCLOSURE

Type Of Information To Be Disclosed: I (we) authorize: any physician; health care provider; hospital; insurance or reinsurance company, pharmacy benefits manager or third party benefits administrator to disclose a copy of my (our) personal health informationh information, including any and all diagnostic, procedural, treatment, claim, prescription or other health related information including records concerning alcohol and/or chemical dependency, reproductive health (including abortion), sexually transmitted diseases, HIV, AIDS, psychiatric disorders and mental illness to LifeWise or its representatives as allowed by law.

Purpose Of Disclosure: I (We) understand that personal information will be used for underwriting, evaluating enrollment in the health plan, determining eligibility for benefits and paying claims. This information will not be used to make a decision on your eligibility for coverage.

Timeframe Of Release: Unless I revoke it, this release will remain valid for twenty-four (24) months from the date of my signature below.

Revocation Of Release: I understand that I may change my mind and revoke this release at any time. I will do this by letting LifeWise know of my decision. Any change will be effective five (5) business days after LifeWise receives my written notice at the address listed on this form. I understand that some or all of this information may already have been used by LifeWise to make decisions, which will not be affected by its revocation.

Redisclosure: LifeWise Health Plan of Washington may be required to redisclose this information to another party that is not subject to state and federal privacy rules.

Effect Of Not Authorizing: This authorization is a condition of your enrollment in our health plan or your eligibility for benefits. If you decide not to sign this authorization, we may decline to enroll you in our health plan or to give you benefits.

Please Note: You or your authorized representative will receive a copy of this authorization.

SECTION 8: SIGNATURES

I hereby apply for enrollment with LifeWise for the family members listed on this application for coverage under my Individual or Group Conversion Contract. I certify that:

a) I have read this form, and I have supplied all of the required information on this form.
b) The persons listed qualify for dependent enrollment as stated in my subscriber contract.
c) Benefits may be subject to pre-existing condition or benefit-specific waiting periods as stated in my subscriber contract.
d) In applying for enrollment as indicated on this application, I declare that to the best of my knowledge, all of the information on all forms necessary for enrollment 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 or answers on behalf of myself or any family members that all entitlements to benefits are void and this Contract may be cancelled or modified retroactively to its effective date. I further understand that 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.
e) I affirm the subscription charge payments are not paid or sponsored by third-party payers including employers, business accounts, providers, not-for-profit agencies, government agencies, or any other third-party payer, either directly or indirectly, expect as required by law.
f) I understand and agree that this coverage is issued as individual health coverage, is not sold or issued for use as a government or third-party sponsored health plan, and is not partially or fully paid for by third-party payers including employers, business accounts, providers, not-for-profit agencies, government agencies, or any other third-party payer, either directly or indirectly, except as required by law.

Important!

Signatures are required for all applicants, 18 years of age or older.

X_____	_____	_____
Signature of Applicant/Policyholder (policy holder must sign if adding legally recognized spouse/registered same-sex domestic partner or child)	Printed Name	Signature Date (mm/dd/yyyy)
X_____	_____	_____
Signature of Legally Recognized Spouse/Registered Same-Sex Domestic Partner	Printed Name	Signature Date (mm/dd/yyyy)
X_____	_____	_____
Signature of child age 18 or over	Printed Name	Signature Date (mm/dd/yyyy)
X_____	_____	_____
Signature of child age 18 or over	Printed Name	Signature Date (mm/dd/yyyy)

If not the primary applicant, I am the: ☐ Parent ☐ Holder of Power of Attorney ☐ Legal Guardian

LifeWise

Discrimination is Against the Law

LifeWise Health Plan of Washington (LifeWise) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. LifeWise does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. LifeWise provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). LifeWise provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that LifeWise has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator ─ Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-6396, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@LifeWiseHealth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-817-3056 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-817-3056（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-817-3056 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-817-3056 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-817-3056 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-817-3056 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки.
Телефонуйте за номером 800-817-3056 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-817-3056 (TTY: 711)។

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-817-3056（TTY:711）まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 800-817-3056 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-817-3056 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-817-3056 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-817-3056 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-817-3056 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-817-3056 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-817-3056 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-817-3056 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-817-3056 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-817-3056 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-817-3056 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-817-3056 (TTY: 711) تماس بگیرید.