# International Student Health Insurance Policy

**Enrollment and Change Form**

## 1. Personal Information

<table>
<thead>
<tr>
<th>Student name (Last)</th>
<th>(First)</th>
<th>Student ID</th>
<th>Phone</th>
<th>E-mail address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home address</th>
<th>City</th>
<th>State</th>
<th>ZIP</th>
<th>Mailing address (if different than home address)</th>
<th>City</th>
<th>State</th>
<th>ZIP</th>
</tr>
</thead>
</table>

## 2. Plan Choice (You must re-enroll every fall quarter regardless of previous coverage status)

<table>
<thead>
<tr>
<th>Enrollment Period – Quarterly Options</th>
<th>Enrollment Period – Annual Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autumn</td>
<td>Winter</td>
</tr>
</tbody>
</table>

## 3. Enrollment Information

**Reason for Add or Drop (New enrollment, birth, marriage, divorce, etc.)**

<table>
<thead>
<tr>
<th>Add</th>
<th>Drop</th>
<th>Relationship to Student</th>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Date of Birth</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Female</td>
</tr>
</tbody>
</table>

**Ethnicity (Optional)**

- American Indian
- Asian
- Black African American
- Native Hawaiian/Pacific Islander

- White
- Hispanic/Latino
- Not Hispanic or Latino

**Primary Language**

- English
- Spanish
- Other

**Secondary Language**

- English
- Spanish
- Other

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Mail to: Membership & Billing, MS 737
PO Box 3048
Spokane, WA 99220

Phone: 800-971-1491
student.lifewiseac.com

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023244 (05-2018)
Does a dependent have a different mailing address?  □ No  □ Yes  
If yes, complete the following: Dependent's Name (L  Fi  MI) 
Dependent's mailing address: ____________________________  City ____________________________  State _______  ZIP _______

Is any child age 26 or over enrolling for coverage due to disability?  □ No  □ Yes. Complete and attach a Request for Certification of Disabled Dependent form.

Has any enrollee had health insurance coverage at any time during the past 3 months before your enrollment date on this plan?

□ No  □ Yes  
If yes, who was covered?  □ Spouse / Registered Domestic Partner (We are either both of the same sex or one of us is at least 62 years of age)  □ Student  □ Dependent Children  
Date coverage began ______ / _____ / ______  Date coverage ended ______ / _____ / ______

Will any enrollee have other current health coverage including Medicare, which will remain in effect when your LifeWise coverage begins?  □ No  □ Yes, please complete and attach an Other Coverage Questionnaire form.

4. STUDENT SIGNATURE

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.

Student signature ____________________________  Date signed _____ / _____ / ______

Please note: 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.

CONDITIONS OF ENROLLMENT/SIGNATURE

Please make sure you understand your school’s credit hour and other requirements for enrolling in this plan as described in the plan brochure available on the university’s website.

By accepting this Conditions of Enrollment/Signature I attest that I am eligible for this coverage and that I authorize the university to provide LifeWise Assurance Company (LifeWise) with my enrollment status to validate eligibility under the plan. LifeWise reserves the right to review, at any time, that the eligibility requirements for enrollment have been met. If it is determined that you do not meet the school’s eligibility requirements for enrollment or you have performed an act or practice that constitutes fraud, your coverage may be voided (voided means to cancel coverage back to its effective date, as if it had never existed at all). If coverage is voided, payments made by the plan shall be recoverable by the plan. Premium is not refundable for any reason other than a determination of ineligibility or unless you, your spouse, or your domestic partner enters the military service on full-time active duty.

I understand and agree that submission of this enrollment information and/or premium payment does not guarantee coverage. Rates are limited to the options listed and are not pro-rated. I authorize LifeWise, at its option, to pay providers directly for services rendered.

I 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.

PRIVACY POLICY

We may collect, use, or disclose personal 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 your records retained by us.

To view or print copies of our detailed Privacy Notice, please visit our web site at student.lifewiseac.com. To have forms mailed to you, please call the number below.

NEWLY ACQUIRED DEPENDENTS

You must enroll your newly acquired dependent within 30 days of marriage or domestic partner registration or within 60 days of birth or placement for adoption in order to enroll them at any other time than when you are purchasing coverage.

REQUIRED SOCIAL SECURITY NUMBER AND CONTACT EMAIL ADDRESS

023244 (05-2018)
Under the Affordable Care Act (ACA), all health plans must provide an IRS Form 1095-B to fully insured members starting in 2017. You'll need Form 1095-B to help you file your taxes, much like your W-2.

If you have any questions about the information included in this notice, please call us at 800-971-1491

Underwritten by LifeWise Assurance Company 7007 - 220TH SW, Mountlake Terrace, WA 98043
Discrimination is Against the Law

LifeWise Assurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. LifeWise Assurance Company does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

LifeWise Assurance Company:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that LifeWise Assurance Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, 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 800-842-5357
Email AppealsDepartmentInquiries@LifeWiseHealth.com

You can file a grievance in person or by mail, fax, or email. If you need help filling 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 Avenue SW, Room 509F, HHH Building

Getting Help in Other Languages

This Notice has Important Information. This notice may have important information about your application or coverage through LifeWise Assurance Company. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs.

You have the right to get this information and help in your language at no cost. Call 800-971-1491 (TTY: 800-842-5357).

Oromoo (Cushite):

Francais (French):

Kreyòl ayisyen (Creole):
Avi sila a gen Enòmsayon Enòpòtan lajann. Avi sila a kapab genyen enòmsayon enòpòtan konsañ aplikasyon w lan oswa konsañan kouvèti asirans lan atravè LifeWise Assurance Company. Kapab genyen dat ki enòpòtan nan avi sila a. Ou ka gen pou pran kòk aksyon ak an sañet dat limit pou ka kende kouvèti asirans sante w lan oswa pou yo ka ede w avék despars yo. Se dwa w pou resèvwa enòmsayon sa a ak asisans nan lang ou pele a, san ou pa gen pou peye pou sa. Rele nan 800-971-1491 (TTY: 800-842-5357).

Deutsche (German):

Hmoob (Hmong):

Ilokô (Ilocano):
Daytoy a Pakdaar ket naglaon itil Napateq nga Impormasion. Daytoy a pakdaar matbii nga adda ket naglaon itil napateq nga impormasion malangganoe itil aplikasyonoe weno coverage babaen ti LifeWise Assurance Company. Daytoy ket matbii dagiti importante a pelsa ti daytoy a pakdaar. Makkina nga adda rumbeng nga aramideno nga adang sakbby dagiti partikular a naluding nga aildaw tapo magatimaliedy nga emittege nga voluntario fillong. Makan nangnangoe a mangila ti daytoy a impormasion ken fillong ti bukdydo a pagasao nga awan ti bawaycano. Tumawag ti numero nga 800-971-1491 (TTY: 800-842-5357).

Italiano (Italian):
日本語 (Japanese):
この通知には重要な情報が含まれています。この通知には、LifeWise Assurance Companyの申告または補償範囲に関する重要な情報が含まれている場合があります。この通知に記載されている可能性がある重要な日付をご確認ください。健康保険や有料サポートを維持するため、特定の目的で作成されるべき情報であることをご理解ください。ご希望の言語による情報とサポートが提供されます。800-971-1491 (TTY: 800-842-5357) までお電話ください。

한국어 (Korean):

فارسی (Farsi):
این اطلاع مهم و ضروری است که ساختمان مالی برای شما در مصرف LifeWise Assurance Company به وسیله یک جهانی های می‌باشد. این مطالعه به طور کامل و دقیق اطلاعات میداند. با توجه به اینکه این اطلاعات مهم و ضروری هستند، برای کسب اطلاعات بیشتر، لطفاً جریان مالی را با معاون شما گفتگو کنید. (کشیریان ترجمه) (800-842-5357) مطالعه که پیشنهاد می‌کند.