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 Application for Individual & Family Insurance

PROVIDENCE Health Plan

www.providence.org/healthplans • 503-574-5000 • 1-800-988-0088

Thank you for choosing Providence Health Plan (PHP) for your individual health insurance coverage. You can also apply on our Web site at **www.providence.org/healthplans.** Please see the Providence Individual and Family Plan Overview or our Web site for additional information about your health plan choices and premium information.

Application instructions

- Please PRINT clearly in black or blue ink and mail completed application and any necessary documentation to:
  Providence Health Plan, P.O. Box 4649, Portland, OR 97208-4649
- Do **not** include payment with this application.
- **Complete all sections of this application**, including your requested effective date (Page 2) and home address and phone number (Page 3). If the application is incomplete or additional information is required, your effective date may be delayed.
- If you are requesting coverage for your dependent(s) only (age 0-17), **complete a separate application for each dependent**.
- If you are making any changes to your existing coverage, other than adding a newborn or adopted child, you will need to complete and submit **all sections** of this application.
- **Please note:** You will be notified by mail regarding the status of your application.
- If you need assistance, please contact your agent or call the Providence Health Plan Sales Team at 503-574-5000 or 1-800-988-0088. TTY (for hearing impaired) 503-574-8702 or 1-888-244-6642.

How did you hear about Providence Health Plan?

☐ Friend/Family ☐ Direct Mail ☐ Internet ☐ TV ☐ Radio ☐ Newspaper ☐ Agent ☐ Other: _____

For agent use only (all fields are required)

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 Providence Health Plan. I have informed the applicant that the effective date of coverage is assigned only by Providence Health Plan and provided the Oregon Disclosure Information required. I certify that the information supplied to me by the applicant has been truly and accurately recorded here.

Agent Name	Agency Name	Date
Andrew Eachon	Century Benefits	

PHP Agent Number	Agent E-mail	Phone Number	FAX Number
169088	andrewe@centurybenefits.com	(503 928 3321	( )

Street Address	City, State, Zip Code

Agent Signature

X _____

For Office Use Only:

W/I or S/M (circle): rcvd: ___/___/___**;** time: _____; rcvd by:____; complete?: ☐y ☐n; item:_____; call'd clnt /agt:1x___/___/___, ☐h ☐w ;
2x:___/___/___, ☐h ☐w ; retrnd:___/___/___, reas:_____ ; snt UW:___/___/___;

UW: rcvd: ___/___/___**;** time_____; Ix entrd: ___/___/___; recds req?: ☐y ☐n; date req:___/___/___; date rcvd:___/___/___; decis:_____, rendered:___/___/___;

Step 1: Type of Application

New coverage:	or	Change to existing coverage:

☐ **For myself only**
You must be at least age 18 and reside in our Service Area. Once enrolled, you, the applicant, will become the policyholder.

☐ **For myself and my family**
*Family includes you, your spouse or domestic partner** and dependent children ages 0-22. You and your spouse or domestic partner must reside in our Service Area. Once enrolled, you will become the policyholder.*

☐ **For my dependent only** (age 0-17)
To apply for a dependent only, you must be at least age 18 and parent or legal guardian of the dependent. Once enrolled, you will become the policyholder. The dependent must reside in our Service Area. Please complete a separate application for each dependent.

Current Policyholder name: _____
Current Policyholder ID number: _____

☐ Add **spouse**
☐ Add **domestic partner****
☐ Add **dependent** (age 0-22)
☐ Add **adult to a dependent-only policy**
Complete all sections of this application.

_____

☐ Add **newborn*** *(within 60 days of birth)*
date of birth: ____/____/_____
☐ Add **adopted child*** *(within 60 days of placement)*
date of placement: ____/____/_____
**** If you are adding a newborn or adopted child, please complete ONLY Step 1, Step 4 and Step 7.***

**A Domestic Partner must be a member of the applicant's same sex, at least 18 years of age and must have legally registered a Declaration of Domestic Partnership and obtained a Certificate of Registered Domestic Partnership in accordance with Oregon state law.

Step 2: Choose your effective date

Request your effective date of coverage: 1st ☐ or 15th ☐ of Month _____ Year _____

You must choose either the first or the fifteenth of the month for an effective date. Your effective date must be no more than 70 days after the signature date on this application. If for any reason there is a delay in the application process, Providence Health Plan will move your requested effective date forward to the next available date.

Step 3: Select a plan

For new applicants only. Please select **one** Providence Individual and Family Plan (See the Providence Individual and Family Plan Overview for detailed plan information and rate sheet.)

Check one	Providence Individual & Family Plans	In-Plan Copayment/ Coinsurance	Out-of-Plan Coinsurance	Deductible Individual / Family	Out-of-Pocket Maximum Individual / Family
☐	**Optimum 500***	$20/20%	40%	$500 / $1,500	$2,500 / $7,500
☐	**Optimum 1000***	$20/20%	40%	$1,000 / $3,000	$2,500 / $7,500
☐	**Optimum 2500**	$20/20%	40%	$2,500 / $7,500	$2,500 / $7,500
☐	**Optimum 5000**	$20/20%	40%	$5,000 / $15,000	$2,500 / $7,500
☐	**Optimum 10,000**	$20/20%	40%	$10,000 / $30,000	$2,500 / $7,500
☐	**Value 500***	$20/30%	50%	$500 / $1,500	$4,000 / $12,000
☐	**Value 1000**	$20/30%	50%	$1,000 / $3,000	$4,500 / $13,500
☐	**Value 2500**	$20/30%	50%	$2,500 / $7,500	$5,500 / $16,500
☐	**Value 5000**	$20/30%	50%	$5,000 / $15,000	$8,500 / $25,500
☐	**Value 7500**	$20/30%	50%	$7,500 / $22,500	$11,000 / $33,000
☐	**Prime 10,000**	50%	Not covered	$10,000 / $30,000	$7,500 / $22,500
☐	**HSA 2500**	$20/20%	40%	$2,500 / $5,000	$5,000 / $10,000
☐	**HSA 3500**	$20/20%	40%	$3,500 / $7,000	$5,250 / $10,500

*FHIAP eligible plans. FHIAP helps uninsured individuals and families pay for health insurance by providing subsidies of up to 95% of the monthly premium. For more information, call FHIAP at 1-888-564-9669, or visit www.fhiap.oregon.gov

Step 4: Enroll for coverage

- Please PRINT CLEARLY and provide complete information. Incomplete information may delay your effective date.

List all Individual or Family Member(s) Applying for Coverage

(Please include full, legal names. If applying for Dependent-only coverage, start at line 3)

Last Name	First Name, Middle Initial	Gender	Height	Weight	Age	Date of Birth (Mo-Day-Yr)	Last 4 Digits of Social Security Number	Residence Zip Code
1. Applicant		☐ Male ☐ Female				/ /		
2. Spouse ☐ or Domestic Partner ☐ *(check one)*		☐ Male ☐ Female				/ /		
3. Dependent Child		☐ Male ☐ Female				/ /		
4. Dependent Child		☐ Male ☐ Female				/ /		
5. Dependent Child		☐ Male ☐ Female				/ /		

Please explain your relationship to any person listed above whose last name is different than yours:

✦ *If you have additional family members to be enrolled, please include them on a separate sheet with this application.*

Applicant or Dependent-only Information

Last Name	**First Name**			**Middle Initial**
Home Address (No Post Office Box)	City	State	Zip Code	County
Mailing Address (if different from Home Address)	City	State	Zip Code	County
Billing Address (if different from Mailing Address)	City	State	Zip Code	County
Home Phone Number / Work Phone/Other Phone Number	E-mail Address			

Policyholder Information for Dependent-only coverage

(If you are applying for Dependent-only coverage, you must fill out the Policyholder information below. The Policyholder is the person who will hold the Individual contract.)

Policyholder Relationship to Dependent					
Policyholder Last Name	Policyholder First Name				Middle Initial
Mailing Address 1	Mailing Address 2	City	State	Zip Code	County
Home Phone Number / Work Phone/Other Phone Number	E-mail Address				

Step 5: Other Insurance Information

1. Have you or any family members listed on this application had Providence Health Plan coverage in the **last five years**?
   ☐ **Yes** ☐ **No**
   1a. If **Yes**, list Member I.D. number(s): _____

2. Do you or any family members listed on this application have current health or medical coverage, such as an Employer Group plan (other than Providence Health Plan), Medicare, Social Security Disability, Tricare or other?
   ☐ **Yes** ☐ **No**
   2a. If **Yes**, list name of insurance company: _____ Policy Number: _____
   Effective date of current medical coverage: __ **/** ___ **/** ___ Termination date of current medical coverage: __ **/** ___ **/** ___

3. Within the **last five years**, has anyone listed on this application been refused health insurance for health reasons?
   ☐ **Yes** ☐ **No**
   3a. If **Yes**, please list below and provide additional details on reason for denial on page 7:

   Name: _____ Insurance Company: _____ Reason for denial: _____

   Name: _____ Insurance Company: _____ Reason for denial: _____

   Name: _____ Insurance Company: _____ Reason for denial: _____

   Name: _____ Insurance Company: _____ Reason for denial: _____

Creditable Coverage

If you have had prior health insurance 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.

4. Do you or any family members listed on this application have a Certificate of Creditable Coverage?
   ☐ **Yes** ☐ **No**
   4a. If **Yes**, please complete the Other Insurance Coverage information below and attach a copy of your **Certificate of Creditable Coverage** with this application.

Other Insurance Coverage		
Insurance Company (Full Name)	Insurance Company Phone Number	
Address of Insurance Company		
Type of Insurance coverage: □ Employer Group □ Individual □ Medicare □ S.S. Disability □ Portability □ Other: (Please list):_____		
Policy and /or Member I.D. number(s) #1_____ #2_____ #3_____		
Name of Insured Family Member(s)	Date coverage started	Date coverage ends
#1_____	_____	_____
#2_____	_____	_____
#3_____	_____	_____

✦ *If you have additional "Other Insurance Coverage Information," please include on a separate sheet with this application.*

Step 6: Health Statement

Oregon Standard Health Statement

(Standard Form per ORS 743.766)

Please mark "Yes" or "No" for every question (for you and any family members requesting coverage). Provide details on page 7 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 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
14. 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 (includes Thyroid) ☐ 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 test result:____/ ____) ☐ Yes ☐ No
27. High blood pressure (If "**Yes**," record last test result:____/____) ☐ 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
32. b. Therapy/counseling within last 5 years (If "**Yes**," record date of last session: ____/____/_____) ☐ 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
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

Oregon Standard Health Statement, (cont)

(Standard Form per ORS 743.766)

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:				
f. Date of last DEPO Provera shot?	____ /____ /____	____ /____ /____	____ /____ /____	____ /____ /____
g. Abnormal Pap smears? (in past 5 years)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
h. Prior Cesarean section or miscarriage? (in past 5 years)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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

If **Yes**, name _____ Due date ____/_____/_____.

52. Is any person on this application, including male applicants and dependent males or females, responsible for a current pregnancy? ☐ Yes ☐ No

If **Yes**, name _____ Due date ____/_____/_____.

53. Please provide the following information for each person on this application. **Within the last five years**, has any person on this application:

a. Had any medical advice, diagnosis, care, or treatment, including prescribed medications, recommended or received from a licensed health care professional, or had any illness, ailment, injury, health problem, symptoms, physical impairment, surgery or hospital confinement **not listed**? ..... ☐ 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 for a future appointment? ..... ☐ 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 (please provide details on page 7):

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

Oregon Standard Health Statement, (cont)

(Standard Form per ORS 743.766)

Please provide specific details below to each question answered "yes" on pages 5 and 6. Include insured/applicant's name; the number of the question to which you answered "yes"; the condition, treatment and date; the result of treatment, including any medications; and the name, address and telephone number of the attending physician, other health care provider, or clinic/hospital.

Health History Details

Please provide details below to any questions answered "YES" on the previous pages.

Name	Question Number	Condition (Diagnosis)	Start to End Dates Month/Year		Treatment Including Medications	Final Result: Ongoing or Resolved	Attending Physician/Health Care Provider or Hospital (Name/Address/Telephone)
			start /	end /		☐ Ongoing ☐ Resolved	
			start /	end /		☐ Ongoing ☐ Resolved	
			start /	end /		☐ Ongoing ☐ Resolved	
			start /	end /		☐ Ongoing ☐ Resolved	
			start /	end /		☐ Ongoing ☐ Resolved	
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			start /	end /		☐ Ongoing ☐ Resolved	
			start /	end /		☐ Ongoing ☐ Resolved	
			start /	end /		☐ 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:

____

____

____

____

IMPORTANT: Please make sure the answers you have provided are complete and accurate. Failure to do so could result in the retroactive cancellation of coverage.

Step 7: Sign & Submit

Certification and Authorization

Certification Of Completion And Correctness
I affirm that the answers given in this Application for Coverage and Oregon Standard Health Statement are complete and correct. I am providing these answers as part of the application procedure required by Providence Health Plan (PHP) to enroll for insurance coverage. I understand that if this application contains any material misstatements or omissions, PHP 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 PHP 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 the effective date determined by PHP and that PHP 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 the Release and Use and Disclosure of Personal Health Information
I authorize any physician, healthcare provider, hospital, insurance or reinsurance company, or other insurance information exchange service to disclose to Providence Health Plan (PHP) or its representatives personal health information relating to me and/or any family members included in this Application for Coverage. Furthermore, I agree to sign any additional forms related to release of personal health information, as needed by PHP to obtain this information. I acknowledge and understand that the health information released to PHP:

- Will only be used for the purpose of determining enrollment in health plan coverage or eligibility for benefits;
- May include claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, medication records, dental records, or hospital records (including nursing records and progress notes); and
- May address all medical and mental health conditions and services, including HIV treatment, but shall exclude psychotherapy notes and genetic information.

I understand that I may cancel this authorization at any time by sending a written request to PHP. My cancellation of this authorization will not affect any action PHP took before it received my request. If I do not revoke this authorization, it will automatically expire upon termination of my coverage with PHP. I understand that if I choose not to sign this authorization that PHP will be unable to process my Application for Coverage.

In addition, if I and/or any of my family members are accepted and enroll in PHP's Individual and Family plan coverage, I understand that PHP may request and disclose personal health information, other than psychotherapy notes, for the purpose of: (a) performing the health plan business operations of PHP; (b) facilitating health care treatment; (c) issuing or facilitating payment for health care services; or (d) as required by law. The disclosure of psychotherapy notes by PHP is restricted to circumstances in which the patient has provided a signed authorization.

For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Notice of Privacy Practices. A copy is available at our Internet site at **www.providence.org/healthplans** or by calling Customer Service.

Acceptance Of Enrollment Procedure

1. I understand that Providence Health Plan will:
   a) notify me in writing as to the status of my application.
   b) send me a legal contract upon enrollment.
2. I am the parent or legal guardian of any dependent listed on this application.
3. I verify that my employer will not be paying the premium on this policy.
4. By signing, I agree to the above conditions.

Signature of Applicant (or the Parent/Legal Guardian signature for a Dependent-Only application)	Relationship to dependent applicant under 18:	Date
X _____		
Signature of Spouse or Domestic Partner*		Date
X _____ ☐ Signed by applicant for spouse or domestic partner*		

** The applicant may sign for a spouse or domestic partner. Please check the appropriate box above.*

Before you submit this application, did you remember to:

- Select an effective date (Page 2)
- Select a health plan (Page 2)
- Include home address and phone number (Page 3)
- Sign and date (Page 8)