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.

NATIONAL FOUNDATION LIFE™
INSURANCE COMPANY

Primary Applicant Information

A. **Primary Applicant Information**

Name _____ Height: _____ Weight: _____
First MI Last
Gender O Male O Female

Social Security #: _____ Date of Birth: _____ Birth Place: _____

Employer: _____ Occupation/Duties: _____

Any form of tobacco or tobacco cessation product in past 12 months? O Yes O No

Resident Address

Address: _____ Home Phone: ( ) _____

City: _____ Business Phone: ( ) _____

State: _____ Zip Code: _____ Cell Phone: ( ) _____

Email: _____ Best time to call: _____

Family Information

B. **Spouse Information**

Name: _____ Height: _____ Weight: _____
First MI Last
Gender O Male O Female

Social Security #: _____ Date of Birth: _____ Birth Place: _____

Employer: _____ Occupation/Duties: _____

Dependent Information

C. Name: _____
First MI Last
O M or O F DOB _____ Ht. _____ Wt. _____

F. Name _____
First MI Last
O M or O F DOB _____ Ht. _____ Wt. _____

D. Name _____
First MI Last
O M or O F DOB _____ Ht. _____ Wt. _____

G. Name _____
First MI Last
O M or O F DOB _____ Ht. _____ Wt. _____

E. Name _____
First MI Last
O M or O F DOB _____ Ht. _____ Wt. _____

H. Name _____
First MI Last
O M or O F DOB _____ Ht. _____ Wt. _____

Agent Information

Agent Name: Andrew Eachon (Please Print) Agent Number: H2H22171

Coverage Selection

PPO Network _____

Premium Rate Guarantee Period : O 12 Months O 24 months O 36 months
Method of Payment: O Bank Draft O Direct Billing (Not available for Monthly Mode) O Credit Card (Initial Payment Only)
Mode of Payment: O Monthly O Quarterly O Semi-Annual O Annual

REQUESTED EFFECTIVE DATE: This effective date request does not guarantee that the application will be approved before the requested date, and thus may not be honored.

O Specific Date / /	O On the next _____ (except 29th, 30th, or 31st) of the month after underwriting decision.	O Date of Application Approval

PRIMARY PLAN

Lifetime Maximum: O $2,000,000 O $5,000,000

O MedEquity

Deductible Options:
Individual O $1,200(80% and 50% plan only) O $2,000 O $2,700 O $3,500 O $5,000 (100% Plan Only)
Family O $2,400(80% and 50% plan only) O $4,000 O $5,400 O $7,000 O $10,000 (100% Plan Only)

Coinsurance Options:
O PPO 100% Non-PPO 80%
O PPO 80% Non-PPO 60%
O PPO 50% Non-PPO 50%

Optional Riders:
O Optional Waiver of Premium Rider
O Optional Alcoholism Treatment Rider
O Other_____

O MedComplete

Deductible Options:
O $1,000 O $2,000 O $3,000 O $5,000
O $1,500 O $2,500 O $4,000 O $10,000

Coinsurance Options:
O PPO 80% of $10,000 Non-PPO 60% of $10,000
O PPO 50% of $5,000 Non-PPO 50% of $15,000
O PPO 50% of $10,000 Non-PPO 50% of $20,000

Optional Riders:
O Optional Waiver of Premium Rider
O Dr. Office Co-Pay Rider
O Optional Alcoholism Treatment Rider
O Other_____

O MedEssential - HSA

Deductible Options:
Individual O $1,200(70% and 50% plan only) O $2,000 O $2,700 O $3,500 O $5,000 (100% Plan Only)
Family O $2,400(70% and 50% plan only) O $4,000 O $5,400 O $7,000 O $10,000 (100% Plan Only)

Coinsurance Options:
O PPO 100% Non-PPO 80%
O PPO 70% Non-PPO 50%
O PPO 50% Non-PPO 50%

Calendar Year Maximum Per Insured for Outpatient Prescription Drugs
O $2,000
O Calendar Year Maximum Per Insured for Outpatient Treatment

Calendar Year Maximum Benefit Per Insured for Outpatient Treatment
O $5,000 O $10,000 O $15,000 O $25,000
(The $5,000 maximum is not available on deductibles of $3,500, $5,000, $7,000 or $10,000)

Optional Riders:
O Optional Waiver of Premium Rider
O Optional Alcoholism Treatment Rider
O Other_____

O MedEssential

Deductible Options:
O $1,200 O $1,700 O $2,500

Coinsurance Options:
O PPO 70% Non-PPO 50%
O PPO 50% Non-PPO 50%

Calendar Year Maximum Per Insured for Outpatient Prescription Drugs
O $2,000
O Calendar Year Maximum Per Insured for Outpatient Treatment

Calendar Year Maximum Benefit Per Insured/Calendar Year Maximum Per Insured for Outpatient Treatment Options:
O $50,000/$2,500 O $100,000/$2,500
O $100,000/$5,000 O $250,000/$5,000
O $250,000/$10,000

Optional Riders:
O Optional Waiver of Premium Rider
O Dr. Office Co-Pay Rider
O Optional Alcoholism Treatment Rider
O Other_____

O **Other** _____ **Total Base Plan Premium** $_____

TOTAL PREMIUM COLLECTED $_____

BENEFICIARY DESIGNATION

Your Beneficiary: _____ Spouse's Beneficiary: _____

Current and Prior Coverage

Other Coverage – Please answer the following questions

1. Does any applicant(s) currently have, or has any applicant made application for any type of health insurance? O Yes O No
   If Yes complete below.

Company Name: _____ Phone # _____ Type of Coverage _____ Date Effective _____

2. Are all applicant(s) covered under prior coverage? If No, list below those not covered: O Yes O No
   _____
3. Is the coverage you are applying for intended to replace your existing coverage? O Yes O No
   If yes, please be advised that you should not cancel your current coverage until you receive and review your policy, if issued.
4. Has any applicant ever been declined, had coverage excluded, been charged extra premium, or been postponed for any kind of personal insurance, or in the past 18 months filed a claim for disability, or are you or any member listed receiving benefits from Social Security or Workers' Compensation? O Yes O No
   If yes, provide details _____

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.

Medical History

Please mark "Yes" or "No" for each item (for you and any family members requesting coverage). Provide details on Page 5 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 problems symptoms, physical impairment, surgery or hospital confinement related to any of the following conditions:

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

20. Endocrine / gland / hormone system	O Yes O No	44. Stroke / paralysis / seizures	O Yes O No
21. Disease or injury of eye / cataract / glaucoma	O Yes O No	45. Tumors	O Yes O No
22. Gallbladder / pancreatic disease	O Yes O No	46. TMJ / jaw joint	O Yes O No
23. Chronic headaches / migraines	O Yes O No	47. Weight fluctuation (+/- 20 lbs.)	O Yes O No
24. Heart / chest pain / angina	O Yes O No	48. Cosmetic surgery / implants, use of prosthetic devices / limbs	O Yes O No

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

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?	O Yes O No	O Yes O No	O Yes O No	O Yes O No
b. Date of last menstrual period.				
c. If (b) is more than 35 days ago, please explain:				
d. Excessive or absent menstrual bleeding?	O Yes O No	O Yes O No	O Yes O No	O Yes O No
e. If (d) is yes, please explain:				
Date of last DEPO Provera shot?				
Abnormal Pap smears?	O Yes O No	O Yes O No	O Yes O No	O Yes O No
Prior Cesarean section or miscarriage?	O Yes O No	O Yes O No	O Yes O No	O Yes O No

51. Is any person on this application now pregnant? O Yes O 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?
O Yes O 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 above? O Yes O No
    b. Had chronic cough, fatigue, diarrhea, or enlarged glands? O Yes O No
    c. Been advised to have or contemplated having an operation or medical procedure not yet performed? O Yes O No
    d. Been scheduled to see a health care provider? O Yes O No
    e. Taken any prescription medication on a regular basis? O Yes O No

54. List all medications 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 3-4. 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 health care provider, or clinic / hospital.

HEALTH HISTORY DETAILS

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

Name	Question Number	Start to end dates	Condition	Treatment **Including Medications**	Final result **Ongoing or Resolved** Please Circle	Attending physician / health care provider or hospital (name / address / telephone)
					O / R	
					O / R	
					O / R	
					O / R	
					O / R	
					O / R	
					O / R	
					O / R	
					O / R	
					O / R	
					O / R	
					O / R	

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

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

HOME OFFICE CORRECTIONS

Applicant's Acknowledgments And Authorizations

By signing below I understand, certify and agree that:

- The health insurance coverage that I am applying for is not designated nor intended to be a health insurance plan that is employer provided.
- I am applying as an individual and the company will individually evaluate and underwrite my application.
- No part of the premiums or benefits are paid by my employer, nor will I be reimbursed through wage adjustment or otherwise for any portion of the premium to be charged.
- The insurance coverage I am applying for shall not be treated by an employer as a part of a plan or program for the purpose of section 162, 106, or section 125 of the Internal Revenue Code.
- National Foundation Life Insurance Company will confirm the information provided on this application for insurance with a verification telephone call. This verification call is a routine process for those applying for coverage with National Foundation Life Insurance Company and that this telephone call will be recorded. I also understand that my application will not be considered if verification is not completed.
  I (or my spouse, if applicable) may be contacted at the telephone numbers listed on the first page. If I cannot be contacted, I will call National Foundation Life Insurance Company at 1-800-221-9039.
- I hereby apply to National Foundation Life Insurance Company for insurance coverage to be issued in reliance upon the answers made to the best of my knowledge and belief and agree that the answers are full, true and complete in their entirety. I agree that the information and answers given shall form the basis for and be a part of any insurance under which coverage is issued. The coverage shall not be effective until a Policy has been actually issued and delivered to the Insured, with first premium paid while the health of all persons named in this Application remains as stated therein.
- The agent is not an officer of the Company and cannot change, alter or amend the application, the Policy or any information requirement of the Company. I further understand that the agent has no authority to make any representations about the conditions under which the Company will issue a Policy or make coverage under the Policy effective.
- If coverage is offered that it shall be subject to the timely payment by me and receipt by the Company of the Initial Premium amount and Policy administration fees. Should payment of such Initial Premium and fees not be timely made and received or returned for insufficiency of funds or in any other way insufficient or not honored, I understand, acknowledge and agree that the corresponding offer of coverage is withdrawn, void and of no effect.
- I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person that has records or knowledge of me, or any member of my family who is to be insured, to give to National Foundation Life Insurance Company or its reinsurer any such information. To facilitate rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, to give all such records or knowledge to any agency employed by National Foundation Life Insurance Company to collect and transmit such information. I authorize National Foundation Life Insurance Company to use such information to make determinations regarding enrollment, underwriting, eligibility of benefits, or any other healthcare operations related to the consumer as a prospective insured or as an insured with National Foundation Life Insurance Company. A photographic or electronic copy of this authorization shall be as valid as the original. This authorization shall be valid for two years from the date signed. I hereby acknowledge receipt of the Medical Information Bureau (MIB), the Notice of Information Practices and Privacy Policy, the Fair Credit Reporting Act (FCRA) notice, an outline of coverage and a disclosure statement.
- My/our answers to the questions and the information provided in application are complete, accurate and true to the best of my/our knowledge and belief. I understand and acknowledge that any fraudulent statement or material misrepresentation on the application and/or amendments may result in claim denial or contract rescission. I further understand that losses due to Pre-existing Conditions, diseases or bodily injuries occurring prior to the effective date of coverage are not covered, subject to Policy provisions, unless otherwise provided.

Be sure to sign and date the application. Spouse's signature is required if married. Signature applies to both "Certificate of Completeness and Correctness" and "Authorization for Release of 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 this insurance carrier to apply for 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 inforce 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.

X_____ X_____

Signature of Applicant | Signature of Spouse, if Applicable

I certify that I have truly and accurately recorded on the application form the information supplied by the applicant and that I am not aware of any other information that might have an adverse effect on the insurability of any person here proposed for insurance.

I certify that I have reviewed this application, and that it has been completed in full for submission to National Foundation Life Insurance Company.

Agent's Signature_____ Agent # H2H22171 Date:_____

Authorization to Use and Disclose Protected Health Information

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person that has records or knowledge of me, or any member of my family who is to be insured, to give (disclose) to National Foundation Life Insurance Company or its reinsurer any such information. To facilitate rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, to give all such records or knowledge to any agency employed by National Foundation Life Insurance Company to collect and transmit such information. I authorize National Foundation Life Insurance Company to use such information in determinations regarding enrollment, underwriting, eligibility of benefits, or any other healthcare operations related to the consumer as a prospective insured or as an insured with National Foundation Life Insurance Company. A photographic or electronic copy of this authorization shall be as valid as the original.This authorization shall be valid for two years from the date signed. I have received a copy of the National Foundation Life Insurance Company Notice of Privacy Practices.

Print Applicant's Name	Applicant's Signature	Date
Print Spouse's Name	Spouse's Signature	Date

Notice to Consumer

You may revoke this authorization at any time. To revoke this authorization, send a written statement to the Company Privacy Official, 3100 Burnett Plaza, 801 Cherry Street, Unit 33, Fort Worth, Texas, 76102. The statement must identify this authorization by referring to the date it was signed. The statement must include the date on which this authorization is no longer in force.

If you revoke this authorization, we may still use and disclose the information for the purposes listed, if we have already taken action in reliance on the authorization. Since this authorization is to permit disclosure of information to an insurance company, in order for you to obtain insurance coverage, the insurance company may still have the legal right to use the information to contest a claim or to contest your coverage.

You may refuse to sign this authorization. You do not need to sign this authorization to receive health care services EXCEPT in the following circumstances:

- If the only purpose for providing you with a service is to obtain health information to disclose to someone else, then you must authorize that disclosure in order to receive the service.
- If the services are related to research, you may be required to authorize the use or disclosure of your health information for the research. This applies only to health information related to the research services. The use and disclosure of your information will be limited to what is necessary for the research. If you do not authorize the use and disclosure of your information for the research, you may not be eligible to receive the services.

You do not have to sign this authorization to receive payment, to enroll in the plan, or to be eligible for benefits, except:

- If this authorization is sought for the purpose of determining your eligibility for benefits or is necessary for any other healthcare operations, then you must authorize National Foundation Life Insurance Company to obtain the necessary information or the benefits, enrollment, or provision of service through other healthcare operations may be denied.
- If this authorization is sought for the purpose of underwriting or risk rating determinations, then you must authorize National Foundation Life Insurance Company to obtain the necessary information or benefits or enrollment may be denied.
- Under Federal law, you do not have to authorize us to receive the private notes from counseling sessions, that are kept by a mental health professional, as a condition of payment, enrollment in a health plan, or eligibility for benefits.

A person or organization that receives your information because of this authorization may have the legal right to disclose this information to other people or organizations without your knowledge or consent.

NATIONAL FOUNDATION LIFE INSURANCE COMPANY

3100 Burnett Plaza, 801 Cherry Street, Unit 33, Fort Worth, Texas 76102

Authorization to Charge Credit Card for Initial Payment Only

I hereby request, authorize, and instruct National Foundation Life Insurance Company to charge my initial payment to my Credit Card account as listed below:

Credit Card Type: ❑ VISA ❑ Master Card ❑ American Express ❑ Discover

Account # _____ Expiration Date _____

Name on Card (First) _____ (Middle) _____ (Last) _____

Billing Address _____

Signature of Cardholder _____

Our preferred method for renewal payments is bank draft, please complete the information below and attach a voided check

Authorization to Honor Checks Drawn by National Foundation Life Insurance Company

I hereby request, authorize, and instruct National Foundation Life Insurance Company (Company) to initiate charges (debits) on my bank and checking account listed below, provided there are sufficient collected funds in the said account. I understand that payments will be debited from the account as designated below, and I requested (select one):

- ❑ to begin withdrawals (debits) on the date my coverage is made effective, if approved.
- ❑ to begin withdrawal to coincide with my requested effective date for the _____ (1-28th) day of the month, if approved.

The Company may revoke payment under this method if any payment is dishonored. I understand and affirm that the Company has my authorization to draft my bank and checking account and it shall remain in effect until I notify, and the Company receives, my request for an alternative payment mode in order to keep the coverage paid current. I also understand that the coverage applied for shall be subject to the terms, provisions and conditions of the Policy or Group Policy, and that the coverage shall not be effective until a Certificate or Policy has been actually issued by the home office of the Company, and delivered to the Primary Applicant, with the first premium paid while the health of all persons named remains as state in the application.

Please attached below a voided check.

Authorized Account Holder: _____

Printed Name of Account Holder if different from applicant.

Signature of Account Holder: _____ Date _____