

**IDAHO INDIVIDUAL  
APPLICATION UPDATE**



Individual Sales  
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Reference ID number: \_\_\_\_\_  
(located in the lower-right corner of the acceptance letter)

**Please type or print neatly in ink.**

The undersigned does hereby certify, acknowledge, understand, and agree as follows:

There have been no changes in the medical information for any person provided on the application for health insurance with PacificSource Health Plans dated \_\_\_\_/\_\_\_\_/\_\_\_\_ except as follows (attach extra paper if more space is needed):

Applicant name: \_\_\_\_\_

Request new effective date: \_\_\_\_/\_\_\_\_/\_\_\_\_. *Note, a new application is required and must be submitted with this form if the original application is not signed within 62 days of this new requested effective date.*

Medical condition(s): \_\_\_\_\_

Treatment(s): \_\_\_\_\_

Dates: \_\_\_\_\_

Changes in medication(s): \_\_\_\_\_

Physician's name: \_\_\_\_\_

Recovery complete? \_\_\_\_\_

Future treatment required? \_\_\_\_\_

1. I affirm that the answers given in this Application Update form are complete and correct and PacificSource Health Plans can rely on this information to determine the insurability of each person applying for coverage.
2. I understand that if this form contains any material misrepresentations or omissions, PacificSource Health Plans may deny coverage retroactively and/or take any other legal action available by law.
3. No coverage shall be in force until approved by PacificSource Health Plans. If approved, coverage will be in force as of the effective date determined by PacificSource Health Plans.
4. This offer can be accepted with a signature from the applicant or the applicant's approved legal guardian, or the applicant's producer (agent).

\_\_\_\_\_  
Applicant Name (please print)

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Producer (Agent) Signature

\_\_\_\_\_  
Date