Regence BlueShield *of Idaho*

An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 1106 - 1602 21st Avenue
Lewiston, Idaho 83501

Washington Individual Plans Deductible Change

OFFICE USE ONLY			
Effective Date			Code ________
Mo.	Day	Year	Firm No. ________ Date to Firm
			CR ________ Action Date

Name ____________________

Regence BlueShield of Idaho Subscriber No. ____________________

Social Security No. ____________________

Age ________ Birthdate ______ / ______ / ______

Address ____________________ Phone ________

City ____________________ State ________ Zip ________

Options

❒ **Pro Plus $750** ❒ **Pro Plus $5,000**

I understand and agree that upon acceptance and approval of this application by Regence BlueShield of Idaho, and payment of dues directly to Regence BlueShield of Idaho in advance, I will be entitled to the benefits of the Washington Protection Plus Health Plan, subject to its terms, limitations, and conditions, including any special endorsements and/or riders attached thereto.

Date ____________________

Subscriber Signature ____________________

Agent Signature ____________________

Agent Number ____________________

***Have you or any family member, or any person residing in your household smoked tobacco during the last twelve (12) months?** ❒ **Yes** ❒ **No**