Regence

Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueCross BlueShield of Oregon

Oregon Individual and Family Plans

Blue Selections Premier
Blue Selections Plus
Blue Selections Basic
Regence HSA Healthplan
and Individual Dentacare

OREGON APPLICATION AND STANDARD HEALTH STATEMENT

Thank you for selecting Regence BlueCross BlueShield of Oregon as your individual health plan insurance company.

www.regence.com

Please return this application to:

Regence BlueCross BlueShield of Oregon
Attn: Individual Enrollment Services, Mail Station E-8U
P.O. Box 1271
Portland, OR 97207-1271
Customer Service 1 (800) 365-3155
Underwriting 1 (888) 671-2950

Please Note: These plans are not portability plans. If you are applying for portability coverage following termination of group health benefits through Regence BlueCross BlueShield of Oregon, please call 1 (800) 365-3155 to obtain portability information.

FOR OFFICE USE ONLY
Additional telephone information received by Regence BlueCross BlueShield of Oregon

Section 1 - Instructions

- Please read carefully.
- **Use ink to complete and sign this application. An application completed in pencil will be returned to you.**
- Make sure all sections of the application are answered completely.
- If you need assistance completing this application, please contact your agent or call Sales at 1-888-REGENCE (734-3623).

Section 2 - Plan Selection

SELECT ONE MEDICAL PLAN PER APPLICATION.

MEDICAL

I am applying for:

- ☐ **New** enrollment
- ☐ **Change** to my existing individual plan or deductible
- ☐ **Addition** of a spouse/domestic partner or dependent to my existing policy. (signature(s) required on page 6)
- ☐ **Child-only** (ages 0-17). Complete a separate form for each child on his or her own plan. Choose a plan and deductible below.

BLUE SELECTIONS PREMIER	BLUE SELECTIONS PLUS	BLUE SELECTIONS BASIC	REGENCE HSA HEALTHPLAN
DEDUCTIBLES: Medical	**DEDUCTIBLES: Medical**	**DEDUCTIBLES: Medical**	**DEDUCTIBLES: Medical Single/Family**
☐ **$1,000**	☐ **$1,000**	☐ **$1,000**	☐ **$1,500/$3,000**
☐ **$2,500**	☐ **$2,500**	☐ **$2,500**	☐ **$2,500/$5,000**
☐ **$5,000**	☐ **$5,000**	☐ **$5,000**	☐ **$3,500/$7,000**
☐ **$7,500**		☐ **$10,000**	
Uses Participating Providers on the **Preferred Provider Plan Network.**	Uses Participating Providers on the **Preferred Provider Plan Network.**	Uses Participating Providers on the **Preferred Provider Network.**	Uses Participating Providers on the **Participating Provider Network.**

DENTAL (optional)

- ☐ I wish to enroll in the optional Individual Dentacare plan for an additional monthly premium.
- ☐ Disenroll all family members on my policy from Individual Dentacare. I understand that I/we cannot reenroll for 12 months.

Please note: Individual Dentacare must be purchased with one of our Blue Selections or Regence HSA Healthplan medical plans. Dental only coverage is not available. If selected, Individual Dentacare must be added for all applicants listed on this form.

(Please initial) X________ "My employer is not contributing to or paying the premium for this individual policy (including cafeteria plans)."

Individual benefit plans are not intended for sale as an employer-sponsored health benefit plan for employees. For information on small employer health benefit plans, contact the Regence BlueCross BlueShield of Oregon (Regence BCBSO) Group Sales department at 1 (800) 452-7278.

Effective dates are assigned by Regence BCBSO on the 1st or the 15th of the month following acceptance and approval. If you wish enrollment to begin on a date in the future (not more than 90 days from the date you signed this form).

Please indicate that date here ____________________

How did you hear about Regence BCBSO?
Please check the box that best describes how you heard about us.

☐ Friend ☐ Agent ☐ Direct mailing ☐ Web site ☐ Other ____________________

Section 3 - Enrollment Information

LIST ALL ELIGIBLE FAMILY MEMBERS TO BE COVERED

Last Name of Family Member	First Name, Middle Initial	Sex	Age	Height	Weight	Birthdate	Social Security Number
Applicant							
☐ Spouse ☐ Certified Domestic Partner ☐ Non-Certified Domestic Partner *							
Child							
Child							
Child							

Explain the relationship to the applicant for any person(s) listed above whose last name is different from the applicant's. We may request a Certificate of Dependency form.

***Non-Certified Domestic Partner must submit an Affidavit of Domestic Partnership.**

OREGON RESIDENCE ADDRESS			
Name		E-mail address (will not be disclosed outside of the company)	
Residence Street Address		PO Box (if applicable)	
City, State, Zip Code			
Home Phone Number ( )	Work Phone Number ( )	County	Office Use CO Code

BILLING ADDRESS (complete only if billing should be sent to an address other than listed above)	
Name c/o	Relationship to Applicant
Address	City, State, ZIP Code

Section 4 - Other Coverage Information

1. Are you or any dependents who are applying for coverage currently covered on any group, individual or self-insured medical plan? ☐ Yes ☐ No

   If **yes**, do you intend to replace your current plan with this contract? ☐ Yes ☐ No

2. Are you currently enrolled in a Regence BCBSO Individual medical plan and do you wish to cancel that coverage? ☐ Yes ☐ No

   If you answered yes, please sign the statement below:

   I wish to terminate my individual medical coverage from Regence BCBSO on the effective date of this individual policy.

   Signature ________________________ Date__________

Regence BCBSO Individual Plans contain a 6-month preexisting condition limitation period, and a 12 month exclusionary period for specific services. Please provide the following information for all applicants, and attach a copy of your Certificate of Coverage from your current or prior carrier or a similar document showing the beginning and ending dates of your current coverage, if applicable.

Name (First, Last)	Birthdate	Insurance Company	Policy Number	Dates of Coverage		Type of Coverage
				Date Coverage Began MM/DD/YYYY	Date Coverage Ended (indicate Active if you are currently covered) MM/DD/YYYY	◆ Employer Group ◆ Individual ◆ Medicare ◆ COBRA ◆ High Risk Pool ◆ Other (describe)
1.						
2.						
3.						
4.						
5.						

OFFICE USE ONLY	Group Number & Pkg.	Identification Number	Contract Effective Date	Bill Period	Agent Number

Section 5 - Oregon Standard Health Statement

Has any insurance company, within the last five years, postponed, refused, restricted or increased premium for life or health insurance coverage for health reasons for you or any of your family members to be covered? ☐ Yes ☐ No

If **"yes"**, indicate name of person affected, reason for action, and name of insurance company ____________________

____

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.

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, 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:

		YES	NO
1.	AIDS, ARC, HIV positive	☐	☐
2.	Alcohol/chemical/drug abuse/habit	☐	☐
3.	Anemia/chronic fatigue	☐	☐
4.	Appendicitis/chronic abdominal pain	☐	☐
5.	Back/neck/spine	☐	☐
6.	Birth defect/congenital deformities	☐	☐
7.	Bladder/urinary tract	☐	☐
8.	Blood/circulatory	☐	☐
9.	Bone/orthopedic	☐	☐
10.	Brain disease or injury/concussion	☐	☐
11.	Breast (lumps or masses)	☐	☐
12.	Cancer	☐	☐
13.	Chemotherapy/radiation treatment	☐	☐
14a.	Colon/rectum/intestine/bowel	☐	☐
14b.	Blood in stool	☐	☐
15.	Convulsion/seizures/epilepsy	☐	☐
16.	Diabetes/sugar in urine	☐	☐
17.	Chronic ear/nose/throat/tonsil condition/disease/disorder	☐	☐
18.	Eating disorders such as, but not limited to, anorexia or bulimia	☐	☐
19.	Emphysema/asthma/chronic lung disease (COPD)	☐	☐
20.	Endocrine/gland/hormone system	☐	☐
21.	Disease or injury of eye/cataract/glaucoma	☐	☐
22.	Gallbladder/pancreatic disease	☐	☐
23.	Chronic headaches/migraines	☐	☐
24.	Heart/chest pain/angina	☐	☐
25.	Hernia	☐	☐
26.	High cholesterol (if "Yes", record last reading on page 5).	☐	☐
27.	High blood pressure (if "Yes", record last reading on page 5).	☐	☐
28.	Kidney/kidney stones	☐	☐
29.	Knee/shoulder/hip/other joints	☐	☐
30.	Liver condition/hepatitis	☐	☐
31.	Lupus, chronic muscle pain, muscle injury or disease, or fibromyalgia	☐	☐
32a.	Mental/emotional condition/depression	☐	☐
32b.	Therapy/counseling within last 5 years (if "Yes", record date of last session on page 5).	☐	☐
33.	Neurological condition/disease/injury	☐	☐
34.	Phlebitis/blood clot	☐	☐
35.	Osteoarthritis/osteoporosis/osteopenia	☐	☐
36.	Prostate/elevated PSA/prostatitis	☐	☐
37.	Reproductive system disorder/infertility	☐	☐
38.	Chronic respiratory/lung condition	☐	☐
39.	Rheumatoid arthritis	☐	☐
40.	Sexually transmitted disease(s)	☐	☐
41.	Skin condition, abnormal or cancerous moles or eczema/cysts/cancer	☐	☐
42.	Sleep apnea/chronic sleep disorder	☐	☐
43.	Stomach disorders/ulcer/acid reflux	☐	☐
44.	Stroke/paralysis/seizures	☐	☐
45.	Tumors	☐	☐
46.	TMJ/jaw joint	☐	☐
47.	Weight fluctuation (+/-20 lbs.)	☐	☐
48.	Cosmetic surgery/implants, use of prosthetic devices/limbs	☐	☐

Section 5 (continued) - Oregon Standard Health Statement

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

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

If "yes" Name______ Due date ____/____/____

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

If "yes" Name______ Due date ____/____/____

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

a. Had any medical advice, diagnosis, care or treatment, including prescribed 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 on page 3? ☐ 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 at a future date? ☐ 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:

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

Section 5 (continued) - Oregon Standard Health Statement

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

Name	Question Number	Start to end dates	Condition	Treatment **including medications**	Final result **Ongoing or Resolved** Please check	Attending physician/health care provider or hospital (name/address/telephone)
					☐ Ongoing ☐ Resolved	
					☐ Ongoing ☐ Resolved	
					☐ Ongoing ☐ Resolved	
					☐ Ongoing ☐ Resolved	
					☐ Ongoing ☐ Resolved	
					☐ Ongoing ☐ Resolved	
					☐ Ongoing ☐ Resolved	
					☐ Ongoing ☐ Resolved	
					☐ Ongoing ☐ Resolved	

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

Name, address, and telephone number of medical provider(s) with current medical record/history:

Section 6 - Agent Certification

FOR AGENT USE ONLY

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 Regence BCBSO. I have informed the applicant that the effective date of coverage is assigned only by Regence BCBSO, 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 (please print or type)	Agent E-mail	Regence BCBSO Agent Number	
	freequote@smarthealthquote.com	**2398-000**	
Agency Name	Phone Number	Fax Number	
SmartHealth	**(503) 287-8808**	**(503) 287-8188**	
Street Address	City	State	ZIP Code
4370 NE Halsey St.	**Portland**	**OR**	**97213**
Agent's Signature (Required)		Date (Required)	
X			

AGENT: COLLECT NO PREMIUM WITH APPLICATION

Section 7 - Certification, Authorization and Signature

Be sure to sign and date the application below. Spouse/Domestic Partner and/or dependent's (age 18 - 22) signature is required, if applicable. Signature applies to both "Certification of Completeness and Correctness" and "Authorization for Use and Disclosure of Protected Health Information":

CERTIFICATION OF COMPLETION AND CORRECTNESS

I affirm that the answers given in this application are true, complete, and correct. I am providing these answers as part of the application procedure required by Regence BCBSO to enroll in their coverage. I understand that Regence BCBSO will rely on each answer in making coverage and rating determinations. For the protection of all our members, fraud or misrepresentation of material fact by me for the purposes of defrauding Regence BCBSO may result in Regence BCBSO taking any action allowed by law or contract, including termination or rescission of coverage, denial of benefits, and/or pursuit of criminal charges and penalties. If coverage is rescinded for fraud or intentionally misleading statements, Regence BCBSO will reimburse premium less any claims paid and will pursue reimbursement for claims paid exceeding any premium. I will promptly inform Regence BCBSO 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 approved by Regence BCBSO. Regence BCBSO may phone me to clarify answers on this application. As the applicant, I understand I have the right to inspect the information in my file.

I further affirm that I received a disclosure statement and outline of coverage from Regence BCBSO or its authorized agent describing the individual contract.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the application form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits, or as required by law.*

Health information requested or disclosed may be related to treatment or services performed by:

- a physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- a clinic, hospital, long-term care or other medical facility;
- any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or;
- an insurance carrier or health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). A separate authorization will be required for psychotherapy notes.

I understand that if this application contains any material misstatements or omissions, Regence BCBSO may deny coverage, modify or cancel coverage and/or take any other legal action available to us by law.

* For more information about such uses and disclosures, including uses and disclosures required by law, or for a description of agent/broker compensation please refer to the Regence Consumer Privacy Notice. A copy is available on our Web site at **www.or.regence.com** or by telephone request at **1 (800) 365-3155.**

Signature of applicant, parent or legal guardian if applicant is under 18 years of age or legally incompetent *	Relationship	Date
X		
Signature of applicant's legal spouse or eligible domestic partner *		Date
X		
Signature of dependent(s) between 18 and 22 years of age *		Date
X		
Signature of dependent(s) between 18 and 22 years of age *		Date
X		

*** If signature by a personal representative of the member/enrollee please complete the following:**

Personal Representative's Name (please print)____________________

Relationship to Individual ____________________ (Attach legal documentation if other than parent of a minor child)

If additional health information is required to qualify you or a family member for coverage, we may send you a separate authorization form for the purpose of obtaining medical information.

THIS AUTHORIZATION MAY NOT BE USED FOR PSYCHOTHERAPY NOTES
(Notes recorded and separately maintained by a mental health professional documenting or analyzing the contents of a conversation during a counseling session.)

PLEASE CONTINUE TO SECTION 8

Section 8 - Premium Billing Options (if application is approved)

PLEASE DO NOT SEND MONEY WITH THIS APPLICATION.

Please indicate one billing option:

- ☐ Monthly (checking account deductions - see below)
- ☐ Quarterly Bill (every three months)
- ☐ Monthly Bill

SUREPAY AUTHORIZATION

Surepay is a simple and convenient way to keep your health coverage in force. If you select the Surepay option of paying for your Regence BCBSO health insurance the payment will be deducted automatically from your account on the 3rd business day of the month or 15th of the month depending on your effective date of coverage. This will provide several advantages to you:

- Your payment will always be made on time (if funds are available in your account).
- You won't have to worry about your coverage accidentally lapsing due to overlooked payments.
- Your monthly bank statement will show a withdrawal notation which is your receipt of payment.
- Please pay your paper bill until you are notified that your electronic funds transfer has been started. Processing may take up to 60 days.

GETTING STARTED is as easy as 1 - 2 - 3:

1. **Complete**, date and sign the authorization below.
2. **Write** "void" on one of your checks.
3. **Return** this completed form and your "voided" check (not a deposit slip).

SOME SUGGESTIONS:

- **Check register reminder:** When you receive your monthly statement be sure to enter the payment amount in your check register. This will help you keep your account in balance and avoid overdraft problems.

- **If you change your bank or wish to cancel your automatic deduction.**
  1. Do this at least 15 days before your next premium is due. We suggest you leave enough money in your old bank account to cover your payments in case there is a delay in processing the change.
  2. Just send us a copy of your new "voided" check and a note explaining that you have changed banks.
  3. Changes may also be made by calling Customer Service at 1 (800) 365-3155.

SUREPAY AUTHORIZATION

1. COMPLETE and sign this authorization form. **2. ATTACH** your voided check (**not** a deposit slip).
3. RETURN to Regence BlueCross BlueShield of Oregon (PO Box 1271, MS5K, Portland, OR 97201-1271).

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. 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.

Financial Institution	Transit/Routing Numbers	Account Number

Account Holder's Name (please print)

Account Holder's Authorized Signature(s) - as it appears on bank records

Date