Century Benefits

Application Instructions for Oregon Health Applications

1. Print all pages of the application including these instructions
2. Complete all questions and sections of the application
3. Complete the fax cover letter on the next page and fax to Century Benefits for review along with the completed application. If you do not have access to a fax machine, mail the completed application to Century Benefits along with the required **first month's payment.** (Be sure check is made out to the Insurance carrier, not us).

HELPFUL TIPS:

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- □ List only health conditions that you have been **diagnosed/treated** within the last **five years**.
- □ Select your billing method.
  Monthly electronic draft is highly recommended.
- □ Sign and date the application.

IMPORTANT:

If you have requested that your monthly premium be deducted automatically from your checking account, you must attach a voided check to the area provided and also complete, sign, and date the authorization form.

Or enclose a check for the required payment made payable to the insurance carrier, not Century Benefits, if you are requesting a monthly bill.

Send completed applications and check to:
Century Benefits
Attn: New Enrollment
25 NW 23rd Pl
Suite 6156
Portland , OR 97210

Fax: 503-922-2348

Century Benefits will review your application for completeness and accuracy before we submit it to the carrier. This will reduce the underwriting time because carriers will not process unclear or incomplete applications until missing information has been gathered.

Please contact us if you have any questions regarding the application or the application process. You may reach us at 866-530-7743 or e-mail us at contact@centurybenefits.com.

FAX COVER LETTER
(Please ignore this form if you do not have access to a fax machine.)

**Please FAX this cover letter with the completed application to:
Century Benefits
FAX# 503-922-2348

Dear Century Benefits,

Please accept my completed application for submittal and contact me to confirm receipt of this application

Name _____
E-mail _____
Date _____
Time _____

- ❑ Please contact me at this phone number _____ after you have reviewed my application for completeness and accuracy.
- ❑ I will contact Century Benefits at 866-530-7743 to verify receipt of my application.

**I understand that Century Benefits will not review this application until the following business day if I faxed this application after 5:00PM or on a weekend.

OREGON STANDARD HEALTH STATEMENT

(Standard Form Per ORS 743.766)

AGENT INFORMATION

Agency Name and Time Number Century Benefits 935DD1

Agent Name and Time Number Joel Beaudoin 935DD0 Phone # 503-608-7768

Agent Fax Number 503-922-2348 General Agent is located in the state of OR

TYPE OF ACTIVITY check appropriate box

☐ **New Applicant**

☐ Upgrading Coverage
Existing Policy #

☐ **Change to an existing policy. Policy #**_____
☐ Adding Dependent
☐ Reinstatement of Coverage
☐ Other _____

APPLICANT INFORMATION

Name: _____

1. Resident Address

_____
Street City State Zip

2. Home Phone Number _____ Best time to call _____
Area Code Number

POLICY & DISCOUNT PROGRAM INFORMATION

If signed proposal is provided, this section does not need to be completed.

Premium Amount

Plan Name: SEE ATTACHED
Plan Type:
☐ MaxPlan ☐ OneDeductible Traditional ☐ RightStart Traditional ☐ SaveRight HSA Traditional
☐ CoreMed ☐ OneDeductible PPO ☐ RightStart PPO ☐ SaveRight HSA PPO
If PPO, Network Selected_____ ☐ Other _____
Plan Deductible: _____ **Rate of Payment:** _____
Lifetime Maximum: _____ **Prescription Drug Card Deductible:** _____
HSA Type: ☐ HSA Fundamentals ☐ HSA Tools ☐ Other ☐ None
Optional Coverage:
☐ Doctor's Office Copayment ☐ Dental Benefit - Basic ☐ Dental Benefit - Plus
☐ First Dollar Preventive Services Benefit ☐ Cancer Outpatient Maximum Benefit
☐ Accident Medical Expense: First Dollar Amount $ _____
☐ Other _____

Indicate any plan or coverage changes from original proposal/quote, sign and initial. Not all optional coverages are available with all plan types. For additional information contact your agent.

Discount Programs:
☐ Dental-Vision Discount Plan ☐ Other_____

The Dental-Vision Discount Plan is a discount program and not an insurance product.

Primary Insured $_____
Spouse/Domestic Partner $_____
Children $_____
Rx Drug Card $_____
D.O.C. $_____
First Dollar Preventive Services $_____
Dental Benefit $_____
Cancer Outpatient Maximum Benefit $_____
AME $_____
Lifetime Maximum Buy-Up Option $_____
RightStart Prescription Drug Buy-Up Option $_____
Other $_____
TOTAL PREMIUM $_____
PROCESSING FEE $_____
DENTAL-VISION DISCOUNT PLAN $_____

BILLING

3. ☐ Monthly Check-O-Matic ☐ Quarterly ☐ Semi-Annual ☐ Annual ☐ List Bill *(monthly only)*

Credit Card: ☐ First Payment Only* ☐ Quarterly ☐ Semi-Annual ☐ Annual

**With this option, you must select a secondary billing mode for subsequent payments. Please make selection above and provide all necessary information.*

If billing address is different than resident address, please complete:

_____
Payor Name Address City State ZIP

OTHER COVERAGE IN FORCE OR APPLIED FOR

4. Are any of the proposed insureds covered by, or has application been made for any type of medical insurance?
☐ Yes (Complete section below) ☐ No

Proposed Insured's Name	Company Name	Company Phone Number	Group/ Individual	Type of Coverage	Effective Date	Term Date

5. Were all proposed insureds covered under the prior plan listed above? ☐ Yes ☐ No
(If no, list those not covered) _____
6. Will this proposed coverage replace or change any existing health insurance? ☐ Yes ☐ No
7. Do you or any family member work for an employer who offers health benefits to employees? ☐ Yes ☐ No
Are you or any family members enrolled? ☐ Yes ☐ No
If no, why? _____

_____

PART B: OREGON STANDARD HEALTH STATEMENT

NOTICE TO APPLICANT: You are not required to disclose any information on any part of this application about genetic testing or genetic information relating to you or to any blood relative. You are not required to disclose any decision by an insurance company that is based on a genetic test or on genetic information.

Has any insurance company declined, postponed, rated up, refused, or restricted life or health insurance coverage for you or any of your family members to be covered within the last five years? ☐ Yes ☐ No

If yes, name of person affected and name of insurance company: _____

List all family members to be covered.

	Last name of family member	First name, initial	Height	Weight	Sex	Age	Date of Birth	Social Security Number
Subscriber								
Spouse/ Domestic Partner								
Child								
Child								
Child								

Explain relationship to the subscriber for any person listed above whose last name is different from the subscriber:

_____

Please mark "Yes" or "No" for each item (for you and any family members requesting coverage). Provide details on Page 5 to any questions answered "Yes." **(For the purpose of these questions, chronic means persistent, continuous, or periodic, or a combination of any of these terms.)**

Within the last five years, has **anyone** listed on this application had any medical advice, diagnosis, care, or treatment, including prescribed medications, recommended or received from a licensed health care professional or had any illness, ailment, injury, health problem, symptoms, physical impairment, surgery or hospital confinement related to any of the following conditions:

1. AIDS, ARC, HIV positive ☐ Yes ☐ No
2. Alcohol/chemical/drug abuse/habit ☐ Yes ☐ No
3. Anemia/chronic fatigue ☐ Yes ☐ No
4. Appendicitis/chronic abdominal pain ☐ Yes ☐ No
5. Back/neck/spine ☐ Yes ☐ No
6. Birth defect/congenital deformities ☐ Yes ☐ No
7. Bladder/urinary tract ☐ Yes ☐ No
8. Blood/circulatory ☐ Yes ☐ No
9. Bone/orthopedic ☐ Yes ☐ No
10. Brain disease or injury/concussion ☐ Yes ☐ No
11. Breast (lumps or masses) ☐ Yes ☐ No
12. Cancer ☐ Yes ☐ No
13. Chemotherapy/radiation treatment ☐ Yes ☐ No
14. a. Colon/rectum/intestine/bowel ☐ Yes ☐ No
    b. Blood in stool ☐ Yes ☐ No
15. Convulsion/seizures/epilepsy ☐ Yes ☐ No
16. Diabetes/sugar in urine ☐ Yes ☐ No
17. Chronic ear/nose/throat/tonsil condition/disease/disorder ☐ Yes ☐ No
18. Eating disorders such as, but not limited to, anorexia or bulimia ☐ Yes ☐ No
19. Emphysema/asthma chronic lung disease (COPD) ☐ Yes ☐ No
20. Endocrine/gland/hormone system ☐ Yes ☐ No
21. Disease or injury of eye/ cataract/glaucoma ☐ Yes ☐ No
22. Gallbladder/pancreatic disease ☐ Yes ☐ No
23. Chronic headaches/migraines ☐ Yes ☐ No
24. Heart/chest pain/angina ☐ Yes ☐ No
25. Hernia ☐ Yes ☐ No
26. High cholesterol (if "Yes," record last reading on page 5) ☐ Yes ☐ No
27. High blood pressure (if "Yes," record last reading on page 5) ☐ Yes ☐ No
28. Kidney/kidney stones ☐ Yes ☐ No
29. Knee/shoulder/hip/other joints ☐ Yes ☐ No
30. Liver condition/hepatitis ☐ Yes ☐ No
31. Lupus, chronic muscle pain, muscle injury or disease, or fibromyalgia ☐ Yes ☐ No
32. a. Mental/emotional condition/depression ☐ Yes ☐ No
    b. Therapy/counseling within last 5 years (if "Yes," record date of last session on page 5) ☐ Yes ☐ No
33. Neurological condition/disease/injury ☐ Yes ☐ No
34. Phlebitis/blood clot ☐ Yes ☐ No
35. Osteoarthritis/osteoporosis/osteopenia ☐ Yes ☐ No
36. Prostate/elevated PSA/prostatitis ☐ Yes ☐ No
37. Reproductive system disorder/infertility ☐ Yes ☐ No
38. Chronic respiratory/lung condition ☐ Yes ☐ No
39. Rheumatoid arthritis ☐ Yes ☐ No
40. Sexually transmitted disease(s) ☐ Yes ☐ No
41. Skin condition, abnormal or cancerous moles or eczema/cysts/cancer ☐ Yes ☐ No
42. Sleep apnea/chronic sleep disorder ☐ Yes ☐ No
43. Stomach disorders/ulcer/acid reflux ☐ Yes ☐ No
44. Stroke/paralysis/seizures ☐ Yes ☐ No
45. Tumors ☐ Yes ☐ No
46. TMJ/jaw joint ☐ Yes ☐ No
47. Weight fluctuation (+/-20 lbs.) ☐ Yes ☐ No
48. Cosmetic surgery/implants, use of prosthetic devices/limbs ☐ Yes ☐ No

49. Has any person on this application used tobacco products in any form within the last 5 years? ☐ Yes ☐ No

    If yes,:

    Name: _____ type of product _____

    Name: _____ type of product _____

    Name: _____ type of product _____

50. Please provide the following information for each **female** on this application:

Family member	**Name:**	**Name:**	**Name:**	**Name:**
a) Initial menstrual cycle begun?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) Date of last menstrual period?				
c. If (b) is more than 35 days ago, please explain:				
d) Excessive or absent menstrual bleeding?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e) If (d) is yes, please explain				
Date of last DEPO Provera shot?				
Abnormal Pap smears?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Prior Cesarean section or miscarriage?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

51. Is any person on this application now pregnant? ☐ Yes ☐ No
If yes, name _____ due date _____/_____/_____.

52. Is any person on this application, including male applicants and dependent males or females, ☐ Yes ☐ No
responsible for a current pregnancy?
If yes, name _____ due date _____/_____/_____.

53. Please provide the following information for each person on this application.
Within the last five years, has any person on this application:

a. Had any medical advice, diagnosis, care, or treatment, including prescribed medications, recommended or received from a licensed health care professional, or had any illness, ailment, injury, health problem, symptoms, physical impairment, surgery or hospital confinement not listed above? ☐ Yes ☐ No

b. Had chronic cough, fatigue, diarrhea, or enlarged glands? ☐ Yes ☐ No

c. Been advised to have or contemplated having an operation or medical procedure not yet performed? ☐ Yes ☐ No

d. Been scheduled to see a health care provider? ☐ Yes ☐ No

e. Taken any prescription medication on a regular basis? ☐ Yes ☐ No

54. List all medications currently being taken by any person on this application:

Name	Medications	Prescribed by (name/address/phone)	Date prescribed
Attach additional pages if necessary. ☐ I have attached _____ page(s).			

Please provide specific details below to each question answered "yes" on pages 3 & 4. Include insured/applicant's name; the number of the question to which you answered "yes"; the condition, treatment and date; the result of treatment, including any medications; and the name, address and telephone number of the attending physician, other health care provider, or clinic/hospital.

HEALTH HISTORY DETAILS

Please provide specific details below to any question answered "Yes" on the previous pages.

Name	Question Number	Start to end dates	Condition	Treatment **Including Medications**	Final Result Ongoing **or Resolved** Please Circle	Attending physician/health care provider or hospital (name/address/ telephone)
					O / R	
					O / R	
					O / R	
					O / R	
					O / R	
					O / R	
					O / R	
					O / R	
					O / R	
					O / R	
					O / R	

Attach additional pages if necessary. ☐ I have attached _____ page(s).

Name, address, and telephone number of medical provider with current medical records/history:

EMPLOYER SPONSORED BUSINESS (ESB) STATEMENT

You understand and agree that you are applying for individual health insurance for you (and your family). You further understand that this application for health insurance will be fully medically underwritten and that coverage is not guaranteed. You are personally paying the entire premium for this health insurance coverage. Your employer is not contributing in any way to the payment of premium, either directly or indirectly.

Do you agree with this statement? ..... ☐ Yes ☐ No

Time Insurance Company Authorization for Check-O-Matic and Credit Card Billing

AUTHORIZATION FOR CHECK-O-MATIC BILLING ONLY – *Choose the following option that applies:*

☐ **To begin Check-O-Matic withdrawals:**

Select a desired withdrawal day (1–28): _____

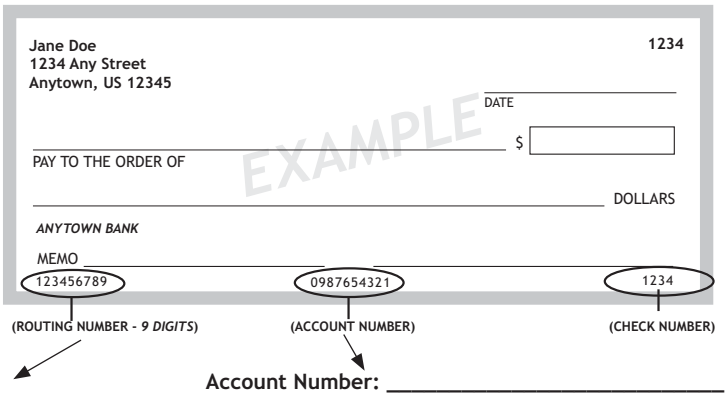
Bank Name: _____

City: _____ State: _____

☐ **To add this policy to an existing Check-O-Matic:**

Existing COM Number: _____

Associated Policy Number: _____



Routing Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Account Number: _____

Check-O-Matic *(Complete authorization below)*

I (we) hereby authorize Time Insurance Company, hereinafter called COMPANY, to initiate debit entries to the account and depository, hereinafter called DEPOSITORY, indicated on the other side, to debit the same to such account. This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

_____ _____

Signature of Payor Date Signed

AUTHORIZATION FOR CREDIT CARD PAYMENTS

When selecting MasterCard/VISA Card: I authorize Assurant Health to charge my account for the Individual Medical policy listed above. I understand there will be no refund of premium after the 10-day free look period in the contract.

☐ Visa Card Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

☐ MasterCard Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Exp. Date: _____ / _____

Name as it appears on card: _____

Signature of Payor: _____ Date: _____

AUTHORIZATION

I agree that:

Except as otherwise provided in the Conditional Receipt, the insurance, if approved by Time Insurance Company, will be in force only when issued by Time Insurance Company. The first full premium must be paid. Coverage will become effective on the later of: A) The date we receive the enrollment form; B) the requested Effective Date. A change in the health of the proposed insured(s) after the completion of the enrollment form and before the delivery of the contract may affect my eligibility for insurance with the company. The contract may only be effective prior to the contract delivery subject to the terms of the Conditional Receipt.

I agree that a photographic copy of this authorization shall be valid for two years from the date signed.

I acknowledge receiving the notification regarding the Medical Information Bureau, the Abbreviated Notice of Insurance Information Practices and the Outline of Coverage for Health Insurance, if required.

We, the undersigned Proposed Insured(s) and agent, acknowledge that the Proposed Insured(s) has read the completed enrollment form. We understand and acknowledge that any fraudulent statement or material misrepresentation or omission on the enrollment form and/or any amendments may result in claim denial or contract rescission, subject to the time limit on certain defenses or incontestability provisions of the contract.

I hereby authorize any health care provider or medically related facility, pharmacy or pharmacy related facility, the Medical Information Bureau, Inc., consumer reporting agency, insurance or reinsurance company or employer having information about me or my minor children to provide all such information as may be requested to Time Insurance Company, its legal representative or any medical records retrieval service Time Insurance Company may engage, including, but not limited to, EMSI and its agents.

This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, prescription history, lab data and EKGs. This information may also be disclosed to the Medical Information Bureau, Inc. and any medical records company engaged by Time Insurance Company, including but not limited to EMSI and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Time Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. A copy of this authorization will be valid as an original.

I understand that this authorization is required in order to enable Time Insurance Company to make eligibility or enrollment determinations relating to me and/or my minor children or for Time Insurance Company's underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, Time Insurance Company may refuse to consider my application for enrollment.

I understand that I may revoke this authorization at any time by notifying Time Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Time Insurance Company, P.O. Box 3050, 501 West Michigan, Milwaukee, WI 53201-3050. Such revocation will not be valid if Time Insurance Company has taken action in reliance on the authorization.

Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: 30 days after denial of my application, or declination of enrollment, or, if insured, 30 days after when I am no longer an insured of Time Insurance Company. But in no event will this authorization be in effect for longer than 24 months from the date signed.

You have the right to revoke your authorization at any time by notifying Time Insurance Company.

CERTIFICATION OF COMPLETION AND CORRECTNESS

I Affirm that the answers given in this "Oregon Standard Health Statement" are complete and correct. I am providing these answers as part of the application procedure required by this insurance carrier to enroll in their insurance coverage. I understand that if this application contains any material misstatements or omissions, the insurance carrier may, within the first two years of coverage, deny coverage, modify or cancel the contract, and/or take any other legal action available to it by law. I will promptly inform the insurance carrier in writing if anything happens before my coverage takes effect that makes this incomplete or incorrect. I understand and agree that no coverage shall be in force until approved by the insurance carrier. If approved, coverage will be in force as of the effective date determined by the carrier. The carrier may phone me to clarify answers on this application. As the applicant, I understand I have the right to inspect the information in my file.

Only medical questions on this application that have been answered "yes" may be inquired about.

_____
Signature of Primary Proposed Insured

_____
Signature of Spouse or Other Insured
(If proposed to be insured)

_____
Signature(s) of Other Dependents 18 or Over
(If proposed to be insured)

_____
Guardian's Signature
(If minor, custodial parents signature is required)

❑ A.M.
❑ P.M.

_____
Date Signed Time Signed City/State

Requested Effective Date_____

Amount Collected $ _____

One-time Processing Fee sent $ _____

Conditional Receipt Given? ❑ Yes ❑ No

ATTENTION: (Agent)

I have reviewed this application to ensure that all required items have been completed.

To the best of my knowledge
❑ there is,
❑ is not
a replacement of Medical Insurance involved in this transaction.

_____
Licensed Resident Agent's Signature

_____
Print Agent Name & Agent Number or Business Number

_____ Initial here if you witnessed the signing of this form by the Proposed Insured(s).