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.

Application for Individual Insurance

503.243.3973 | 877.277.7073 | www.odscompanies.com

Please print legibly in black or blue ink and mail your completed application to:
The ODS Companies | Attn.: Individual Underwriting | 601 S.W. Second Ave. | Portland, OR 97204-3156

Please complete all sections of this application. If the application is incomplete or additional information is required, your effective date may be delayed. Illegible and incomplete applications will be returned. We must receive your complete submission including premium 10 days prior to the requested effective date. **You MUST include a premium check or bank draft information from a PERSONAL checking account with this completed application for your application to be processed as complete.**

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 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.

Section 1: Type of Application

Effective dates are assigned by ODS on the 1st of the month following approval and acceptance. For consideration of a particular date in the future (not more than 60 days from the date you signed this form), **please indicate date:**_____

A. ❑ New enrollment

B. ❑ Child-only (ages 0-17) complete a separate form for each child on his or her own plan.

C. ❑ Upgrade in coverage

D. ❑ Reinstatement of coverage (If within 60 days of ODS **Individual plan termination**)

E. ❑ Addition of a dependent to an existing policy
- Existing policyholder:_____
- ID# of policy:_____
- Spouse/date of marriage:_____
- Registered Partner*/date of registration:_____
- Newborn/date of birth:_____
- Child or children/date of birth:_____
- Adopted child/date of placement or custody:_____
- Other:_____

*Partner registered per the Oregon Family Fairness Act

Section 2: Select a Plan

You must reside in the state of Oregon and live in Oregon at least six months out of the year in order to be eligible for coverage. In order to be eligible to enroll in the ODS individual **dental** plan, you must enroll in an ODS individual **medical** plan. The only time you can enroll in an ODS individual dental plan is when you first enroll in an ODS individual medical plan.

Beneficial Rx

❑ $1,000*
❑ $2,500
❑ $5,000

Beneficial Value

❑ $1,000 ❑ $2,500
❑ $5,000 ❑ $7,500

Optional Rx Rider:
❑ Yes ❑ No

HSA 3000

Individual:
❑ $3,000

Family:
❑ $6,000

HSA Value

Individual:
❑ $2,800

Family:
❑ $5,600

Maximizer

❑ $1,000 ❑ $2,500 ❑ $5,000

DENTAL PLAN

❑ **YES,** enroll me in the ODS Individual Options Premier Dental Plan. I have read the dental plan benefit summary and rate sheet and understand the coverage available to me. I understand if I lose eligibility in an individual options medical plan, I will not be able to continue my Individual Options Dental Plan.

❑ **YES,** enroll me in the ODS Individual Options Preferred PPO Dental Plan. I have read the dental plan benefit summary and rate sheet and understand the coverage available to me. I understand if I lose eligibility in an individual options medical plan, I will not be able to continue my Individual Options Dental Plan.

❑ **NO,** I do not want the ODS Individual Options Dental Plan. I understand that by declining the dental coverage available to me, the "one-time only" enrollment period will expire and I will not be allowed to enroll in the dental plan at a later date.

** Eligible plan for medical premium subsidy through the Family Health Insurance Assistance Program (FHIAP).*

Section 3: Applicant Information

ODS invites you to use the younger spouse/registered partner as the primary applicant if it would help you to receive a lower premium.

Applicant's Social Security No.	Marital Status ❑ Single ❑ Married ❑ Registered partner	Applicant's Height	Applicant's Weight	Home Telephone No.

Applicant's Last Name	First Name	Middle	Gender ❑ Female ❑ Male	Date of Birth	Age	Business Telephone No.

Residence Address	Street	City	State	ZIP Code (+4)

Mailing Address *(if different from residence)*	Street/P.O. Box	City	State	ZIP Code (+4)

E-mail address

LIST ALL FAMILY MEMBERS TO BE COVERED (Dependent children unmarried/not registered as a partner and under 23 years old.)

Last Name of Family Member	First Name	Height	Weight	Gender	Age	Date of Birth	Social Security No.
Spouse/Registered Partner							
Child							
Child							
Child							

Explain relationship to the applicant for any member listed above whose last name is different from the applicant:

Attach additional page if necessary to list other family members to be included on this application.

Section 4: Insurance History

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

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

Please indicate the reason for declination by the insurance company and the date the declination occurred: _____

_____

Do you or any family members have other active health or medical coverage, Medicare, Medicare Advantage or Medicare supplemental coverage? ❑ Yes ❑ No

If yes, name of insurance company: _____

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

Have you had coverage with ODS within the past five years? ❑ Yes ❑ No

If yes, please indicate ID number, group number and name of policyholder insured: _____
As part of the underwriting review, I understand that ODS will review any claims history for the last five years from my prior ODS coverage.

Do you or any family members work for an employer who offers health benefits to employees? ❑ Yes ❑ No

Are you or any family members enrolled? ❑ Yes ❑ No

If no, why? _____

Section 5: Health History Statement

Please mark "yes" or "no" for each item between questions 1 and 53e (for you and any family members requesting coverage). **You must provide details on page 5, under Section 6: Health Statement, to any questions you answer with "yes" between questions 1 and 53e.**

Within the past 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 healthcare professional, or had any illness, ailment, injury, health problem, symptoms, physical impairment, surgery or hospital confinement related to any of the following conditions? (For the purpose of these questions, chronic means persistent, continuous or periodic, or a combination of any of these terms.)

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

Section 5: Health History Statement *(continued)*

49. Has any person on this application used tobacco products in any form within the past five years? ❑ Yes ❑ No

Name: _____ Type of product: _____
Name: _____ Type of product: _____
Name: _____ Type of product: _____

50. Please provide the following information for each **female** on this application: (details on page 5)

Family member's name:				
a. Initial menstrual cycle begun?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
b. Date of last menstrual period: (mm/dd/yy)				
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 the answer to **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

Please mark "yes" or "no" for each item below for questions 51 through 53e and give details to any "yes" answers on page 5.

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. You must provide details on page 5 to any questions you answer with "yes" between questions 53a and 53e.

Within the past 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 healthcare professional, or had any illness, ailment, injury, health problem, symptoms, physical impairment, surgery or hospital confinement not already indicated on this application? ❑ Yes ❑ No
If yes, please indicate question 53a on page 5 and explain.

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 healthcare 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 of applicant	Medication	Prescribed by (Dr.'s name/address/phone)	Date prescribed

Section 6: Health Statement

You **must** provide specific details below to any question answered "yes" on pages 3 and 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 healthcare provider or clinic/hospital. You may attach a separate sheet of paper if necessary.

Name	**Question Number**	**Start to End Dates**	**Condition** (specific illness or injury)	**Treatment** (including medications)	**Final Result, Ongoing or Resolved** (circle one)	**Attending Physician/Healthcare Provider/Hospital**
					O/R	
					O/R	
					O/R	
					O/R	
					O/R	
					O/R	

You **must** list a name, address and telephone number of a medical provider with current medical records/history for each family member to be covered:

	Name	**Primary Provider's Name**	**Location**
Primary Applicant			
Spouse/Registered Partner			
Child			
Child			
Child			

Section 7: Waivers and Downgrades

Would you accept waivers on pre-existing conditions? ❑ Yes ❑ No

(Waiver: Waiving [excluding] from coverage for a maximum of 24 months one or more pre-existing conditions identified by the insurance carrier. A waiver is offered less frequently than a downgrade offer.)

Would you accept a downgrade? ❑ Yes ❑ No

(Downgrade: Insurance carrier may limit the individual health benefit plans in which the individual may elect to enroll because of one or more pre-existing conditions.)

Waivers and downgrades are determined on a case by case basis, and are not guaranteed to be offered in all situations. If you receive a waiver or downgrade offer, you must sign and return the amendment to put the policy into force indicating your acceptance based on the terms stipulated by the offer. A waiver or downgrade cannot be issued to a FHIAP applicant.

Section 8: Prior Coverage Credit

If you have had prior health coverage and you are applying within 63 days of prior coverage termination, you may be eligible for credit toward any pre-existing condition limitation applicable under our plan. Note: Effective date must be within 63 days of end of prior plan.

PRIOR COVERAGE INFORMATION: ATTACH A COPY OF PRIOR PLAN ID CARD OR CERTIFICATE OF CREDITABLE COVERAGE.

Insurance Company	**Policy No./Identification No.**	
Employer Name	**Effective Date of Coverage**	**Termination of Coverage**
List any coverage before this (if above coverage was in force less than six months)		

Do you have 12 months of prior dental insurance with no more than a 90-day break in coverage? ❑ Yes ❑ No

If yes, please provide the following:

1. Name of individual enrolled in prior plan: _____

OR

2. Carrier name: _____
   Carrier telephone number: _____

   Effective: ___/___/___ Termed: ___/___/___

3. Copy of prior dental plan ID card, front and back.

Section 9: Agent of Record Section (To be completed by agent only)

I (the agent) 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 ODS, and provided Oregon Disclosure Information required.

In order for you to become the Agent of Record, you must be actively appointed with ODS. Please sign and date below.

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

Agent Name: _____

Agency Name: _____ Phone No.: _____

Street Address: _____ City: _____ State: _____ ZIP: _____

I affirm all health information provided to me has been accurately reflected on this application I disclose to ODS.

Agent's Signature (required): _____ **Date:** _____

NOTE TO AGENT: COLLECT PREMIUM WITH APPLICATION.

Section 10: Authorization Section

Be sure to sign and date the application below. A spouse's or registered partner's signature is required if applicable. The signature applies to both "Certification of Completeness and Correctness" and "Conditional Authorization to Use/Disclose Protected Health Information":

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 ODS to enroll in its insurance coverage. I understand that if this application contains any material misstatements or omissions, ODS may, within the first two years of coverage, deny coverage, modify or cancel the contract, or take other legal action. I will promptly inform ODS 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 ODS. If approved, coverage will be in force as of the effective date determined by ODS. ODS 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.

MUST LIST EACH APPLICANT FOR COVERAGE, INCLUDING DEPENDENTS (please print):

(If additional space for more dependents is needed, please copy and attach another page 7 to list others.)

CONDITIONAL AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION	
Applicant:	Social Security No.:
Applicant:	Social Security No.:
Applicant:	Social Security No.:
Applicant:	Social Security No.:

I (We) authorize any physician, healthcare provider, hospital, insurance or reinsurance company to use and disclose a copy of my protected health information to ODS Health Plan, Inc. for the purpose of enrollment determination or eligibility, claim payments and policy underwriting.

My protected health information includes medical records, emergency and urgent care records, billing statements, diagnostic imaging reports, transcribed hospital reports, clinical office chart notes, laboratory reports, dental records, pathology reports, physical therapy records, hospital records (including nursing records and progress notes), including records concerning alcohol and/or chemical dependency, reproductive health (including abortion), sexually transmitted diseases, HIV, AIDS, psychiatric disorders, mental illness and any other personal or medical information related to the purpose of this authorization. Information obtained with this authorization will be used for the purpose defined above and will be limited to the minimum necessary information to achieve that purpose.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected under federal law. I have the right to revoke this authorization in writing at any time. If I revoke this authorization, the information described above will no longer be used or disclosed for the reasons covered by this written authorization. Any uses or disclosures already made with my permission cannot be taken back. Unless revoked, this authorization shall be in force and effect for 24 months from the date of the signature below.

To revoke this authorization, please send a written statement to ODS Health Plan, Inc., Privacy Office, 601 S.W. Second Ave., Portland, OR 97204 and state that you are revoking 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 and decline to provide benefits and payment for treatment.

I (We) have reviewed and I (we) understand this authorization.

By: _____ Date: _____

(signature of applicant/policyholder) Note: Policyholder must sign to add spouse, registered partner or child to policy.

By: _____ Date: _____

(signature of spouse/registered partner, if applying for coverage)

By: _____ Date: _____

(Signature of child age 18 or older, if applying for coverage. Attach additional page for signature(s) of other dependents over 18, if necessary.)

By: _____ Date: _____

(signature of minor's representative for any applicant under age 18)

Please indicate relationship to minor: ❑ Parent ❑ Legal guardian* ❑ Holder of Power of Attorney*

* Please attach legal documentation if you are the legal guardian or Holder of Power of Attorney.

Section 11: Billing Information

Please indicate your billing choice.* If you request Auto Pay or draft of the initial premium, please complete the Auto Pay Authorization Agreement and attach a voided check from the account to be drafted.

❑ **AUTO PAY (EFT)**

Save time and paper by having funds transfer automatically around the fifth calendar day of each month. Please attach a photocopy of a voided check from the personal account to be drafted. The initial premium will be deducted via Auto Pay. If you prefer, you may attach a personal check for your first month's premium.

❑ **MONTHLY BILLING STATEMENT**

A $5.00 monthly administration fee is required with this payment method. Please attach a personal check for one month's premium. You will receive a bill every month.

❑ Please indicate here if you would like ODS to draft the initial monthly premium and begin monthly billing statements for subsequent billings.

❑ **QUARTERLY BILLING (EVERY THREE MONTHS)**

A $5.00 quarterly administration fee is required with this payment method. Please attach a personal check for three months' premium. You will receive a bill every three months.

❑ Please indicate here if you would like ODS to draft the initial quarterly premium and begin quarterly billing statements for subsequent billings.

❑ **FAMILY HEALTH INSURANCE ASSISTANCE PROGRAM (FHIAP) APPLICANTS**

You do not need to include a premium, but you must submit a signed copy of your FHIAP Certificate of Eligibility with your application.

**If no billing option is selected, then you are agreeing, by default, to a monthly billing statement with a $5.00 monthly administration fee.*

BILLING WORKSHEET

Billing Option		**MONTHLY**	**QUARTERLY**
Medical plan monthly premium		$_____	$_____
Rx rider (if applicable)	+	$_____	$_____
Dental plan monthly premium	+	$_____	$_____
Total due to ODS	=	$_____	$_____
		(If monthly EFT was chosen, please attach a voided check and fill out the section below.)	*(Multiply times three; do not fill out section below.)*

AUTO PAY AUTHORIZATION AGREEMENT

Instructions:

1. Complete and sign below as account holder for monthly automatic bank deduction of insurance premium.
2. Attach a photocopy of your "voided" personal check from the account to be drafted.
3. Submit the completed application and appropriate documents with your application.

Applicant: _____ Account Holder: _____

I (or we, if this is a joint account) authorize ODS to charge my (our) checking account for monthly insurance premiums for the above named individual. I also authorize my bank named here to honor these monthly charges. This authority will remain in effect until I give my bank a reasonable chance to act upon it. I can stop payment by notifying my bank before my account has been charged.

Name of bank: _____

Signature of Account Holder: _____ Date:_____

You may be billed for the premium payment necessary to begin electronic deductions. If you wish to cancel your bank deductions, we must receive written notice 15 days before the next deduction date.

Please make checks payable to ODS.

***Individual benefit plans are not intended for sale as an employer-sponsored health benefit for employees. For this reason, an individual policy cannot be paid with a business check and must be drawn on personal accounts not affiliated with a business. For information on small employer health benefit plans, contact the ODS Marketing Department at 503-243-3948 or 800-578-1402.**

NOTE: Sending in a check does not guarantee coverage. The first month or quarterly premium amount will not be credited to your account until your application for individual health insurance coverage has been approved by ODS Underwriting. You will be notified in writing of your application status no later than 60 days from receipt. If your application is approved, the coverage effective date will be the first day of the month following approval. If your application is not approved, you will be notified in writing and your check will be returned to you. ODS may change or amend the policy or premiums, upon approval by the Oregon Insurance Division, by giving a 30-day notice before the change is effective.