Regence

Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueCross BlueShield of Oregon
100 SW Market Street
Portland, Oregon 97207-1271
Mail form to: PO Box 1271 MS:E8U
Portland, OR 97207-1271

Individual Application and Standard Health Statement

SECTION 1 - INSTRUCTIONS

- Please read carefully.
- Use ink to complete and sign this application. An application completed in pencil will be returned to you.
- Make sure all sections of the application are answered completely.
- If you need assistance completing this application, please contact your insurance producer or call Individual Marketing at 1-888-REGENCE.

☐ Yes ☐ No I want to do my part for the environment and reduce waste. Please send my Explanation of Benefits (and when possible, other communications) electronically.

EFFECTIVE DATE: Upon approval, you will be eligible for an effective date of the first of the month following the date the completed application was received in our office, unless otherwise indicated. Incomplete applications may receive a later effective date. Requested Effective Date _____

I am applying for:

☐ New enrollment ☐ Addition of a spouse/domestic partner and/or dependent child to my existing policy
☐ Change to existing individual plan or deductible

SECTION 2 - PLAN SELECTION (Detailed benefit information can be found online at www.regence.com)

BASE PLANS (select ONE medical plan)

Evolve Core

☐ $1,000 deductible per member (maximum of 3 deductibles per family)
☐ $2,500 deductible per member (maximum of 3 deductibles per family)
☐ $5,000 deductible per member (maximum of 3 deductibles per family)
☐ $7,500 deductible per member (maximum of 3 deductibles per family)
☐ $10,000 deductible per member (maximum of 3 deductibles per family)

Evolve Plus

☐ $1,000 deductible per member (maximum of 3 deductibles per family)
☐ $2,500 deductible per member (maximum of 3 deductibles per family)
☐ $5,000 deductible per member (maximum of 3 deductibles per family)
☐ $7,500 deductible per member (maximum of 3 deductibles per family)

Evolve HSA

☐ $1,500 self-only deductible / 50% coinsurance
☐ $1,500 self-only deductible / 80% coinsurance
☐ $3,500 self-only deductible / 50% coinsurance
☐ $3,500 self-only deductible / 80% coinsurance
☐ $3,000 family deductible / 50% coinsurance
☐ $3,000 family deductible / 80% coinsurance
☐ $7,000 family deductible / 50% coinsurance
☐ $7,000 family deductible / 80% coinsurance

Evolve HSA 100

☐ $5,000 self-only deductible
☐ $10,000 family deductible

DENTAL OPTIONS (select ONE of the following dental options)

☐ **Dental Option 1** - 100/80/50; $750 annual maximum benefit that may increase over time to $1,500
☐ **Dental Option 2** - 100% of first $200 and 50% of next $1,100 ($750 annual maximum benefit)
☐ **No Dental**

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SECTION 3 - ENROLLMENT INFORMATION

LIST ALL ELIGIBLE FAMILY MEMBERS TO BE COVERED

Eligible family members include a spouse/domestic partner, and/or any unmarried child who is under age 23, financially dependent upon you, or who is medically certified as disabled and dependent upon you for support. Copy of certification required.

Last Name	First Name, MI	Gender	Age	Height	Weight	Birthdate	Social Security Number
Applicant							
☐ Spouse ☐ Non-Certified Domestic Partner* ☐ Certified Domestic Partner							
Child 1							
Child 2							
Child 3							

Explain the relationship to the applicant for any person(s) listed above whose last name is different from the applicant's. We may request a Certificate of Dependency form. *Non-Certified Domestic Partners must submit an Affidavit of Domestic Partnership.

OREGON RESIDENCE ADDRESS

To be eligible to apply for our individual plans, you must reside in our service area and continue to live in our service area for six months out of the year. A photocopy of a valid Oregon state driver's license, identification card, or current utility bill with name and address may be requested as proof of residency.

Residence Street Address	Mailing Address (if different than residence street address)
City, State, ZIP Code	E-Mail Address (will not be disclosed outside of the company)

Home Phone Number	Work Phone Number	County

SECTION 4 - OTHER COVERAGE INFORMATION

1. Are you or any dependents who are applying for coverage currently covered on any group, individual or self-insured medical plan? ☐ Yes ☐ No

   If yes, do you intend to replace your current plan with this contract? ☐ Yes ☐ No

2. Are you currently enrolled in a Regence BlueCross BlueShield of Oregon Individual medical plan and wish to cancel that coverage? ☐ Yes ☐ No

If you answered yes, please sign the statement below:

I wish to terminate my current individual medical coverage from Regence BlueCross BlueShield of Oregon on the effective date of this individual policy.

Signature ▶ _____ Date _____

Regence BlueCross BlueShield of Oregon Individual Plans contain a 6-month preexisting condition limitation period. Please provide the following information for all applicants, and attach a copy of your Certificate of Coverage from your current or prior carrier or a similar document showing the beginning and ending dates of your current coverage, if applicable.

Name (First Last)	Insurance Company	Policy Number	Dates of Coverage		Type of Coverage
			Date Coverage Began MM/DD/YYYY	Date Coverage Ended (indicate Active if you are currently covered) MM/DD/YYYY	• Employer Group • Individual • Medicare • COBRA • High Risk Pool • Other (describe)
1.					
2.					
3.					
4.					
5.					

SECTION 5 - OREGON STANDARD HEALTH STATEMENT

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

If "yes", indicate name of person affected, reason for action, and name of insurance company _____

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.

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, 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:

	Yes	No
1. AIDS, ARC, HIV positive	☐	☐
2. Alcohol/chemical/drug abuse/habit	☐	☐
3. Anemia/chronic fatigue	☐	☐
4. Appendicitis/chronic abdominal pain	☐	☐
5. Back/neck/spine	☐	☐
6. Birth defect/congenital deformities	☐	☐
7. Bladder/urinary tract	☐	☐
8. Blood/circulatory	☐	☐
9. Bone/orthopedic	☐	☐
10. Brain disease or injury/concussion	☐	☐
11. Breast (lumps or masses)	☐	☐
12. Cancer	☐	☐
13. Chemotherapy/radiation treatment	☐	☐
14a. Colon/rectum/intestine/bowel	☐	☐
14b. Blood in stool	☐	☐
15. Convulsion/seizures/epilepsy	☐	☐
16. Diabetes/sugar in urine	☐	☐
17. Chronic ear/nose/throat/tonsil condition/disease/disorder	☐	☐
18. Eating disorders such as, but not limited to, anorexia or bulimia	☐	☐
19. Emphysema/asthma/chronic lung disease (COPD)	☐	☐
20. Endocrine/gland/hormone system	☐	☐
21. Disease or injury of eye/cataract/glaucoma	☐	☐
22. Gallbladder/pancreatic disease	☐	☐
23. Chronic headaches/migraines	☐	☐
24. Heart/chest pain/angina	☐	☐
25. Hernia	☐	☐

	Yes	No
26. High cholesterol (if "Yes", record last reading on page 5)	☐	☐
27. High blood pressure (if "Yes", record last reading on page 5)	☐	☐
28. Kidney/kidney stones	☐	☐
29. Knee/shoulder/hip/other joints	☐	☐
30. Liver condition/hepatitis	☐	☐
31. Lupus, chronic muscle pain, muscle injury or disease, or fibromyalgia	☐	☐
32a. Mental/emotional condition/depression	☐	☐
32b. Therapy/counseling within last 5 years (if "Yes", record date of last session on page 5)	☐	☐
33. Neurological condition/disease/injury	☐	☐
34. Phlebitis/blood clot	☐	☐
35. Osteoarthritis/osteoporosis/osteopenia	☐	☐
36. Prostate/elevated PSA/prostatitis	☐	☐
37. Reproductive system disorder/infertility	☐	☐
38. Chronic respiratory/lung condition	☐	☐
39. Rheumatoid arthritis	☐	☐
40. Sexually transmitted disease(s)	☐	☐
41. Skin condition, abnormal or cancerous moles or eczema/cysts/cancer	☐	☐
42. Sleep apnea/chronic sleep disorder	☐	☐
43. Stomach disorders/ulcer/acid reflux	☐	☐
44. Stroke/paralysis/seizures	☐	☐
45. Tumors	☐	☐
46. TMJ/jaw joint	☐	☐
47. Weight fluctuation (+/-20 lbs.)	☐	☐
48. Cosmetic surgery/implants, use of prosthetic devices/limbs	☐	☐

SECTION 5 - OREGON STANDARD HEALTH STATEMENT (continued)

Yes No

49. Has any person on this application used tobacco products in any form within the last 5 years? ☐ ☐

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(s):				
a. Initial menstrual cycle begun?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b. Date of last menstrual period. mm/dd/yyyy				
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? mm/dd/yyyy				
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, responsible for a current pregnancy? ☐ Yes ☐ No

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 on page 3 & 4? ☐ 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 at a future date? ☐ Yes ☐ No

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

SECTION 5 - OREGON STANDARD HEALTH STATEMENT (continued)

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

Name	Medications	Prescribed by (name/address/telephone number)	Date prescribed

Please provide specific details below to each question answered "yes" on pages 3 - 5. 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

Name	Question Number	Start to end dates	Condition	Treatment including medications	Final result Ongoing or Resolved Please check	Attending physician/health care provider or hospital (name/address/telephone)
					☐ Ongoing ☐ Resolved	
					☐ Ongoing ☐ Resolved	
					☐ Ongoing ☐ Resolved	
					☐ Ongoing ☐ Resolved	
					☐ Ongoing ☐ Resolved	
					☐ Ongoing ☐ Resolved	
					☐ Ongoing ☐ Resolved	

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

Name, address, and telephone number of medical provider(s) with current medical record/history:

SECTION 6 - PRODUCER CERTIFICATION

If you have a producer, that producer may receive bonuses, commissions, administrative service fees, or other compensation, including non-cash compensation, from Regence BlueCross BlueShield of Oregon. Incentives may be based on any of several factors, including the products you buy, your producer's volume of business with Regence BlueCross BlueShield of Oregon, and the other services your producer provides you. These incentives may have an indirect impact on your rates. For more information, please contact your producer.

FOR PRODUCER USE ONLY

I, (the producer) certify I have explained the eligibility provisions to the applicant. I have not made any statements about benefits, conditions or limitations of the contract except through written material furnished by Regence BlueCross BlueShield of Oregon. I have informed the applicant that the effective date of coverage is assigned only by Regence BlueCross BlueShield of Oregon and provided the Oregon Disclosure Information required.

I certify that the information supplied to me by the applicant has been truly and accurately recorded here.

Producer Name (please print or type)	Regence Producer Number
Andrew Eachon	0100269-0001
Producer's Signature (Required)	**Date (Required)**
X	

Producer: COLLECT NO PREMIUM WITH APPLICATION

SECTION 7 - CERTIFICATION, AUTHORIZATION AND SIGNATURE

Be sure to sign and date the application below. Spouse/Domestic Partner and/or dependent's (age 18 - 23) signature is required, if applicable. Signature applies to both "Certification of Completeness and Correctness" and "Authorization for Use and Disclosure of Protected Health Information":

CERTIFICATION OF COMPLETION AND CORRECTNESS

I affirm that the answers given in this application are true, complete, and correct. I am providing these answers as part of the application procedure required by Regence BlueCross BlueShield of Oregon to enroll in their coverage. I understand that Regence BlueCross BlueShield of Oregon will rely on each answer in making coverage and rating determinations. For the protection of all our members, fraud or misrepresentation of material fact by me for the purposes of defrauding Regence BlueCross BlueShield of Oregon may result in Regence BlueCross BlueShield of Oregon taking any action allowed by law or contract, including termination or rescission of coverage, denial of benefits, and/or pursuit of criminal charges and penalties. If coverage is rescinded for fraud or intentionally misleading statements, Regence BlueCross BlueShield of Oregon will reimburse premium less any claims paid and will pursue reimbursement for claims paid exceeding any premium. I will promptly inform Regence BlueCross BlueShield of Oregon in writing if anything happens before my coverage takes effect that makes this application incomplete or incorrect. I understand and agree that no coverage shall be in force until approved by Regence BlueCross BlueShield of Oregon. Regence BlueCross BlueShield of Oregon 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. **I further affirm that I received a disclosure statement from Regence BlueCross BlueShield of Oregon or its authorized insurance producer describing the individual contract.**

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the application form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits, or as required by law.*

Health information requested or disclosed may be related to treatment or services performed by:

- a physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- a clinic, hospital, long-term care or other medical facility;
- any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or;
- an insurance carrier or health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). A separate authorization will be required for psychotherapy notes.

I understand that if this application contains any material misstatements or omissions, Regence BlueCross BlueShield of Oregon may deny coverage, modify or cancel coverage and/or take any other legal action available to us by law.

*For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Regence Consumer Privacy Notice. A copy is available on our Web site at **www.or.regence.com** or by telephone request at **1 (800) 365-3155.**

THIS AUTHORIZATION MAY NOT BE USED FOR PSYCHOTHERAPY NOTES
(Notes recorded and separately maintained by a mental health professional documenting or analyzing the contents of a conversation during a counseling session.)

SIGNATURES

Signature of applicant, parent or legal guardian if applicant is under 18 years of age or legally incompetent*	Relationship	Date
X		
Signature of applicant's legal spouse or eligible domestic partner*		Date
X		
Signature of dependent(s) between 18 and 23 years of age*		Date
X		
Signature of dependent(s) between 18 and 23 years of age*		Date
X		

***If signature by a personal representative of the member/enrollee please complete the following:**

Personal Representative's Name (please print)_____

Relationship to Individual _____ (Attach legal documentation if other than parent of a minor child)

If additional health information is required to qualify you or a family member for coverage, we may send you a separate authorization form for the purpose of obtaining medical information.

SECTION 8 – PREMIUM BILLING OPTIONS (if application is approved)

BILLING ADDRESS (complete only if billing should be sent to an address other than the Residence Street Address listed on the front of the application.)

Name	Relationship to Applicant

Address	City, State, ZIP Code

☐ Yes ☐ No Is your employer reimbursing or paying for any portion of this policy's premium? Individual benefit plans are not intended for sale as an employer-sponsored health benefit plan for employees.

Please indicate which billing option you want to use. (If billing option is left blank, your policy will automatically default to Monthly Billing).

- ☐ Monthly Billing
- ☐ FHIAP ID# _____ (please attach a copy of the signed FHIAP Certificate of Eligibility listing all eligible parties, to this application).
- ☐ Quarterly Billing
- ☐ SurePay (monthly automatic bank deduction)

Note: If selecting SurePay, please fill out the information below.

SUREPAY is a simple and convenient way to keep your health coverage in force. If you select the SUREPAY option of paying for your Regence BlueCross BlueShield of Oregon health insurance the payment will be deducted automatically on the draft date you choose below. This will provide several advantages to you:

- Your payment will always be made on time (if funds are available in your account).
- You won't have to worry about your coverage accidentally lapsing due to overlooked payments.
- Your monthly bank statement will show a withdrawal notation. This will serve as receipt of payment.
- Claims will be paid promptly due to your policy always being paid current.

GETTING STARTED IS EASY by mail or phone:

1. **Complete,** date and sign the SurePay Authorization information below.
2. **Write** "void" on one of your checks and return your "voided" check with this application (not a deposit slip). *For savings account please provide proof of ownership of the account.*

SUREPAY AUTHORIZATION

Please indicate which day you want your payment made.

- ☐ **5th of the month** - will pay the current month's charges
- ☐ **15th of the month** - will pre-pay the next month's charges
- ☐ **25th of the month** - will pre-pay the next month's charges

AUTHORIZATION TO MY BANK

☐ Checking Account ☐ Savings Account

As a convenience and on behalf of the Account Holder identified below, I/we hereby request and authorize you to pay and charge to the account identified below, checks or electronic debits drawn on the account by and payable to the order of Regence BlueCross BlueShield of Oregon, Portland, OR. I/we agree that your rights to each such check or electronic debit shall be the same as if it were an actual check drawn on you and signed by me/us. This authority is to remain in effect until revoked by me/us in writing, and until you actually receive such notice, I/we agree that you shall be fully protected in honoring any such check. I/we further agree that if any checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. A photocopy of this executed authorization shall be as valid as the original.

Financial Institution	Transit/Routing Numbers	Account Number

_____
Account Holder's Name (please print)

▶ _____ _____
Account Holder's Authorized Signature(s) - as it appears on bank records Date