

Oregon Application for Individual & Family Insurance



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
PHP Agent Number	Agent E-mail	Phone Number ()	FAX Number ()	
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: ____; lx entrd: __/__/__; recds req?: y n; date req: __/__/__; date rcvd: __/__/__; decis: _____, rendered: __/__/__;

Step 1: Type of Application

New coverage:	or	Change to existing coverage:
<p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> 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.</p>	<p>Current Policyholder name: _____ Current Policyholder ID number: _____</p> <p><input type="checkbox"/> Add spouse <input type="checkbox"/> Add domestic partner** <input type="checkbox"/> Add dependent (age 0-22) <input type="checkbox"/> Add adult to a dependent-only policy Complete all sections of this application.</p> <hr/> <p><input type="checkbox"/> Add newborn* (within 60 days of birth) date of birth: ____/____/____ <input type="checkbox"/> 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.</p>	

**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
<input type="checkbox"/>	Optimum 500*	\$20/20%	40%	\$500 / \$1,500	\$2,500 / \$7,500
<input type="checkbox"/>	Optimum 1000*	\$20/20%	40%	\$1,000 / \$3,000	\$2,500 / \$7,500
<input type="checkbox"/>	Optimum 2500	\$20/20%	40%	\$2,500 / \$7,500	\$2,500 / \$7,500
<input type="checkbox"/>	Optimum 5000	\$20/20%	40%	\$5,000 / \$15,000	\$2,500 / \$7,500
<input type="checkbox"/>	Optimum 10,000	\$20/20%	40%	\$10,000 / \$30,000	\$2,500 / \$7,500
<input type="checkbox"/>	Value 500*	\$20/30%	50%	\$500 / \$1,500	\$4,000 / \$12,000
<input type="checkbox"/>	Value 1000	\$20/30%	50%	\$1,000 / \$3,000	\$4,500 / \$13,500
<input type="checkbox"/>	Value 2500	\$20/30%	50%	\$2,500 / \$7,500	\$5,500 / \$16,500
<input type="checkbox"/>	Value 5000	\$20/30%	50%	\$5,000 / \$15,000	\$8,500 / \$25,500
<input type="checkbox"/>	Value 7500	\$20/30%	50%	\$7,500 / \$22,500	\$11,000 / \$33,000
<input type="checkbox"/>	Prime 10,000	50%	Not covered	\$10,000 / \$30,000	\$7,500 / \$22,500
<input type="checkbox"/>	HSA 2500	\$20/20%	40%	\$2,500 / \$5,000	\$5,000 / \$10,000
<input type="checkbox"/>	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		<input type="checkbox"/> Male <input type="checkbox"/> Female				/ /		
2. Spouse <input type="checkbox"/> or Domestic Partner <input type="checkbox"/> (check one)		<input type="checkbox"/> Male <input type="checkbox"/> Female				/ /		
3. Dependent Child		<input type="checkbox"/> Male <input type="checkbox"/> Female				/ /		
4. Dependent Child		<input type="checkbox"/> Male <input type="checkbox"/> Female				/ /		
5. Dependent Child		<input type="checkbox"/> Male <input type="checkbox"/> 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: <input type="checkbox"/> Employer Group <input type="checkbox"/> Individual <input type="checkbox"/> Medicare <input type="checkbox"/> S.S. Disability <input type="checkbox"/> Portability <input type="checkbox"/> 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 | <input type="checkbox"/> Yes <input type="checkbox"/> No | 26. High cholesterol (If "Yes," record last test result: ___/___) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Alcohol/chemical/drug abuse/habit | <input type="checkbox"/> Yes <input type="checkbox"/> No | 27. High blood pressure (If "Yes," record last test result: ___/___) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Anemia/chronic fatigue | <input type="checkbox"/> Yes <input type="checkbox"/> No | 28. Kidney/kidney stones | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Appendicitis/chronic abdominal pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | 29. Knee/shoulder/hip/other joints | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Back/neck/spine | <input type="checkbox"/> Yes <input type="checkbox"/> No | 30. Liver condition/hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Birth defect/congenital deformities | <input type="checkbox"/> Yes <input type="checkbox"/> No | 31. Lupus, chronic muscle pain, muscle injury or disease, or fibromyalgia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Bladder/urinary tract | <input type="checkbox"/> Yes <input type="checkbox"/> No | 32. a. Mental/emotional condition/depression | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Blood/circulatory | <input type="checkbox"/> Yes <input type="checkbox"/> No | 32. b. Therapy/counseling within last 5 years (If "Yes," record date of last session: ___/___/___) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Bone/orthopedic | <input type="checkbox"/> Yes <input type="checkbox"/> No | 33. Neurological condition/disease/injury | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Brain disease or injury/concussion | <input type="checkbox"/> Yes <input type="checkbox"/> No | 34. Phlebitis/blood clot | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Breast (lumps or masses) | <input type="checkbox"/> Yes <input type="checkbox"/> No | 35. Osteoarthritis/osteoporosis/osteopenia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | 36. Prostate/elevated PSA/prostatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Chemotherapy/radiation treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | 37. Reproductive system disorder/infertility | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. a. Colon/rectum/intestine/bowel | <input type="checkbox"/> Yes <input type="checkbox"/> No | 38. Chronic respiratory/lung condition | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. b. Blood in stool | <input type="checkbox"/> Yes <input type="checkbox"/> No | 39. Rheumatoid arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 15. Convulsion/seizures/epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | 40. Sexually transmitted disease(s) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16. Diabetes/sugar in urine | <input type="checkbox"/> Yes <input type="checkbox"/> No | 41. Skin condition, abnormal or cancerous moles or eczema/cysts/cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 17. Chronic ear/nose/throat/tonsil condition/disease/disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | 42. Sleep apnea/chronic sleep disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 18. Eating disorders such as, but not limited to, anorexia or bulimia | <input type="checkbox"/> Yes <input type="checkbox"/> No | 43. Stomach disorders/ulcer/acid reflux | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 19. Emphysema/asthma/ chronic lung disease (COPD) | <input type="checkbox"/> Yes <input type="checkbox"/> No | 44. Stroke/paralysis/seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 20. Endocrine/gland/hormone system (includes Thyroid) | <input type="checkbox"/> Yes <input type="checkbox"/> No | 45. Tumors | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 21. Disease or injury of eye/ cataract/glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | 46. TMJ/jaw joint | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 22. Gallbladder/pancreatic disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | 47. Weight fluctuation (+/-20 lbs.) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 23. Chronic headaches/migraines | <input type="checkbox"/> Yes <input type="checkbox"/> No | 48. Cosmetic surgery/implants, use of prosthetic devices/limbs | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 24. Heart/chest pain/angina | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Hernia | <input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Date of last menstrual period.	___/___/___	___/___/___	___/___/___	___/___/___
c. If (b) is more than 35 days ago, please explain:				
d. Excessive or absent menstrual bleeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. If (d) is yes, please explain:				
f. Date of last DEPO Provera shot?	___/___/___	___/___/___	___/___/___	___/___/___
g. Abnormal Pap smears? (in past 5 years)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Prior Cesarean section or miscarriage? (in past 5 years)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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		Treatment Including Medications	Final Result: Ongoing or Resolved	Attending Physician/Health Care Provider or Hospital (Name/Address/Telephone)
			Month/Year	Month/Year			
			start /	end /		<input type="checkbox"/> Ongoing <input type="checkbox"/> Resolved	
			start /	end /		<input type="checkbox"/> Ongoing <input type="checkbox"/> Resolved	
			start /	end /		<input type="checkbox"/> Ongoing <input type="checkbox"/> Resolved	
			start /	end /		<input type="checkbox"/> Ongoing <input type="checkbox"/> Resolved	
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			start /	end /		<input type="checkbox"/> Ongoing <input type="checkbox"/> Resolved	
			start /	end /		<input type="checkbox"/> Ongoing <input type="checkbox"/> 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) X _____	Relationship to dependent applicant under 18:	Date
Signature of Spouse or Domestic Partner* X _____	<input type="checkbox"/> Signed by applicant for spouse or domestic partner*	
		Date

* 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)