

Parent or Guardian Consent

Notice is hereby given that _____
 (Name of Child --- Please Print)

 (Child's Social Security Number)

who is under the age of eighteen years is making application for Regence BlueShield of Idaho individual health care coverage, with my full knowledge and consent. I request that you consider the child for such health care coverage. I accept full responsibility for the payment of monthly premium and the contents for the application attached hereto.

An eligible individual is an Idaho resident individual or dependent of an Idaho resident or dependent of an Idaho resident who does not receive health insurance benefits subject to the regulation of chapter 47, title 41, Idaho Code (Small Employer Health Insurance Availability Act), and who is under the age of sixty-five (65) years. An eligible individual can be the dependent of an eligible employee as defined in section 41-4703(14), Idaho Code, which eligible employee is receiving health insurance benefits subject to the regulation of chapter 47, title 41, Idaho Code, provided that no insurer shall be required to issue a basic or standard health benefit plan to any individual who is covered under any other arrangement that provides benefits equal to or better than the basic or standard plan.

I certify that the child named herein is an eligible individual and is not covered as a dependent on the Regence BlueShield of Idaho health care coverage of his or her natural parent, adoptive parent (if applicable), or legal guardian (if applicable).

I understand that upon approval of the application for coverage by Regence BlueShield of Idaho and upon payment of the applicable monthly premium, the above named child will be enrolled for coverage the first of the month following such approval, or upon request, following such approval, the date of receipt of the application, under a Basic Individual, Standard Individual, or Individual Choice policy based upon the program for which application is being made. I further understand that the child only and no other person will receive coverage under the offered plan.

Signature

Name (Please Print)

Social Security Number

Relationship to Child

Date

Mailing Address

City, State, Zip Code

Phone #

Signature

Name (Please Print)

Social Security Number

Relationship to Child

Date

Mailing Address

City, State, Zip Code

Phone #