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.

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest

Section 1 – Instructions

- Please use a **pen** to complete and sign this application.
- Make sure this application is complete and signed. Parents or legal guardians must sign for children under the age of 18. Applicants who are 15 years of age and older must sign the *Authorization to Obtain or Release Medical Information*. We are unable to process applications without appropriate signatures.
- If you would like help completing this application, please call **1-888-813-3700**.
- To be eligible for Kaiser Permanente Individuals and Families, you must live in our Oregon service area.
- **If this application contains any material misstatements or omissions, Kaiser Foundation Health Plan of the Northwest (KFHPNW) 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. Applicant must promptly inform KFHPNW in writing if anything happens before coverage takes effect that makes the application incomplete or incorrect. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.**

Section 2 – Plan selection

Choose one Kaiser Permanente Individuals and Families plan

Copayment plans	Deductible plans		Deductible HSA plans
❑ Platinum Rx	❑ Gold $500	❑ Silver $3,500	❑ $1,500 Deductible/Rx with HSA Option
❑ Platinum	❑ Gold $1,000	❑ Bronze $5,000	❑ $1,500 Deductible with HSA Option
	❑ Silver $1,500	❑ Bronze $7,500	❑ $2,600 Deductible/Rx with HSA Option
	❑ Silver $2,500		❑ $2,600 Deductible with HSA Option

Additional information is available upon request.

Please allow a minimum of 10 days for the processing of each completed application. Effective date of coverage cannot be more than **60 days** from the date the application is signed.

❑ I am adding a new person to an existing Kaiser Permanente Individuals and Families account.

Subscriber's health record number | | | | | | | | |

Note: Your plan options may be limited based on review of your application and medical history.

Section 3 – Enrollment information

Complete the following information and submit one application for **each** family member **applying**:

Applicant	Last name	First name	Middle initial	Previous name(s)	Marital status ❑ Married ❑ Single
Date of birth	Gender ❑ M ❑ F	Height	Weight	Social Security number	Health record number
Address			City	State	ZIP
Home phone			Work phone		

Names of other family members submitting applications (This helps us to process family members together.)

Spouse/ Domestic partner*	Last name	First name	Middle initial	Date of birth	Previous name(s)
Child					
Child					
Child					

*A domestic partner is a person legally recognized as your domestic partner in a valid Certificate of Registered Domestic Partnership issued by the state of Oregon.

For official use only

Date received	❑ New account	❑ Reapplication	Effective date _____
	❑ Conversion	❑ Upgrade	❑ Approved ❑ Denied
	❑ Add-on		

Section 4 – Prior or current coverage

This coverage has a six-month waiting period for pre-existing conditions. This means that we do not pay for expenses incurred by you or your enrolled dependent(s) for pre-existing conditions during the six months following your or your enrolled dependent's effective date of coverage. A *pre-existing condition* is any medical condition, illness, or injury within the six months prior to the effective date of coverage for which medical advice was given, for which a health care provider recommended or provided treatment, or for which a prudent person would have sought advice or treatment.

In certain circumstances, we will waive or credit this waiting period based on current or prior coverage. To help us determine if you qualify for crediting the pre-existing condition waiting period, please provide responses to **all** the information requested below. For questions about waiting periods or pre-existing conditions, call **1-888-813-3700**. For questions about prior or current coverage, call **1-503-813-2000**.

Details regarding current or prior coverage

1. Do you currently have insurance or have you had insurance in the past?
   - ❑ Yes
   - ❑ No

2. Name of insurance company

   _____

   Phone (_____) _____

3. Date coverage began _____

   Date coverage ended/ends _____

4. Type of coverage:
   - ❑ Group plan
   - ❑ Church plan
   - ❑ Individual plan
   - ❑ OMIP
   - ❑ Health options plan
   - ❑ Federal plan (e.g., TRICARE, FEBHP, or Peace Corps Act)
   - ❑ Plan established/maintained by a foreign country or any political subdivision thereof
   - ❑ Plan of Indian Health Service or tribal organization
   - ❑ College, school, or short-term insurance

5. Deductible amount per year:

   Individual _____

   Family _____

6. Coinsurance _____

7. Coverage does or did include:
   - ❑ Maternity
   - ❑ Hospital only
   - ❑ Prescription drug
   - ❑ Waiting periods for organ transplants
   - ❑ None of the above

8. Names of individuals covered by current or prior insurer

   _____

   _____

9. Are you currently on or did you recently exhaust COBRA or state continuation coverage?
   - ❑ Yes
   - ❑ No

   If Yes, date coverage began

   _____

   Date coverage ended

   _____

10. Are you eligible for the following?

    Medicare Part A or B ❑ Yes ❑ No

    Medicaid ❑ Yes ❑ No

Section 5 – Questionnaire

Oregon Standard Health Statement
(Standard form per ORS 743.766)

All questions must be answered to begin processing. Please mark Yes or No for each item. Provide details in the health history details section (No. 55) 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.)

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.

Within the last 5 years, have you 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. Convulsions/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 in No. 55) ❑ Yes ❑ No
27. High blood pressure (if Yes, record last reading in No. 55) ❑ 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 in No. 55) ❑ 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

(*continues on page 4*)

Note: All questions must be answered to begin processing.

Section 5 – Questionnaire (*continued*)

Oregon Standard Health Statement
(Standard form per ORS 743.766)

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. a. Have you used tobacco products in any form within the last 5 years? ❑ Yes ❑ No
    b. If Yes, please list each type of product(s): _____
    _____
    _____
50. For females only—please provide the following information:
    a. Initial menstrual cycle begun? ❑ 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
    e. If (d) is Yes, please explain:
    _____
    _____
    f. Date of last Depo-Provera shot ___/___/____
    g. Abnormal Pap smears? ❑ Yes ❑ No
    h. Prior cesarean section or miscarriage? ❑ Yes ❑ No
51. a. Are you currently pregnant? ❑ Yes ❑ No
    b. If Yes, due date ___/___/____
52. a. Are you (including male applicants and dependent males or females) responsible for a current pregnancy? ❑ Yes ❑ No
    b. If Yes, due date ___/___/____
53. Within the last 5 years, have you:
    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 you are currently taking:

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

55. Please provide specific details below to any questions answered Yes on the previous pages.

Question no.	Dates	Condition	Treatment	Final result

Do you have Medicare or Medicaid coverage? ❑ Yes ❑ No

Section 6 – Billing information

Application must be accompanied by payment information for your initial premium. Please make certain that you have provided all information requested on this page.

1. Financially responsible party's billing address:

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss

Last name

First name MI

Street address Apt./Unit #

City State ZIP

2. Effective date:

If approved, I would like to be enrolled with an effective date of:

❑ 1st of the month immediately following the date the application is approved (application must be received by the 23rd of the preceding month)

❑ 1st of the month plus one additional month following the date the application is approved (application must be received by the 23rd of the preceding month)

3. Credit/debit card information: ❑ Credit ❑ Debit

❑ VISA ❑ Discover
❑ MasterCard ❑ American Express

Name as it appears on card

Credit/debit card number

Credit/debit card security number

Expiration date

❑ Please charge my card for the first month's premium only.

Section 7 – Certification/Authorization

Certification of completion and correctness

By completing this application, 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 health care service contractor to enroll in its health plan. I understand that if this application contains any material misstatements or omissions, the health care service contractor 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 health care service contractor 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 health care service contractor. If approved, coverage will be in force as of the effective date determined by the health care service contractor. The health care service contractor 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.

X _____

Applicant's signature

Producer authorization

(if you are working with a health insurance producer)

I (the member) authorize the insurance producer listed below to share enrollment, disenrollment, and summary plan information specific to this application with the health care service contractor.

I understand that the insurance producer of record may receive monetary and/or nonmonetary payments from Kaiser Foundation Health Plan of the Northwest (KFHPNW) in connection with the purchase of this health plan coverage.

X _____

Applicant's signature

I (the producer) have not made any representations to the applicant about any provisions, benefits, conditions, or limitations of the policy except through written materials furnished by KFHPNW. The applicant has been informed that the effective date of coverage is assigned by KFHPNW. I certify that the information supplied to me by the applicant has been truly and accurately recorded.

Century Benefits

Agency name

11375

Agency number

Joel Beaudoin

Producer's name

X _____

Producer's signature

Authorization to Obtain or Release Medical Information

I authorize any physician or other health care professional, hospital or other health care facility, counselor, therapist, or any other medical or medically related facility or professional who has provided any services to an *Applicant* (defined as me or any of my dependents applying for or having membership in any Kaiser Foundation Health Plan of the Northwest product) to give *Kaiser Permanente* (defined as Kaiser Foundation Health Plan of the Northwest or its affiliates), its respective agents, employees, designees, or representatives, including my Kaiser Permanente producer, any Applicant's *Medical Information* (defined as **any and all information or records relating to medical history, medical examinations, services rendered, or treatment given, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, sexually transmitted diseases, HIV [human immunodeficiency virus] status, AIDS [acquired immune deficiency syndrome], or ARC [AIDS related complex]).** However, Medical Information does not include genetic information or *psychotherapy notes* (as defined by 45 C.F.R. § 164.501). I understand that such Medical Information may be requested and used in connection with the review, investigation, or evaluation of enrollment or of any claim for benefits after enrollment.

I also authorize Kaiser Permanente to disclose any and all such Medical Information related to any Applicant to any health care provider, health care service plan, self-insurer, or insurance company for the purpose of review, investigation, or evaluation of enrollment or of any claim for benefits after enrollment.

I authorize Kaiser Foundation Health Plan of the Northwest to disclose to my insurance producer the status of my application for coverage, as well as that of any dependent on whose behalf I am executing this authorization, including whether an application was received, accepted, or rejected; if accepted, the effective date of coverage; and information regarding the status of bills and payments for amounts due for the coverage.

I will sign new authorizations, if necessary, so that in connection with the review, investigation, or evaluation of enrollment or of any claim for benefits, Kaiser Permanente may request, use, and disclose Medical Information, HIV/AIDS- or ARC-related information, and psychotherapy notes.

Medical Information, once disclosed, may no longer be protected by federal privacy law, and may be further disclosed.

This authorization is effective immediately and will remain in effect for a period of thirty (30) months, except that it will remain in effect for use by Kaiser Permanente in connection with the review, investigation, or evaluation of any claim for benefits for an Applicant if that Applicant is still a member of Kaiser Foundation Health Plan of the Northwest. A photocopy of this authorization is as valid as the original, and I and my Kaiser Permanente producer are entitled to receive a copy of this form.

I may revoke this authorization (to the extent applicable to my Medical Information) at any time prior to its expiration. However, revocation is not effective to the extent that Kaiser Permanente has already taken action in reliance on it, or for so long as Kaiser Permanente may contest my enrollment or any claim for benefits. I understand that the instructions for revoking authorizations are in Kaiser Permanente's *Notice of Privacy Practices*.

X		
Primary applicant/Parent or legal guardian	Today's date	Date of birth

X		
Applicant's spouse/Domestic partner	Today's date	Date of birth

X		
Applicant (age 15 or over)	Today's date	Date of birth

Signatures (required)

Important: All Applicants age 18 or over must sign and date above on the appropriate signature line (Primary applicant/Parent or legal guardian, Applicant's spouse/domestic partner). A parent or legal guardian must sign for dependents under the age of 18. In addition, all Applicants age 15 or over must sign and date above on the designated signature line.

Use black ink only.

Please read and sign in all the places noted and photocopy for your records.
We will be unable to process your application without your signature.