# Adding Family Members Form

If you would like to enroll yourself or a family member on your Basic Health account, your income must meet Basic Health's income guidelines. Social security numbers are voluntary, unless you are applying for Basic Health *Plus* or maternity benefits. You must send the following with this form:

- Proof of your total gross family income (before taxes) from all sources for the most recent 30 days or complete calendar month.
- A copy of the most recent federal income tax return (IRS Form 1040 and all applicable schedules) for you and your spouse, whether filed jointly or separately.

**Subscriber: If you do not have Basic Health coverage and wish to enroll, please complete the following.**

| Social security number | Last name | First name | M.I. | Birth date |
|---|---|---|---|---|
| - - | | | | / / |

| Daytime phone number | Are you legally married? ❑ Yes ❑ No | U.S. citizen? | ❑ Male | Pregnant?* ❑ Yes ❑ No |
|---|---|---|---|---|
| ( ) | Date of marriage: / / | ❑ Yes ❑ No | ❑ Female | If yes, estimated due date: / / |

| Applying for coverage? | Receiving assistance from DSHS? | Eligible for Medicare? | Are you disabled? | Are you receiving Social Security Disability? |
|---|---|---|---|---|
| ❑ Yes ❑ No | ❑ Yes ❑ No | ❑ Yes ❑ No | ❑ Yes ❑ No | ❑ Yes ❑ No |

**Spouse: You must be legally married. If you are living in the same household but are not married, your partner cannot be added to your account. For a separate application call 1-800-660-9840 or visit online at www.basichealth.hca.wa.gov.**

| Social security number | Last name | First name | M.I. | Birth date |
|---|---|---|---|---|
| - - | | | | / / |

| Daytime phone number | Are you legally married? ❑ Yes ❑ No | U.S. citizen? | ❑ Male | Pregnant?* ❑ Yes ❑ No |
|---|---|---|---|---|
| ( ) | Date of marriage: / / | ❑ Yes ❑ No | ❑ Female | If yes, estimated due date: / / |

| Applying for coverage? | Receiving assistance from DSHS? | Eligible for Medicare? | Are you disabled? | Are you receiving Social Security Disability? |
|---|---|---|---|---|
| ❑ Yes ❑ No | ❑ Yes ❑ No | ❑ Yes ❑ No | ❑ Yes ❑ No | ❑ Yes ❑ No<br>If yes, entitlement date: / / |

**Dependents: If you are adding more than one dependent, please copy this form or use a separate piece of paper.**

| Dependent's last name | First name | M.I. | Social security number | Birth date | U.S. citizen? |
|---|---|---|---|---|---|
| | | | - - | / / | ❑ Yes ❑ No |

| Enroll in Basic Health? | Enroll in Basic Health *Plus**? | Disabled and over age 19? | ❑ Male | Pregnant?* ❑ Yes ❑ No |
|---|---|---|---|---|
| ❑ Yes ❑ No | ❑ Yes ❑ No | If yes, receiving Social Security Disability? ❑ Yes ❑ No<br>Entitlement date: / / | ❑ Female | If yes, estimated due date: / / |

| Receiving assistance from DSHS? | Is child living in your home? | Full-time student (age 19-22)? ❑ Yes ❑ No | Relationship to subscriber |
|---|---|---|---|
| ❑ Yes ❑ No | ❑ Yes ❑ No | If yes, send proof of enrollment from the accredited school. | ❑ Son ❑ Daughter<br>❑ Other _____ |

If you checked "yes" to enroll in Basic Health *Plus,* do you **want to pay** for regular Basic Health until a decision is made on your eligibility for Basic Health *Plus*? ❑ Yes ❑ No

***If you add a family member for Basic Health *Plus*, or who is pregnant, we will send you an application for those programs.**

## Signatures required

**I certify under penalty of perjury that the information I have provided in this application and attachments is true to the best of my knowledge. I understand that:**

- I must promptly report any changes to the information provided, as explained in the *Member Handbook*, and provide proof of my gross family income.
- Either Basic Health or the Department of Social and Health Services may verify this information through other state or federal agencies.
- **Anyone who submits false information may face penalties for prosecution and collection, may lose coverage, and may be required to pay additional premium amounts due or the cost of services obtained under Basic Health.**
- Any changes requested to my account are not approved until I am notified in writing by Basic Health.

I authorize Basic Health to verify my family income and authorize my health plan or medical provider to give Basic Health medical records needed for my or my dependent children's participation in Basic Health. If approved, coverage changes will take effect January 1, 2005, provided the billing statement I receive for January coverage (usually in November) is paid on time. Washington State law may require disclosure of any information submitted as a public record. The Health Care Authority's (the agency that administers Basic Health) Privacy Notice is available upon request by calling 360-923-2822 or online at **www.hca.wa.gov.**

Subscriber's signature _____ Date _____

Spouse's signature _____ Date _____

Signature of dependent over age 18 _____ Date _____



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