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.

A Applicant Information

COMPLETE ALL SECTIONS IN INK.

Applicant's Name Last	First	Middle	Age
Birthdate (M/D/Y)	Social Security Number		Gender: ❑ Male ❑ Female
Home Phone	Work Phone	E-mail Address	

Oregon Residence Address		
Home Address		County
City	State	ZIP

Mailing Address (if different than listed above)		
Mailing Address		County
City	State	ZIP

OMIP ONLY

List all dependents you would like to insure – *See Member Handbook for the definition of a dependent*:

Name *(Last, first, middle initial)*	**Gender**	**Birthdate**	**Relationship**	**SSN**
Spouse/Domestic Partner:				
Child:				
Child:				
Child:				

B Health Plan Options — You must select a Plan

Select One Plan — ***See Section D for plan eligibility*** (Note: Plan changes are only allowed during open enrollment):

OMIP including HCTC:	***FMIP (Individual Applicants Only):***	***OMIP Portability:***
❑ **Medical Plan 750**[1]	❑ **Medical Plan 500**[1]	❑ **Portability Plan 750**[1]
❑ **Medical Plan 1000**	❑ **Medical Plan 750**[1]	❑ **Portability Plan 1500**
❑ **Medical Plan 1500**		

[1] *Family Health Insurance Assistance Program, (FHIAP) members may only select Medical Plan 750 or Portability Plan 750*

[2] *If you qualify for coverage through FMIP you will be directed to select plans offered through FMIP.*

— OFFICE USE ONLY —

Group No.	Class Code	ID	OED	Credits	BE	Misc.

C Health Conditions

Within the last five (5) years, have you (the applicant) had ANY diagnosis, treatment, or professional medical advice relating to any of the following medical conditions? If yes, please check those conditions which apply. If you have one of these conditions and you are an Oregon resident you automatically qualify for OMIP/FMIP coverage under the Medical Eligibility Criteria. A physician must verify and confirm the presence of any pre-existing condition(s).

- ❑ AIDS/HIV+
- ❑ Alcohol Dependence/ Chemical Dependency
- ❑ Alzheimer's
- ❑ Amyotrophic Lateral Sclerosis
- ❑ Aneurysm
- ❑ Angina Pectoris
- ❑ Anorexia/Bulimia
- ❑ Aplastic/Sickle Cell/Splenic Anemia
- ❑ Arteriosclerosis Obliteran
- ❑ Artificial Heart Valve
- ❑ Ascites
- ❑ Barrett's Esophagitis
- ❑ Blood Coagulation Disorder
- ❑ Brain Tumors
- ❑ Cancer/Metastatic Cancer
- ❑ Celiac Disease
- ❑ Cerebral Palsy
- ❑ Chronic Obstructive Pulmonary Disease
- ❑ Cirrhosis of the Liver
- ❑ Congestive Heart Failure/ Cardiomyopathy
- ❑ Coronary Insufficiency/Occlusion/ Artery Disease
- ❑ Crohn's Disease
- ❑ Cystic Fibrosis
- ❑ Dementia
- ❑ Dermatomyositis
- ❑ Diabetes
- ❑ Emphysema
- ❑ Fibromyalgia
- ❑ Friedreich's Disease
- ❑ Gastric Bypass Surgery
- ❑ Hemophilia
- ❑ Hepatitis B, C, D, E
- ❑ Hodgkin's Disease
- ❑ Huntington's Chorea
- ❑ Hydrocephalus
- ❑ Hypertensive Renal Disease
- ❑ Intermittent Claudication
- ❑ Joint Replacement
- ❑ Kidney Failure
- ❑ Lead Poisoning (Cerebral)
- ❑ Liver Failure
- ❑ Lupus
- ❑ Malignant Tumor
- ❑ Melanoma
- ❑ Multiple or Disseminated Sclerosis
- ❑ Muscular Atrophy/Dystrophy
- ❑ Myasthenia Gravis
- ❑ Myotonia
- ❑ Obesity (BMI >30)
- ❑ Open Heart Surgery
- ❑ Pancreatitis
- ❑ Paraplegia/Quadriplegia
- ❑ Parkinson's Disease
- ❑ Pending Surgery
- ❑ Peripheral Arteriosclerosis
- ❑ Pituitary Gland Disorders
- ❑ Polyarteritis
- ❑ Polycystic Kidney
- ❑ Polycystic Ovarian Syndrome
- ❑ Postero-Lateral Sclerosis
- ❑ Pregnant (currently)
- ❑ Pulmonary Fibrosis
- ❑ Rheumatoid Arthritis
- ❑ Schizophrenia
- ❑ Silicosis
- ❑ Sleep Apnea
- ❑ Still's Disease
- ❑ Stroke
- ❑ Syringomyelia
- ❑ Topectomy and Lobotomy
- ❑ Transient Ischemic Attack
- ❑ Transplants
- ❑ Ulcerative Colitis
- ❑ Von Willebrand's Disease
- ❑ Wilson's Disease

Newborn *ONLY* Conditions:

- ❑ Imperforate Anus
- ❑ Prematurity
- ❑ Spina Bifida

Identify condition from the list above. Applicant ***MUST*** *have been treated within the last 5 years. Physician's note specifying one of the above conditions is acceptable.*

Physician's name (please print): ____

Physician's signature: ____________________________________ **Date:** ____________

Please do not modify or write in conditions that are not listed above.

D Proof of Eligibility

Oregon resident: means you must be a permanent resident of Oregon to be eligible for OMIP/FMIP. A resident is a person who maintains a residence in Oregon, lives there at least 180 days ***per benefit enrollment year*** and files personal income taxes in Oregon.

Once you enroll in OMIP/FMIP, you must maintain a principal place of residence in Oregon and physically reside in this state at least 180 days each benefit enrollment year and file personal income taxes in Oregon.

_________ **Initial here showing you read and understand the eligibility requirements, attesting you are an Oregon resident and attach one of the following:**

- ❑ Current Oregon Driver License or Oregon identification card; or
- ❑ Current utility bill (utility bills include, gas, garbage, phone, or electric); or
- ❑ Current rental or lease agreement; or
- ❑ Current FHIAP ***Letter of Eligibility*** with the date of eligibility and applicant's name.

Please **check** the boxes below that apply:

1. Medical Eligibility

❑ I have one or more of the conditions listed in ***Section C of this application. (Complete Section C).***

❑ Within the last six months, I was denied an individual health insurance policy due to health reasons. ***(Attach a copy of the carrier's denial letter).***

❑ Within the last six months, I was offered an individual health insurance policy that excluded coverage for a specific medical condition. ***(Attach copy of letter from carrier denying specific condition).***

❑ Within the last six months, I was offered an individual health insurance policy but the carrier limited my choice of plans it was willing to offer me due to a specific medical condition. ***(Attach copy of carrier letter only offering a limited policy).***

❑ I have permanently moved to Oregon and am transferring from another state's high-risk pool. ***(Attach Certificate of Creditable Coverage from prior high-risk pool.)***

State: ________________ Name of State High Risk Pool: ___________________________ ID #:__________________

❑ I have permanently moved to Oregon and am transferring from another federal high-risk pool. ***(Attach Certificate of Creditable Coverage from prior federal high-risk pool.)***

State: ________________ Name of Federal High Risk Pool: _________________________ ID #:__________________

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2. Portability Eligibility — *OMIP applicants only*

In all cases below, you must submit a Certificate of Coverage to verify your coverage is terminated, you had at least 180 consecutive days of group coverage or at least 18 months of creditable coverage without a gap in coverage greater than 63 days, with the most recent coverage ending in group insurance. Your application must be received by OMIP within 63 days of the termination date of your prior coverage. You must obtain a Certificate of Coverage from your prior health insurance company. Please call 1-800-848-7280 with questions.

Note: Your OMIP coverage starts the date your former coverage ends meaning you will owe premiums from that date which may include more than one month of premium.

❑ I have exhausted all COBRA or state continuation benefits available, and no portability options are available from my previous health carrier. ***Attach a letter from your previous health insurer indicating all COBRA or state continuation benefits are exhausted and terminated and no portability options are available.***

❑ No COBRA, state continuation coverage, or portability coverage was available through my previous group plan. ***(Attach a letter from your current carrier or former employer stating that these plans are not available.)***

❑ I am eligible for Oregon portability through my previous plan but I moved from my prior insurance carrier's service area or my insurance carrier no longer services the area where I live. ***(Attach a letter from your current carrier that you have moved from the carrier's service area and no further coverage is available.)***

3. Federal Health Coverage Tax Credit Eligibility — *OMIP only*

- ❑ If you are eligible to receive a Federal Health Coverage Tax Credit (HCTC) under Section 36 of the Internal Revenue Code, then you are automatically eligible to receive health coverage through one of the three medical plan options. ***(Attach documentation from the federal government showing you are eligible for this program.)***

E OMIP Credit Toward Pre-Existing Limitation Period

Not applicable to enrollees in OMIP under the age of 19, portability, and FMIP.

OMIP will not pay benefits during the first six months of enrollment for coverage of expenses incurred for a pre-existing condition unless we grant you credits. A pre-existing condition is one for which professional medical advice, diagnosis, care, or treatment was recommended or received or a treatment plan was prescribed in the six months prior to your OMIP effective date.

We will grant credits toward the pre-existing limitation period for each month of prior creditable health coverage you or your enrolled dependent(s) had prior to becoming insured by OMIP. ***To receive credits, your application must be received by OMIP no later than 63 days from the termination date of the prior creditable coverage.***

There is ***not*** a six-month waiting period for qualified Federal HCTC enrollees who have had 90 days of prior creditable coverage without any breaks in coverage greater than 63 days and whose application was received by OMIP within 70 days from the date on the HCTC eligibility certificate.

Creditable coverage means prior substantially equivalent health insurance coverage that reimburses for medical and hospital expenses without regards to a specific medical condition or disease and has comparable, similar benefits and payout amounts to OMIP's health benefit plan.

OMIP may not credit coverage for benefits and services that your previous health plan did not cover or credit benefits that had not been satisfied during the previous plan's exclusion period except portability.

- ❑ I have credit toward the six-month pre-existing limitation period. ***(Attach a copy of your prior plan's benefit summary with a Certificate of Coverage stating your begin and end dates.)***

F Statistical & Eligibility Information

We require that you complete the following information. The program will use only information about other insurance or employer-based benefits to determine eligibility. We also use this data for evaluating future insurance market reform.

1. Are you (check one) ❑ an employee ❑ self-employed ❑ not employed ❑ retired

   If you are an employee, or self-employed, what is your occupation?____________________

   What is the name and location of your employer?____________________

   Does your employer offer health insurance to its employees? ❑ Yes ❑ No

   If yes, are you currently, or have you ever been, covered under your employer's plan? ❑ Yes ❑ No

   If no, do you currently have access to other medical insurance coverage? ❑ Yes ❑ No

   If yes, with which medical insurance carrier? ____________________

   If yes, on what date did that coverage end and why? End date:__________ Reason: ____________________

   If your employer offers health insurance to its employees and you are not covered under your employer plan, why didn't you take your employer's insurance? ____________________

2. Have you ever been enrolled in OMIP? ❑ Yes ❑ No

   If yes, what date did your coverage begin?__________________What date did your coverage end?____________________

3. In the last 6 months, have you applied for Medicaid/Oregon Health Plan (OHP)?
   ❑ Yes Month applied: ______________________ ❑ No
   If yes, were you eligible? ❑ Yes ❑ No ❑ Do not know
   If yes, is your application still being considered for eligibility? ❑ Yes ❑ No

4. In the last 12 months, have you or your eligible dependent(s) been insured by any other insurance program (including Medicare, Medicaid/OHP, employer-sponsored insurance (group), private insurance (individual), or COBRA, Portability or Healthy Kids Connect)?
   ❑ Yes ❑ No
   If no, why have you gone without coverage? ______________________

   If yes, answer the following:
   Who was listed as the primary insured under the policy? ______________________
   What is that person's social security or ID number? ______________________
   What is the name of the insurance company? ______________________
   What date did the policy begin? ______________ What date did the policy end? ______________
   Why did the policy end? ______________________
   Was this policy purchased through an agent? If so, please provide the agent's name: ______________
   Was the insurance group ***(through the employer)*** or individual insurance? ❑ Group ❑ Individual ❑ Do not know
   If it was group insurance, what is the name of the employer who offered the policy? ______________

The following section is for statistical purposes only and does not determine eligibility.

5. Are you (check one) ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Child

6. If you are married, is your spouse employed? ❑ Yes ❑ No
   If yes, does your spouse's employer offer health insurance to its employees? ❑ Yes ❑ No
   If yes, are you currently enrolled in your spouse's employer's plan? ❑ Yes ❑ No
   If no, why not? ______________________

7. If you are under age 18, is your parent or guardian employed? ❑ Yes ❑ No
   If yes, does their employer offer health insurance for its employees? ❑ Yes ❑ No
   If yes, are you currently enrolled in your parent or guardian's employer's plan? ❑ Yes ❑ No
   If no, why not? ______________________

8. What is your total annual gross household income
   ❑ $0-$11,076 ❑ $25,001-$35,000 ❑ $45,001-$55,000 ❑ $65,001-$75,000
   ❑ $11,077-$15,000 ❑ $35,001-$45,000 ❑ $55,001-$65,000 ❑ $75,001 or more
   ❑ $15,001-$25,000

9. What is your ethnic heritage? ❑ Hispanic ❑ Latino ❑ Not Hispanic or Latino

10. What is your racial heritage?
    ❑ American Indian/Alaskan Native ❑ Asian ❑ Black or African American
    ❑ Native Hawaiian or Other Pacific Islander ❑ White

G Affirmation, Understanding & Disclosure Authorization

I understand that I am applying to the Oregon Medical Insurance Pool (OMIP)/Federal Medical Insurance Pool (FMIP), a State of Oregon program located within the Oregon Health Authority, for an individual policy of medical, surgical, prescription and hospital insurance. I also understand that my coverage will become effective on the first of the month following approval and acceptance of the application by OMIP/FMIP, unless I am eligible for portability coverage. If eligible for portability coverage, I understand that my coverage will become effective the date my prior group coverage is terminated. I will be responsible for paying premiums from my effective date forward.

I affirm that the foregoing answers on the application are complete and correct. I understand that no coverage will be in effect until the full initial premium is paid after this application has been approved and accepted by OMIP/FMIP.

1. Pre-existing conditions will **not** be covered until the OMIP **policy has been in effect for six months**, unless OMIP waives the pre-existing condition limitation period. The pre-existing limitation period will be waived if you are under the age of 19, applying for portability (with a certificate of creditable coverage) or FMIP. A pre-existing condition is a condition for which medical treatment or diagnosis was rendered during the six-month period immediately preceding the OMIP effective date of coverage. Pregnancy, alcoholism, and transplants are considered pre-existing conditions.

   _____ ***ALL*** **parties on this application** ***MUST*** **initial here showing you have read and understand the above paragraph.**
   (Parent/legal guardian if applicant is under 18 years of age or legally incompetent.)

2. If this application contains any material misrepresentations or omissions or you falsified or concealed eligibility requirements we may terminate your policy back to the effective date of OMIP/FMIP coverage. In addition, we may retain your premiums to cover any claims and administration costs OMIP/FMIP paid retroactive to the date we terminate your policy and recover from you any amounts we paid in excess of the premiums.

   _____ ***ALL*** **parties on this application** ***MUST*** **initial here showing you have read and understand the above paragraph.**
   (Parent/legal guardian if applicant is under 18 years of age or legally incompetent.)

3. The information you provide on this application may be shared with other government agencies for the purposes of establishing eligibility.

   _____ ***ALL*** **parties on this application** ***MUST*** **initial here showing you have read and understand the above paragraph.**
   (Parent/legal guardian if applicant is under 18 years of age or legally incompetent.)

FMIP Applicants Only *Proof of U.S. citizenship.*

FMIP is required to verify your citizenship status. Please see page 4 of the Member Handbook for the list of acceptable proof of citizenship, if we cannot verify your citizenship using public records your application will be pended and you will receive a letter requesting citizenship documentation.

You must sign either 1a or 1b AND 2 to acknowledge the following:

1a. *I am a U.S. citizen (see page 4):*

Signature: **Maiden name:** **Date:**

1b. *I am not a citizen but am lawfully present in the U.S. (Attach proof of lawful presence. See page 4 of the Member Handbook):*

Signature: **Date:**

2. *I have been uninsured for the past six months. Exception: My most recent insurance was the Affordable Care Act Pre-existing Condition Insurance Program from another state.*

Signature: **Date:**

INDIVIDUAL AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

On behalf of ourselves and the family member(s) listed on this application, I authorize any physician, health-care provider, hospital, insurance or reinsurance company, or other insurance information exchange to disclose to the Oregon Medical Insurance Pool (OMIP)/Federal Medical Insurance Pool (FMIP), an agency of the State of Oregon, or its representatives, our health information (including alcohol, chemical dependency, mental treatment, genetic testing or HIV treatment). We acknowledge and understand that this information will be used only for the purpose of determining enrollment, eligibility for benefits, and payment of claims, case management, quality assurance reviews or audits. Health information may include claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

If I choose not to sign this authorization, OMIP/FMIP may refuse to enroll me(us) in an OMIP/FMIP health plan or pay future claims that we may incur if we obtain OMIP/FMIP insurance coverage.

I may cancel this authorization at any time by sending a written request to OMIP/FMIP. My cancellation of this authorization will not affect any action OMIP/FMIP took before it received my request.

Federal law requires OMIP/FMIP to tell me that, if the party to whom OMIP/FMIP discloses my personal information shares it with anyone else, some state and federal laws may no longer protect it. This excludes alcohol and drug abuse records, which are protected by federal confidentiality rules (42 CFR, Part 2). Federal law prohibits redisclosure of this information without specified written authorization.

My signature on this application authorizes disclosure to OMIP/FMIP of health insurance coverage, health insurance applications, Medicaid eligibility and medical record information about myself and my family members, listed on this application, if needed to: 1) determine eligibility for coverage; 2) preauthorize or process claims for benefits; 3) perform case management (including concurrent review) or quality assurance reviews; or 4) conduct an audit. OMIP/FMIP shall not release the medical record information it obtains to anyone else except as allowed by state and federal law.

This authorization takes effect on the date I sign this application and remains in effect for the lifetime of the OMIP/FMIP coverage or the duration of any claim, whichever is longer.

A photocopy of this authorization is as valid as the original.

Signature of applicant (or parent/legal guardian if applicant is under 18 years of age or legally incompetent):	**Date:**
Signature of spouse/domestic partner if covered in this application:	**Date:**
Signature of dependent over the age of 18 if covered in this application:	**Date:**

If signed by a personal representative of the applicant, please complete the following:

Personal representative name (please print): ______________________________

Relationship to individual: ____________________(attach legal documentation if other than parent)

Date you want your insurance to begin? ______________________________

Applications are processed in the order they are received. It may take up to 30 days for processing. However, if you are applying to OMIP/FMIP because you are medically eligible, your insurance starts the first of the month after we receive a completed (including all required documents) application unless you ask for a future date.

H Premium Payment

DO NOT SEND PREMIUM PAYMENT WITH THIS APPLICATION

Note: You cannot have OMIP/FMIP premiums paid or reimbursed by a public entity, employer, or a health care provider for the purpose of reducing the payer's financial loss or obligation.

If you are approved, you will receive information regarding your premium payment.

I would like to pay my premium with the following method (check one):

❑ Monthly automatic payment directly from my bank *(If checked, complete authorization agreement that follows.)*

❑ Monthly billed directly

❑ Quarterly billed directly

❑ FHIAP ID # ______________________________
Please attach a copy of the signed ***FHIAP Certificate of Eligibility*** listing all eligible parties, to this application.

❑ CareAssist ID # ______________________________

AUTHORIZATION AGREEMENT FOR MONTHLY AUTOMATIC BANK PAYMENT (SUREPAY)

Name of Applicant or Policy Holder	Social Security Number

Authorization to my bank: ❑ Checking Account ❑ Savings Account

As a convenience and on behalf of the Account Holder identified below, I/we hereby request and authorize you to pay and charge to the account identified below, checks or electronic debits drawn on the account by and payable to the order of Regence BlueCross BlueShield of Oregon, Portland, Oregon on behalf of the Oregon Medical Insurance Pool/Federal Medical Insurance Pool. I/we agree that your rights to each such check or electronic debit shall be the same as if it were an actual check drawn on you and signed by me/us. This authority is to remain in effect until revoked by me/us in writing, and until you actually receive such notice, I/we agree that you shall be fully protected in honoring any such check. I/we further agree that if any checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. A photocopy of this executed authorization shall be as valid as the original.

Please provide a voided check.

Financial Institution	Transit/Routing Numbers	Account Number

____
Account Holder's Name (please print)

______________________________ ______________
Account Holder's Authorized Signature(s) – as it appears on bank statement Date

Billing Address (if different than mailing address)		
Billing Address		
City	State	ZIP

I Agent Information

I certify by my signature that follows, that I have explained eligibility provisions to the applicant and have reviewed the application to assure that the application is complete and accurate. I have made no statements of benefits, conditions, limitations or exclusions of the agreement except through written material furnished by OMIP/FMIP. I have informed the applicant that the Oregon Medical Insurance Pool/Federal Medical Insurance Pool will determine the effective date of coverage upon receipt of a completed application, which includes the required attachments, and verification of eligibility.

Agent signature certifies that the agent has reviewed the application ***AFTER*** it was completed and the application is complete and accurate. **If the application is not complete, including all of the agent information below, OMIP/FMIP may choose not to pay the agent fee.**

Field	Value	Field	Value
Print Agent Name	andrew eachon	Tax I.D. No.	205570418
Agency Name	century benefits	Oregon Lic. No.	817719
Street Address	25 nw 23rd pl #6156	City	portland
State	or	Zip	97210
E-mail	andrewe@centurybenefits.com	Phone	5039283321
Fax			
Agent Signature		Date	

NOTE: This page is removed before the "original" application is returned back to the enrollees.

Document Checklist

Did you remember to:

Yes No

- ❑ ❑ Answer all questions completely?
- ❑ ❑ If an applicant doesn't provide a declination letter a physician's signature in Section C needs to be provided or a letter confirming the condition(s) checked in Section C on application.
- ❑ ❑ Attach proof of residency? ***(Section D on application)***
- ❑ ❑ Initial residency acknowledgement statement ***(Section D on application)***
- ❑ ❑ Attach proof of lawful presence in the U.S. if you are not a citizen. ***(See page 4 of the Member Handbook)***
- ❑ ❑ Initial the affirmations, understandings, and disclosure authorization and then sign and date the application. ***(Section G on application)***
- ❑ ❑ If applying for credit toward the six-month pre-existing condition exclusion, attach ***Certificate of Coverage*** from prior insurance carrier reflecting your beginning and ending dates of coverage and stating your previous coverage has been terminated?
- ❑ ❑ If applying through portability eligibility, please attach a COBRA exhaustion letter. This tells us that your COBRA coverage is exhausted and that no portability options are available. Or, attach any of the other required documents reflecting portability eligibility. Please also provide a ***Certificate of Coverage*** with termination dates to verify that this coverage has been terminated.