LIFEWISE | HEALTH PLAN OF OREGON

PO Box 3048
Spokane, WA 99220
www.lifewiseor.com

MEMBER ENROLLMENT AND CHANGE APPLICATION

For groups with up to 50 employees

1. GROUP INFORMATION (to be completed by the group)

Group name	Group ID	Enrollment reasons: New Employee, Rehired Employee, Open Enrollment, Plan Transfer, Employee Entered Eligible Class (please indicate part-time to full-time, temporary to permanent, hourly to salaried, etc.), CHIP, Marriage, Legal Separation, Divorce, Death, Birth, Adoption (legal documents required), Dependent Change, Involuntary Loss of Other Coverage, COBRA, or State Continuation (COC)		
Employee date of hire / /	Date employee entered eligible class ☐ Same as hire date ☐ Other / /	Effective date / /	☐ New ☐ Change	Reason (select from list above)	Date of event / /
Employee job title	Employee class (if applicable)	If COBRA, indicate number of month's eligible for coverage: ☐ 18 months ☐ 29 months ☐ 36 months If State Continuation (COC), eligible period of coverage cannot exceed 9 months.			

2. EMPLOYEE INFORMATION (employee to complete sections 2 through 4)

Employee name (Last) (First) (MI)	☐ Married ☐ Unmarried	Daytime phone ( )	E-mail address		
Home address	City		State	ZIP	
Mailing address (if different than home address)	City		State	ZIP	

3. ENROLLMENT INFORMATION

Medical plan choice, if applicable

NOTE: *In order for dependents to qualify for a benefit selection, the employee must select the same benefit.*
Please indicate each member's name as you would like it to appear on the ID card. ID card names are limited to 26 characters and spaces.

Add	Drop	Relationship to Employee	Last Name	First Name	MI	Social Security No. (Required for 40+)	Date of Birth	Gender	Benefit Selection
☐	☐	☐ Self					/ /	☐ Male ☐ Female	☐ Medical ☐ Dental
☐	☐						/ /	☐ Male ☐ Female	☐ Medical ☐ Dental
☐	☐						/ /	☐ Male ☐ Female	☐ Medical ☐ Dental
☐	☐						/ /	☐ Male ☐ Female	☐ Medical ☐ Dental
☐	☐						/ /	☐ Male ☐ Female	☐ Medical ☐ Dental
☐	☐						/ /	☐ Male ☐ Female	☐ Medical ☐ Dental

Does a dependent have a different mailing address? ☐ No ☐ Yes, complete the following: Dependent's Name (Last, First, MI) _____

Dependent's mailing address _____ City _____ State _____ ZIP _____

Is any child over the dependent age limit applying for coverage due to disability? ☐ No ☐ Yes, complete and attach the *Request for Certification of Disabled Dependent* form (#013948).

Has any person applying for coverage had health insurance coverage at any time during the past 63 days before your enrollment date on this plan?
☐ No ☐ Yes, attach your *Certificate of Creditable Coverage* from your current or prior health plan. You may be eligible for prior coverage credit towards pre-existing or other coverage limitations.

Is any dependent child age 23 through 25 eligible for a group health plan other than that of a parent? ☐ No ☐ Yes, please complete and attach the *Coordination of Benefits* form (#014612).
(**Note**: In accordance with federal law, certain dependent children age 23 through 25 will not be eligible for enrollment under the plan. If your employer's plan is a grandfathered plan and this child is eligible for another group health plan, they may not be entitled to enroll. If your employer's plan is a non-grandfathered plan, they will be entitled to enroll. For questions about your plan's grandfathered status, please contact your employer.)

Do you or your dependent(s) have current health coverage that will remain in effect when your LifeWise coverage begins? ☐ No ☐ Yes, complete and attach the *Coordination of Benefits* form (#014612).

4. EMPLOYEE SIGNATURE

In applying for enrollment as indicated on this application, I declare that to the best of my knowledge, all of the information on this form is true and complete, and all of the persons for whom I am requesting enrollment are eligible for coverage. I have also read and understand the provisions as stated on the reverse side. The changes on this form supersede all previous forms submitted.

Employee signature _____ Date signed _____ / ____ / _____

LIFEWISE PRIVACY POLICY

We may collect, use, or disclose certain information about you, including health information, your address, telephone number or Social Security number. We may receive this information from, or release it to, health-care providers, insurance companies, or other sources to conduct our routine business operations such as: underwriting and determining your eligibility for benefits and paying claims; coordinating benefits with other health-care plans; conducting care management, case management, or quality reviews. This information may also be collected, used or released as required or permitted by law.

To safeguard your privacy and ensure your information remains confidential, we train all employees on our written confidentiality policy and procedures. If a disclosure of your personal information is not related to a routine business function, we will remove anything that could be used to easily identify you, unless we have your prior authorization to release such information.

You have the right to request inspection and/or amendment of records retained by us that contain your personal information.

To view or print copies of our detailed Privacy Notice and other forms, please visit our web site at *www.lifewiseor.com*. To have forms mailed to you, please call the number listed below.

SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or dependents (including your spouse) because of other health care coverage, you may in the future enroll yourself or your dependents in this plan prior to the next open enrollment period. To do this, you must have involuntarily lost your other coverage and we must receive your enrollment application within 30 days after your other coverage ended (60 days if the prior coverage was through Medicaid or CHIP). Additionally, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and dependents, provided we receive your completed enrollment application within 30 days after the marriage, birth, adoption, or placement for adoption, unless a different time limit has been specified in your benefit booklet. You may also be eligible for a 60-day special enrollment period if you qualify for premium assistance under Medicaid or CHIP. You must request enrollment and we must receive your enrollment application within 60 days of the date you qualify for premium assistance.

LATE ENROLLEES

A “late enrollee” is an individual or family dependent who did not enroll when first eligible for coverage under this plan and does not qualify as a special enrollee. If you or your dependents are late enrollees, you or your dependents may enroll during the next occurring annual group enrollment period.

PRE-EXISTING CONDITION

Your plan includes a 6-month pre-existing condition exclusion period, for members age 19 and older. This means that LifeWise will not provide benefits for a medical condition for which medical advice, diagnosis, care or treatment was recommended or received within six months of your enrollment date in this plan until the earlier of: six months following your effective date of coverage or 10 months following the start of any required eligibility waiting period for small employer groups; six months following your effective date of coverage or 12 months following the start of any required eligibility waiting period for large employer groups.

The length of your pre-existing condition exclusion period will be reduced by the amount of any creditable coverage you or your family had before your enrollment date in this plan. Creditable coverage will be applied if the coverage is still in effect on or terminated within 63 days of your enrollment date.

Please provide us with a copy of the certificate of creditable coverage you received from your prior insurance carrier. If you do not have a Certificate of Creditable Coverage you may contact your prior insurance carrier and ask them to send a certificate to you. If you need help to obtain creditable coverage information from your prior plan or prior insurance carrier, please call us at the number listed below and we will assist you.

CREDITABLE COVERAGE

Creditable coverage means prior or ongoing health care coverage as defined in 42 U.S.C. 300gg, as amended and in effect on July 1, 1997. Creditable coverage includes any group health care coverage (including the Federal Employees Health Benefits Plan and the Peace Corps), individual health care coverage (including student health plans), Medicare, Medicaid, CHAMPUS, Indian Health Service or tribal organization coverage, state high-risk pool coverage, state Children’s Health Insurance Programs (SCHIP), a public health plan established or maintained by a state, the U.S. government, a foreign country, or any political subdivision of a state, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

If you have any questions about the information included in this notice, please call LifeWise Customer Service at 1-800-596-3440.

LIFEWISE | HEALTH PLAN OF OREGON