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 Individual Enrollment Application

LIFEWISE
HEALTH PLAN OF OREGON

Please read all accompanying materials before completing this application. **All questions must have complete and accurate answers.** Omissions or incomplete answers will result in the return of your application and may cause a delay in processing your coverage. Please **PRINT**, sign and date in blue or black ink. **Applications that contain correction fluid or tape will not be accepted.** You must be a resident of the state of Oregon and not eligible for Medicare to apply.

SECTION 1 – TYPE OF APPLICATION. Must be received 10 days prior to requested effective date.

☐ New Enrollment Application: Requested effective **Month**: ______________ **Day:** ☐ 1st ☐ 15th (no more than 60 days after the signature date)

☐ Plan Change **(from and to a current LifeWise Plan)**: Member ID# ________________________ (first of the month effective date only)

☐ Adding Legally Recognized Spouse / Registered Domestic Partner: Member ID# __________________________
Date of Marriage / Registered Domestic Partnership: _____/_____/_____ (Signature of spouse/registered domestic partner required on page 7)

☐ Adding Child: Member ID# ________________________ ☐ Newborn ☐ Adoption Date of Birth / Placement: _____/_____/_____

☐ Adding Child: Legal Ward/Guardianship/Medical Child Support Order Date of Order: _____/_____/_____ (attach copy of court order or placement papers)

SECTION 2 – SUBSCRIBER & DEPENDENT INFORMATION (attach additional page(s) if necessary)

Name—Last, First, Middle Initial (as it will appear on your ID card. Only the first 26 characters will be displayed.)	If last name is different than applicant, explain relationship	Social Security #	Height (ft. in.)	Weight	Gender	Date of Birth (MM/DD/YYYY)
Self: ▶					☐ Male ☐ Female	/ /
Legally Recognized Spouse / Registered Domestic Partner: ▶					☐ Male ☐ Female	/ /
Dependent Child (under 23 only): ▶					☐ Male ☐ Female	/ /
Dependent Child (under 23 only): ▶					☐ Male ☐ Female	/ /
Dependent Child (under 23 only): ▶					☐ Male ☐ Female	/ /

Address	City / State / ZIP	County	Telephone
Home Address (not P.O. Box) required	City / State / ZIP	County	Home Telephone Number ( )
Mailing Address (if different from Home Address)	City / State / ZIP	County	Work Telephone Number ( )
Billing Address (if different from Mailing Address)	City / State / ZIP	County	Cell Telephone Number ( )
E-mail Address of Primary Applicant			

SECTION 3 – BENEFIT PLAN SELECTION

Check one box to indicate your family's plan selection and deductible option:

Plan					
1. WiseEssentials™	Deductible Options:	☐ $1,500	☐ $2,500	☐ $5,000	☐ $7,500
2. WiseChoices™	Deductible Options:	☐ $500	☐ $1,000	☐ $2,500	☐ $5,000

Health Savings Account (HSA) Qualified Plans

Plan		
3. WiseSavings™ (Individual)	Deductible Options:	☐ $3,000
4. WiseSavings™ (Family)	Deductible Options:	☐ $6,000

Optional Benefit

5. Alcoholism Endorsement ☐ $4,500 limit per 24 month period

SECTION 4 – ELIGIBILITY

To be eligible for coverage, applicants:

- Must be a resident of and continue to remain a resident of Oregon state. We may require proof of residency.
- Must not be entitled to Medicare (including entitlement due to disability).
- Must be under 65 years of age.

SECTION 5 – RATE/BILLING INFORMATION

DO NOT SEND PAYMENT with this application.

PAYMENT OPTIONS—Select One: ☐ Monthly Billing (by mail) ☐ Monthly Automatic Funds Transfer (complete Section 6.)

SECTION 6 – AUTOMATIC FUNDS TRANSFER AUTHORIZATION

I have selected the Automatic Funds Transfer (AFT), and I hereby authorize LifeWise Health Plan of Oregon (LifeWise) to initiate funds transfer from the bank or depository financial institution account indicated below. I authorize my financial institution to honor these transfers.

Financial Institution or Bank Name:	☐ Checking ☐ Savings
Account Holder's Name (print):	
City, State, ZIP:	
Bank Routing Number*:	Account Number:**

* The bank routing number is the 9-digit number at the bottom of check (for checking account) or deposit slip (for savings account). See example, below.
** Your account number is to the right of the bank routing number. See example, below.

Please attach a voided check (for checking account) or deposit slip (for savings account) from the account TO BE DEDUCTED in the space provided below.

Your Name
123 Main Street
Anytown, USA 12345

0001

DATE ____________

PAY TO THE ORDER OF ____________ $ ______

______________ DOLLARS

Affix your voided check HERE

Notes ____________

⑆123456789⑆ 9876543210⑈ 0001

Bank Routing Number — Account Number

Additional Terms and Conditions:

- Premium payments will be deducted each month on the **3rd working (business) day**, or as soon thereafter as practical. The deduction will also include any outstanding balance on my account.
- I have the right to stop payment of a transfer from my bank account to LifeWise. I must notify LifeWise no later than the **20th of the month** to be effective for the following month's automatic withdrawal.
- I agree to indemnify and hold harmless LifeWise for any claim arising out of transfers or deductions from my account pursuant to this agreement.
- I understand there may be a delay in processing this authorization through my bank. I agree that, until then, I will continue to submit the monthly premium payment directly to LifeWise.

I affirm that premiums for this policy are not paid or sponsored by an employer (please initial)**:** ____________

Signature of Account Holder: **X** ________________________ Date (MM/DD/YYYY): ____/____/____

SECTION 7 – INSURANCE INFORMATION

1. Has any insurance company within the last five years declined, postponed, refused, restricted or increased premium for health reasons for life or health insurance coverage for you or any of your family members to be covered?

○ **No**

☐ **Yes**—Name of affected person: ______________________

Name of Insurance Company: ______________________

Reason: ______________________

2. List name and Social Security Number of anyone on this application who is currently insured or has previously been insured by LifeWise:

____

3. Do you or any family members have other active health or medical coverage, Medicare, Medicare Advantage or Medicare supplement coverage?

○ **No**

☐ **Yes**—Name of insurance company: ______________________

Effective date of current medical coverage: _____/_____/_____

Termination date of current medical coverage: _____/_____/_____

4 Do you or any family member work for an employer who offers health benefits to employees?

○ **No**

☐ **Yes**—Are you or any family members enrolled? ○ **No** ☐ **Yes** If "**No**," why?

____

____

____

5. Are you applying within 63 days of the termination of any prior health coverage?

○ **No**

☐ **Yes**—You may be eligible for prior coverage credit towards pre-existing or other coverage limitations on these plans.

PLEASE COMPLETE INFORMATION BELOW TO RECEIVE PRIOR COVERAGE CREDIT.

Name and address of other insurance company: ______________________

____

Policy Number: ______________________ Phone Number: (_____) ______________

Name of Policyholder: ______________________ Date of Birth: _____/_____/_____

Social Security Number: ______________________

List first name(s) of all persons covered on that policy: ______________________

Will you terminate current coverage upon approval of LifeWise plan? ○ **No** ☐ **Yes**

Does the other plan provide medical coverage? ○ **No** ☐ **Yes**

Effective Date: _____/_____/_____ Termination Date: _____/_____/_____

SECTION 8 – HEALTH QUESTIONNAIRE

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 6 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:

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

Please check each item either Yes or No	Yes	No
26. High cholesterol **(if "Yes," record last reading on page 6)**	Y	N
27. High blood pressure **(if "Yes," record last reading on page 6)**	Y	N
28. Kidney/kidney stones	Y	N
29. Knee/shoulder/hip/other joints	Y	N
30. Liver condition/hepatitis	Y	N
31. Lupus, chronic muscle pain, muscle injury or disease, or fibromyalgia	Y	N
32 a. Mental/emotional condition/depression	Y	N
32 b. Therapy/counseling within last 5 years (if "Yes," record date of last session on page 6)	Y	N
33. Neurological condition/disease/injury	Y	N
34. Phlebitis/blood clot	Y	N
35. Osteoarthritis/osteoporosis/osteopenia	Y	N
36. Prostate/elevated PSA/prostatitis	Y	N
37. Reproductive system disorder/infertility	Y	N
38. Chronic respiratory/lung condition	Y	N
39. Rheumatoid arthritis	Y	N
40. Sexually transmitted disease(s)	Y	N
41. Skin condition, abnormal or cancerous moles or eczema/cysts/cancer	Y	N
42. Sleep apnea/chronic sleep disorder	Y	N
43. Stomach disorders/ulcer/acid reflux	Y	N
44. Stroke/paralysis/seizures	Y	N
45. Tumors	Y	N
46. TMJ/jaw joint	Y	N
47. Weight fluctuation (+/-20 lbs.)	Y	N
48. Cosmetic surgery/implants, use of prosthetic devices/limbs	Y	N

(continued)

Please provide details on page 6 to any questions answered "Yes."

SECTION 8 – HEALTH QUESTIONNAIRE (continued)

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

○ **No**

☐ **Yes**—Name ______________________ Type of Product ______________________

Name ______________________ Type of Product ______________________

Name ______________________ Type of Product ______________________

50. Please provide the following information for each female, age 13 and over, listed on this application:

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

51. Is any person on this application now pregnant?

○ **No** ☐ **Yes**

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?

○ **No** ☐ **Yes**

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? ○ No ☐ Yes

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

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

d. Been scheduled to see a health-care provider at a future date? ○ No ☐ Yes

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

(continued)

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

Name	Medications (including milligrams and daily dosage)	Prescribed by (name/address/telephone)	Date prescribed

HEALTH HISTORY DETAILS

Please provide specific details below to each question answered "Yes" in Section 8. 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.

Name	Question number	Start to end dates	Condition/Diagnosis	Treatment **Including Medications**	Final result: **Ongoing or Resolved**	Attending physician/health care provider or hospital (name/address/telephone)
					☐ Ongoing ☐ Resolved	
					☐ Ongoing ☐ Resolved	
					☐ Ongoing ☐ Resolved	
					☐ Ongoing ☐ Resolved	
					☐ Ongoing ☐ Resolved	
					☐ Ongoing ☐ Resolved	

Attach additional pages, if necessary.

☐ I have attached ________ page(s).

Please provide the name, telephone number and address of the medical provider with your current medical records/history:

Name of Medical Provider	Telephone Number ( )
Address (City / State / ZIP)	

SECTION 9 – IMPORTANT INFORMATION

- ✓ It is an eligibility requirement of these plans that the applicant is, and continues to remain, an Oregon resident.
- ✓ The application must be signed by both the applicant and legally recognized spouse/registered domestic partner, no more than 60 days prior to the requested effective date of coverage.
- ✓ The application must be received a minimum of **10 days prior** to the effective date of coverage.
- ✓ The premiums for this policy are not paid or sponsored directly by my employer.
- ✓ Please be advised that an improperly completed application or requests for medical records may cause delays in the processing of this application.
- ✓ I understand that if I/we are declined for the Plan requested on this application I/we may be offered a Plan(s) for which I/we would be accepted.
- ✓ I understand that this application becomes a part of the policy if issued.

SECTION 10 – CERTIFICATION AND AUTHORIZATION

CERTIFICATION OF COMPLETION AND CORRECTNESS

I affirm that the answers given in this "Oregon Standard Health Statement" are complete and correct. I have provided these answers as part of the application procedure required by this insurance carrier to enroll in its 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, or take other legal action. **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 contact me to clarify answers on this application. As the applicant, I understand I have the right to inspect the information in my file.

AUTHORIZATION FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

TYPE OF INFORMATION TO BE DISCLOSED: I (We) authorize: any physician; health care provider; hospital; insurance or reinsurance company; or the Medical Information Bureau, Inc. (MIB) to disclose a copy of my (our) personal health information, including any and all diagnostic, procedural, treatment, claim, prescription or other health related information including records concerning alcohol and/or chemical dependency, reproductive health (including abortion), sexually transmitted diseases, HIV, AIDS, psychiatric disorders, mental illness and genetic testing to LifeWise Health Plan of Oregon or its representative.

PURPOSE OF DISCLOSURE: I (We) understand that personal information will be used for underwriting, evaluating enrollment in the health plan, determining eligibility for benefits and paying claims.

TIMEFRAME OF RELEASE: Unless I revoke it, this release will remain valid for twenty-four (24) months from the date of my signature below.

REVOCATION OF RELEASE: I understand that I may change my mind and revoke this release at any time. I will do this by letting LifeWise know of my decision. Any change will be effective five (5) business days after LifeWise receives my written notice at the address listed on this form. I understand that some or all of this information may already have been used by LifeWise to make decisions, which will not be affected by its revocation.

REDISCLOSURE: LifeWise Health Plan of Oregon may be required to redisclose this information to another party that is not subject to state and federal privacy rules.

EFFECT OF DECLINING TO SIGN THIS AUTHORIZATION: This authorization is a condition of your enrollment in our health plan or your eligibility for benefits. If you decide not to sign this authorization, we may decline to enroll you in our health plan or to give you benefits.

I/we authorize separate policies issued to any combination of family members approved, even if coverage for the main applicant is declined. ☐ Yes ○ No

Be sure to sign and date the application. Legally recognized spouse's/registered domestic partner's signature is required if applicable. Signature applies to both "Certificate of Completeness and Correctness" and "Authorization for Release of Information." All persons listed on the application who are 18 years of age or older <u>must</u> sign and date below.

X		/ /
Signature of Applicant/Policyholder* (policyholder must sign if adding legally recognized spouse/registered domestic partner or child)	Printed Name	Signature Date (mm/dd/yy)
X		/ /
Signature of Legally Recognized Spouse/Registered Domestic Partner	Printed Name	Signature Date (mm/dd/yy)
X		/ /
Signature of child age 18 or over	Printed Name	Signature Date (mm/dd/yy)
X		/ /
Signature of child age 18 or over	Printed Name	Signature Date (mm/dd/yy)

*If not the applicant, I am the ☐ Parent ☐ Holder of Power of Attorney ☐ Legal Guardian (If you are the legal guardian or holder of a power of attorney for the applicant, attach legal documentation.)

DO NOT SEND PAYMENT WITH THIS APPLICATION.

SECTION 11 – AGENT USE ONLY

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

I CERTIFY THAT THE INFORMATION SUPPLIED TO ME BY THE APPLICANT HAS BEEN TRULY AND ACCURATELY RECORDED HERE.

Agent Name (Please print or type)			Agent No.
Agency Name (If applicable)		Telephone Number ( )	
Street Address	City	State	ZIP
Agent's Signature		Date / /	

FOR INTERNAL USE ONLY

LifeWise Health Plan of Oregon
815 SW Bond Street
P.O. Box 7709
Bend, Oregon 97708-7709

Individual Plan Sales: 1-800-290-1278

Customer Service: 1-800-596-3440

www.lifewiseor.com