St Luke's™ Health Plan

Idaho Individual Application Cover Sheet

For enrollment outside of the Idaho Exchange

Our Region

For residents of Ada, Adams, Blaine, Boise, Camas, Canyon, Cassia, Custer, Elmore, Gem, Gooding, Jerome, Lemhi, Lincoln, Minidoka, Owyhee, Payette, Twin Falls, Valley, and Washington counties.

Welcome to St. Luke's Health Plan

To apply for medical coverage, please complete this form and return it with the completed Idaho Individual Universal Application to St. Luke's Health Plan. This completed application must be received by St. Luke's Health Plan no later than the last day of the month to become effective the 1st of the following month. The first month's premium payment must be received by the end of the month prior to the effective date. Incomplete information will delay processing of the application.

Mail to: St. Luke's Health Plan, PO Box 91010, Seattle, WA 98111-4659

Please keep a copy for your records.

Section 1: Enrollment Information

1a. Are you: ☐ A new applicant (adult) ☐ Responsible party (if you are not applying for coverage for yourself but are enrolling dependent children for coverage, you are considered the responsible party and not the applicant.)

Name of 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.

1c. Please list each family member enrolling in medical coverage. The applicant may be a child if no adults are applying for coverage.
*Optional: If you have more dependents to include, copy this page and attach.

Dependent Address if different than Applicant (dependent name followed by street number, city, state, zip code)
Applicant
Dependent 1
Dependent 2
Dependent 3
Dependent 4
Dependent 5
Dependent 6

***ESSENTIAL HEALTH BENEFITS DISCLAIMER:**

The medical policy you are applying for does not include coverage for pediatric dental care, which is considered an essential health benefit under the Affordable Care Act. You have access to pediatric dental plans as a separate policy with other dental insurance carriers. Please contact us, your insurance agent, or Your Health Idaho if you want to learn more about the stand-alone pediatric dental insurance plans available in the market.

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.**

☐ Expanded Bronze ☐ 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

St. Luke's Health Plan, PO Box 91010, Seattle, WA 98111-4659
memberservices@stlukeshealthplan.org

Section 3: Termination of Other Coverage

If you have existing coverage that will be replaced by St. Luke's Health Plan, be sure to terminate the policy prior to this one becoming effective. Are you currently enrolled in other coverage?

☐ **No** If No, please sign and date in the Signatures section below.

☐ **Yes** If Yes, do you wish to terminate this coverage? ☐ Yes ☐ No

Plan Identification Number(s): _____

Section 4: 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 at FPO.com and provides notification by email to the email address you supply in your application when we post a new communication to your secure account.

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.

☐ No, I do not want electronic distribution of communications. Unless my consent is not required for an electronic distribution, I elect to receive communications related to my coverage in a paper format.

Section 5: Replacement of Existing Coverage

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

If YES, please read, and check box below acknowledging your understanding.

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 6: Initial Payment

☐ Check or money order, payable to St. Luke's Health Plan.

I have or will submit my payment by:

☐ Mailing to St. Luke's Health Plan, PO Box 91010, Seattle, WA 98111-4659

☐ Dropping it off in person at St. Luke's Health Plan offices, 800 E. Park Ave, Boise, ID 83712.

Section 7: 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.

Signatures

Signature: _____ Date: _____

Applicant or Responsible Party

Signature: _____ Date: _____

Spouse, if applying for coverage

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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