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.

PacificSource Elect Policy Application

PO Box 7068
Eugene, Oregon 97401
(866) 695-8684 ● (541) 684-5442
Fax (541) 225-3646
individual@pacificsource.com

SECTION 1 – INSTRUCTIONS

- Please read carefully.
- Please type or print neatly in ink and sign this application.
- Make sure all sections of the application are answered completely. Please be advised that incomplete applications or requests for medical records may cause a delay in the processing of your application.
- If you need assistance completing this application, please contact your insurance agent or call our Individual Sales department at (541) 684-5442, or toll-free at (866) 695-8684.

SECTION 2 – PLAN SELECTION

This application is *(check one):*

☐ For new coverage for myself and my eligible family member(s) listed below.
☐ To change my existing coverage in a PacificSource Elect plan. Current policy ID # ____________
☐ To add eligible family members to my existing PacificSource Elect plan. Current policy ID # ____________
Reason for addition: ____________ Date: ____________
☐ For my dependent child(ren) only. Complete a separate form for each child on his or her own plan. If on a separate plan, dependent children age 18 or older must complete their own application.

Choose a plan and a deductible:

Elect Premiere	Elect Preferred	Elect Value Option	Elect FlexPerks
☐ $ 500 deductible	☐ $ 500 deductible	☐ $ 2,500 deductible	☐ $1,500 deductible
☐ $ 750 deductible	☐ $ 750 deductible	☐ $ 5,000 deductible	☐ $2,000 deductible
☐ $1,000 deductible	☐ $1,000 deductible	☐ $ 7,500 deductible	☐ $3,000 deductible
☐ $2,500 deductible	☐ $2,500 deductible	☐ $10,000 deductible	☐ $5,000 deductible
☐ $5,000 deductible	☐ $5,000 deductible		
☐ $7,500 deductible	☐ $7,500 deductible		
☐ $10,000 deductible	☐ $10,000 deductible		
☐ Optional alcoholism coverage	☐ Optional alcoholism coverage	☐ Optional alcoholism coverage	☐ Optional alcoholism coverage

Requested effective date: (no more than 60 days after the signature date) ❑ **1st** ❑ **15th** ____________**Month/Year**

Will your employer pay any portion of your premium? ☐ **Yes** ☐ **No** *PacificSource individual policies may not be used for an employer-based plan. If the employer pays or reimburses any part of the premium or if the health plan is treated as part of a plan or program for the purposes of section 106 or 162 of the Internal Revenue Code of 1986. PacificSource does not accept premium payment from employers for individual policies.*

I would consider an alternative plan offering if I am not approved for the deductible that I requested? ☐ **Yes** ☐ **No**

SECTION 3 – APPLICANT INFORMATION

Last Name	First Name	Middle Initial	
Social Security Number	Sex ❑ Male ❑ Female	Birth Date (mo/day/year)	
Marital Status ❑ Single ❑ Married ❑ Registered Domestic Partnership ❑ Unregistered Domestic Partnership*		Height	Weight
Mailing Address (Street or PO box)	City	Zip	County
Home Address (if different)	City	Zip	County
E-mail Address	Home Phone		

List all family members to be insured. Only your legal spouse, domestic partner, and dependent children are eligible.

Last Name	First name, middle initial	Height	Weight	Sex	Birth Date	Social Security No.
Spouse/Domestic Partner*						
Child						
Child						
Child						
Child						
Child						

Explain the relationship to you of any person listed above whose last name is different from yours. If spouse, attach copy of marriage certificate. If registered domestic partner, attach copy of certificate of domestic partnership. If guardian, attach copy of documentation:____

For all dependent children age 19 or older, please provide full-time student information, including the name and location of the institution and the number of credit hours taken: ____

If you or any other person listed on this application are not approved for coverage, do you want a policy issued for those who are approved for coverage? ☐ Yes ☐ No

* Unregistered domestic partners must submit an Affidavit of Domestic Partnership with this application.

SECTION 4 – OTHER INSURANCE INFORMATION

Do you or any family members have other active health or medical coverage, Medicare, Medicare Advantage, or Medicare supplement coverage? ☐ Yes ☐ No. If yes, provide insurance company's name in the box below.

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?____

If anyone listed on this application has had health coverage through PacificSource within the last five years, list their name and PacificSource ID number or social security number: ____

____

How did you hear about PacificSource? ☐ Insurance Agent ☐ Mailing ☐ TV ☐ Web site ☐ Other ______________

The policy's exclusion periods for pre-existing conditions and specified conditions may be reduced if you or a family member had creditable coverage to within 63 days of the effective date of this policy. To reduce the exclusion periods, you must demonstrate creditable coverage. You may do that by attaching a Certificate of Coverage issued by the prior insurance company or group policyholder, or by presenting evidence of creditable coverage through other documents, records, third party statements, or other means. If you are currently covered under another health policy, or are requesting credit toward the exclusion periods for prior coverage, please complete the following:

List current or prior insurance coverage here:		
Names of individuals covered under a current or prior policy:		
Name and address of other insurance company (include phone no. if available):		
Effective dates of coverage: From_________To ___________	Policy no.:	If group insurance, name of group policyholder:

SECTION 5 – OREGON STANDARD HEALTH STATEMENT

***Notice to Applicant:** You are not required to disclose any information on any part of this application about genetic testing or genetic information relating to you or to any blood relative. You are not required to disclose any decision by any insurance company that is based on a genetic test or on genetic information. The Oregon Standard Health Statement that follows does not ask for information regarding genetic testing or genetic information, but only about conditions for which anyone has received medical advice, diagnosis, care, or treatment.*

Please mark either "Yes" or "No" for each item (for you and any family members requesting coverage). Provide details on page 4 to any questions answered "Yes." **(For the purpose of these questions, *chronic* means persistent, continuous, or periodic, or a combination of any of these terms.)**

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

1. AIDS, ARC, HIV positive ☐Yes ☐No
2. Alcohol/chemical/drug abuse/habit ☐Yes ☐No
3. Anemia/chronic fatigue ☐Yes ☐No
4. Appendicitis/chronic abdominal pain ☐Yes ☐No
5. Back/neck/spine ☐Yes ☐No
6. Birth defect/congenital deformities ☐Yes ☐No
7. Bladder/urinary tract ☐Yes ☐No
8. Blood/circulatory ☐Yes ☐No
9. Bone/orthopedic ☐Yes ☐No
10. Brain disease or injury/concussion ☐Yes ☐No
11. Breast (lumps or masses) ☐Yes ☐No
12. Cancer ☐Yes ☐No
13. Chemotherapy/radiation treatment ☐Yes ☐No
14. a. Colon/rectum/intestine/bowel ☐Yes ☐No
    b. Blood in stool ☐Yes ☐No
15. Convulsion/seizures/epilepsy ☐Yes ☐No
16. Diabetes/sugar in urine ☐Yes ☐No
17. Chronic ear/nose/throat/tonsil condition/disease/disorder ☐Yes ☐No
18. Eating disorders such as, but not limited to, anorexia or bulimia ☐Yes ☐No
19. Emphysema/asthma/chronic lung disease (COPD) ☐Yes ☐No
20. Endocrine/gland/hormone system ☐Yes ☐No
21. Disease or injury of eye/ cataract/glaucoma ☐Yes ☐No
22. Gallbladder/pancreatic disease ☐Yes ☐No
23. Chronic headaches/migraines ☐Yes ☐No
24. Heart/chest pain/angina ☐Yes ☐No
25. Hernia ☐Yes ☐No
26. High cholesterol (if "Yes," record last reading on page 4) ☐Yes ☐No
27. High blood pressure (if "Yes," record last reading on page 4) ☐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 five years (if "Yes," record date of last session on page 4) ☐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 diseases ☐Yes ☐No
41. Skin condition, abnormal or cancerous moles, or eczema/cysts/cancer ☐Yes ☐No
42. Sleep apnea/chronic sleep disorder ☐Yes ☐No
43. Stomach disorders/ulcer/acid reflux ☐Yes ☐No
44. Stroke/paralysis/seizures ☐Yes ☐No
45. Tumors ☐Yes ☐No
46. TMJ/jaw joint ☐Yes ☐No
47. Weight fluctuation (+/- 20 lbs.) ☐Yes ☐No
48. Cosmetic surgery/implants, use of prosthetic devices/limbs ☐Yes ☐No

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

Name: ____________________ Type of product: ____________________

Name: ____________________ Type of product: ____________________

Name: ____________________ Type of product: ____________________

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

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

51. Is any person on this application now pregnant? .... ☐Yes ☐No

If yes: Name: ____________________ Due Date: ____________________

52. Is any person on this application, including male applicants and dependent males or females, 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 medication, recommended or received from a licensed healthcare 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 healthcare provider (at a future date)? .... ☐Yes ☐No

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

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

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

Please provide specific details below to each question answered "Yes" on pages 2 and 3. 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.

Health History Details:

Please provide details below to any questions answered "Yes" on pages 2 through 4:

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

Health History Details, continued:						
Name	Question number	Start to end dates	Condition	Treatment **Including Medications**	Final result	Attending physician/healthcare provider or hospital (name/address/telephone)
					☐ Ongoing ☐ Resolved	
					☐ Ongoing ☐ Resolved	

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

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

____

____

____

SECTION 6 – CERTIFICATION AND DECLARATION

Be sure to sign and date the application on the following page. Your spouse's or domestic partner's signature is also required if applicable. Your signature applies to both the "Certification of Completeness and Correctness" and "Authorization for Release of Information."

Certification of Completeness and Correctness

I affirm that the answers given in this application are complete and correct. I am providing these answers as part of the application procedure required by PacificSource to enroll in their insurance coverage. I understand that if this application contains any material misstatements or omissions, PacificSource 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 PacificSource in writing if anything happens before my coverage takes effect that makes this application incomplete or incorrect. I understand and agree that no coverage will be in force until approved by PacificSource. If approved, coverage will be in force as of the effective date determined by PacificSource. A representative of PacificSource may phone me to clarify answers on this application. Representations made by the applicant are deemed to be representations made on behalf of each person covered under this policy. However, changes to the application will not be effective until approved in writing by the applicant. An application received by PacificSource requiring alterations will be modified by amendment and sent to the applicant for signature. As the applicant, I understand I have the right to inspect the information in my file.

SECTION 7 – CONDITIONAL AUTHORIZATION TO USE/ DISCLOSE PROTECTED HEALTH INFORMATION

Names of all applicants: ____

ID# or Social Security #: ____

I (We) authorize any physician, healthcare provider, hospital, insurance or reinsurance company, or the Medical Information Bureau, Inc., to use and disclose a copy of my protected health information to PacificSource Health Plans, PO Box 7068, Eugene, Oregon 97401 for the purpose of enrollment determination or eligibility 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), and any personal or medical information related to the purpose of this authorization. Information obtained with this authorization will be used solely for the purpose defined above and will be limited to the minimum necessary information needed to achieve that purpose.

If the information to be disclosed contains any of the types of records or information listed immediately below, additional laws relating to use and disclosure of the information may apply. I (We) understand and agree that such information will be disclosed if I place my initials in the applicable space next to the type of information to be included with the disclosure:

________ HIV/AIDS test or result information and related records

________ Mental health information

________ Genetic testing information

________ Drug/alcohol diagnosis, treatment, or referral information

I understand I have the right to refuse to sign this authorization. My refusal to sign this authorization could affect my enrollment in a health plan, eligibility for health benefits, and claims payment.

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 except to the extent that action has been taken in reliance on this authorization. Any uses or disclosures already made with my permission cannot be taken back. I understand that revocation of this authorization could affect my enrollment in a health plan, eligibility for benefits, and payment of claims.

To revoke this authorization, please send a written statement to PacificSource Health Plans, Compliance Department, PO Box 7068, Eugene, Oregon 97401, and state that you are revoking this authorization.

I (We) understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I (we) also understand that federal or state law may restrict re-disclosure of HIV/AIDS test or result information, mental health information, genetic information, and drug/alcohol diagnosis, treatment, or referral information.

Unless revoked, this authorization shall be in force for the purpose of enrollment or eligibility determination or policy underwriting for a period not to exceed 24 months. Once an enrollment or eligibility determination has been made, this authorization to use or disclose this protected health information expires.

Each of us authorize you, on behalf of ourselves and the listed family members, to give medical information (including alcohol, chemical dependency, mental treatment, or HIV treatment) you have about us to PacificSource or its representatives.

An insurer offering an insurance contract accepts significant financial risk. Complete information is necessary concerning all health conditions, however minor, to determine whether coverage will be offered. The questions on the application are intended to reveal any and all significant health conditions. Please take the time to give complete and accurate responses, as the insurer may rely solely upon your answers. Any material mistake could completely invalidate (void) the policy at any time within the next two years, even after claims are approved and paid.

I (We) have reviewed and I (we) understand this authorization and the “Certification of Correctness” above.

Applicant’s Signature ________________ Date ________

Spouse’s/Domestic Partner’s Signature (if applying for coverage) ________________ Date ________

Signature of child age 18 or over (if applying for coverage) ________________ Date ________

Required if applicant is a minor:

Signature of (check one) ☐ *Parent* ☐ *Guardian* ________________ *Date* ________

Printed Name of Parent or Guardian ________________

This application must be signed and dated no more than 60 days prior to the requested effective date.

All fields must be completed for this authorization to be valid.

If approved, PacificSource will provide the policyholder with a copy of this completed form with the policy.

SECTION 8 – PRODUCER AUTHORIZATION

I, the insurance producer, have not made any representations to the applicant about any provisions, benefits, conditions, or limitations of the policy except through written material furnished by PacificSource. The applicant has been informed that the effective date of coverage is assigned only by PacificSource. **I hereby certify that information supplied to me by the applicant has been truly and accurately recorded hereon.**

Century Benefits

Producer’s Name (printed) ________________ PacificSource Producer Number ________

Producer’s Signature ________________ Date ________

Office Use Only

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION

Thank you for choosing to pay your PacificSource individual policy premium by electronic funds transfer (EFT). We think you will appreciate the convenience and security of this payment option.

- New EFTs take 30 days to set up. New policies may require the initial premium payment before the EFT takes effect.
- Once your EFT is set up, you will receive a letter notifying you of the date your first premium transfers. Until then, you must make any premium payments by check or your account will become past due and your policy could be subject to termination. On occasion, the second month's premium may become due before the first transfer occurs.
- Transfers will be made for the premium balance due. If your premium is past due when your EFT begins, your first withdrawal will include your current premium as well as the outstanding amount.
- Transfers occur on the 5th of each month. If the 5th falls on a weekend or a holiday, the transfer will occur on the next business day.
- PacificSource must receive your EFT changes and cancellations in writing at least ten business days before the transfer date.
- If you have any questions, you are welcome to contact our Membership Services Department at (541) 225-1988, or toll-free at (800) 591-6579, or by e-mail at membership@pacificsource.com.

INSTRUCTIONS

- Complete the form below.
- Attach a voided check.
- Return the above to: PacificSource Health Plans, Attn: Membership Services, PO Box 7068, Eugene, OR 97401.

AUTHORIZATION

We authorize and direct PacificSource Health Plans to withdraw funds as follows:

Amount of monthly withdrawal: $___________ *Withdrawals will occur on the 5th of each month.*

Select one: ☐ Begin transfers on the next available date ☐ Delay transfers until ___________(month)

Bank information:

Bank name: ____________________________________ Account number: _________________________

Account Type: ☐ Checking–*attach a voided check* ☐ Savings–*attach a voided savings withdrawal slip*

This authorization will remain in effect until termination by either party. If the individual policy premium changes due to a rate increase, alternate plan selection, or age migration of the policyholder, this authorization will automatically be amended to authorize withdrawal of an amount equal to the new premium.

_________________________________ Policyholder's Name (please print)

_________________________________ Signature of Bank Account Holder

_________________________________ Policyholder's ID No. or Social Security No.

_________________________________ Date