PacificSource Health Plans
Individual and Family Policy Application

Fax Completed Application to 503-488-5597

Thank you for choosing PacificSource! You may also apply online at **PacificSource.com/find-a-plan**.

1. What you'll need to complete this application:

- A blue or black pen.
- Health information for all family members applying, including the names and dosages of any medications.
- The name (and if possible, the address and phone numbers) of doctors or other healthcare providers you and your family use.
- Information, such as your old ID card, from any insurance company that currently or recently covered you or your family.
- A copy of any documentation you may need to show legal guardianship. If you are part of an unregistered domestic partnership, attach a notarized Affidavit of Domestic Partnership (found on our website under For Employers > Forms and Materials > Administrative Forms).

2. You are eligible to apply if:

- ☑ You are under age 65 or otherwise not eligible for Medicare.
- ☑ You are a resident of the state of Oregon.
- ☑ Your spouse/domestic partner (if applicable) is your legal spouse or registered domestic partner. (See #1 for unregistered domestic partners.)
- ☑ Your children (if applicable) are your natural or adopted children, under age 26 or you are their legal guardian.
- ☑ Your employer will not be paying, or reimbursing you for, any part of the premium.
- ☑ You do not have other health insurance, or you will be cancelling any other health insurance if you are accepted for a PacificSource policy.

3. Where to send this application when you've finished:

Mail: PacificSource Health Plans
PO Box 7068
Springfield, OR 97475-0068

Fax: (541) 225-3646

Email: individual@pacificsource.com

PacificSource HEALTH PLANS

4. What type of coverage would you like?

New Coverage

☐ For myself only

☐ For myself and my family

☐ For my child(ren) or legal dependent(s) only*

*For this option, complete a separate application for each child. If the child is age 18 or older, they should complete and sign their own application.

OR

Change to my Current Coverage

Current Member ID #_____

☐ Add family member(s)

Reason:

☐ Change my plan as shown below

Choose a plan and a deductible (check one):

Premiere	☐ $1,000	☐ $2,500	☐ $5,000	☐ $7,500	☐ $10,000	
Preferred	☐ $500	☐ $1,000	☐ $2,500	☐ $5,000	☐ $7,500	☐ $10,000
Balance	☐ $2,500	☐ $5,000	☐ $7,500			
Value Option	☐ $2,500	☐ $5,000	☐ $7,500	☐ $10,000		
HSA	☐ $1,500	☐ $2,000	☐ $3,000	☐ $5,000		

What date would you like the coverage to begin? (The date must be within 60 days of the date you sign this application.) ☐ 1st or ☐ 15th of _____/_____Mo/Yr

5. Enrolling Myself and My Family

Name (First, MI, Last)	Gender (M/F)	Social Security Number	Date of Birth (MM-DD-YYYY)	Height (ft. in.)	Weight
Myself:					
My spouse or domestic partner:					
My dependent child:					
My dependent child:					
My dependent child:					
Address:			Email:		
Mailing address (if different):			Phone:		

Attach additional pages if needed. ☐ I have attached ___ page(s).

If any of the applicants are not approved for coverage, would you like a policy issued for those who were approved?..... ☐ Yes ☐ No

Would you like to add optional alcoholism coverage? ..... ☐ Yes ☐ No

Would you like to apply for a PacificSource Individual dental policy?..... ☐ Yes ☐ No

6. My Other Insurance Information

A. Do you, or any people listed on this application, have other active health insurance coverage, including Medicare, Medicare Advantage, or Medicare supplemental coverage? ..... ☐ Yes ☐ No

Name of other insurance company (include address and phone number if available):	
Name(s) of individual(s) covered under the policy:	
Date coverage began: ____/____/____ Date coverage ended: ____/____/____ ☐ Coverage is still in effect	Policy number: If group insurance, name of group:

Remember: any other active coverage must be terminated before you can be issued a PacificSource individual and family plan.

B. Do you, or any people listed on this application, work for an employer who offers health insurance benefits to employees? ..... ☐ Yes ☐ No

Are you, or any people listed on this application, enrolled in the employer's plan? ..... ☐ Yes ☐ No

If no, why? _____

C. In the last five years, have you, or any people listed on this application, had PacificSource coverage? ..... ☐ Yes ☐ No

If yes, PacificSource may review its claims history for that time period. Please provide the name(s), Social Security number(s), and Member ID number(s) (if available) for those who had coverage.

Name: _____ Social Security number: _____ Member ID number: _____

Name: _____ Social Security number: _____ Member ID number: _____

Name: _____ Social Security number: _____ Member ID number: _____

D. In the last five years, have you, or any people listed on this application, had coverage declined, postponed, or restricted, or had increased premium for health reasons by another life or health insurance company? ..... ☐ Yes ☐ No

If yes, please provide the name of the person, the reason for the action, date of the action, and the name of the insurance company:

_____

_____

An important note about Creditable Coverage and Pre-existing Conditions:
If you currently have, or have had prior health insurance and it has been less than 63 days since that coverage ended, you may be eligible for credit to reduce (or waive) any pre-existing condition waiting periods your new policy may have. To receive this credit, please provide us with a Certificate of Coverage (also called a "COC") from your previous insurance company.

Need help? ***If you have questions about any part of this application, we'd be happy to help. You can reach an Individual Sales Representative at (866) 695-8684.***

7. My Family's Health Information

You are not required to disclose any information on any part of this application about genetic testing or genetic information related to you or to any blood relative. You are not required to disclose any decision by any insurance company that is based on a genetic test or on genetic information. A person under the age of 19 applying for an individual health benefit plan may not be denied enrollment or excluded from coverage due to health reasons. However we still need complete health history for the last five years in case coordination of care is needed.

Please mark either "Yes" or "No" for each item (**for you and any family members requesting coverage**). Provide details on page 6 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 healthcare professional. Or, within the last five years, has anyone listed on this application had any illness, ailment, injury, health problem, symptoms, physical impairment, surgery, or hospital confinement related to any of the following conditions:

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

Applicant name: _____

Type of product: _____

Applicant name: _____

Type of product: _____

Applicant name: _____

Type of product: _____

50. Please provide the following information for each **female** on this application:

	Applicant Name: ▶	Applicant Name: ▶	Applicant Name: ▶
a. Initial menstrual cycle begun?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b. Date of last menstual period:			
c. If (b) is more than 35 days ago, please explain:			
d. Excessive or absent menstrual bleeding?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e. If (d) is "Yes" please explain:			
If using Depo Provera, date of last shot:			
Abnormal Pap smears?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Prior cesarean section or miscarriage?	☐ 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:

- Had any medical advice, diagnosis, care, or treatment, including prescribed medication, recommended or received from a licensed healthcare professional not listed above? ..... ☐ Yes ☐ No
- Had any illness, ailment, injury, health problem, symptoms, physical impairment, surgery, or hospital confinement not listed above? ..... ☐ Yes ☐ No
- Had chronic cough, fatigue, diarrhea, or enlarged glands? ..... ☐ Yes ☐ No
- Been advised to have or contemplated having an operation or medical procedure not yet performed? ..... ☐ Yes ☐ No
- Been scheduled to see a healthcare provider (at a future date)? ..... ☐ Yes ☐ No
- Taken any prescription medication on a regular basis? ..... ☐ Yes ☐ No

54. List all medication currently being taken by any person on this application:

Applicant name	Medications	Prescribed by	Date prescribed
▶	Name: Dosage: Frequency:	Provider name: Address: Phone:	
▶	Name: Dosage: Frequency:	Provider name: Address: Phone:	
▶	Name: Dosage: Frequency:	Provider name: Address: Phone:	
▶	Name: Dosage: Frequency:	Provider name: Address: Phone:	
▶	Name: Dosage: Frequency:	Provider name: Address: Phone:	
▶	Name: Dosage: Frequency:	Provider name: Address: Phone:	

Health History Details

Please provide specific details below to each question answered "Yes" on pages 4 through 5. Include 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 healthcare provider, or clinic/hospital.

Applicant name	Question number	Start to end dates	Condition	Treatment, including medications	Final result	Healthcare provider or hospital
▶					☐ Ongoing ☐ Resolved	Name: Address: Phone:
▶					☐ Ongoing ☐ Resolved	Name: Address: Phone:
▶					☐ Ongoing ☐ Resolved	Name: Address: Phone:
▶					☐ Ongoing ☐ Resolved	Name: Address: Phone:

Health History Details, continued

Applicant name	Question number	Start to end dates	Condition	Treatment, including medications	Final result	Healthcare provider or hospital
▶					☐ Ongoing ☐ Resolved	Name: Address: Phone:
▶					☐ Ongoing ☐ Resolved	Name: Address: Phone:
▶					☐ Ongoing ☐ Resolved	Name: Address: Phone:
▶					☐ Ongoing ☐ Resolved	Name: Address: Phone:
▶					☐ Ongoing ☐ Resolved	Name: Address: Phone:
▶					☐ Ongoing ☐ Resolved	Name: Address: Phone:
▶					☐ Ongoing ☐ Resolved	Name: Address: Phone:
▶					☐ Ongoing ☐ Resolved	Name: Address: Phone:

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

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

____

____

____

____

8. How Do You Prefer to Pay?

☐ Send me a paper bill by mail each month. (Continue to section 9.)

☐ Through automatic withdrawal from my bank account (EFT)

We authorize and direct PacificSource Health Plans to withdraw funds as follows:

Amount of monthly withdrawal: $_____ Withdrawals will occur on the 5th of each month.

Select one: ☐ Begin transfers on the next available date ☐ Delay transfers until_____(month)

Bank information:

Bank name: _____ Account number: _____

Account Type: ☐ Checking—attach a voided check ☐ Savings—attach a voided savings withdrawal slip

This authorization will remain in effect until termination by either party. If the individual policy premium changes due to a rate increase, alternate plan selection, or age change of the policyholder, this authorization will automatically be amended to authorize withdrawal of an amount equal to the new premium.

_____ _____

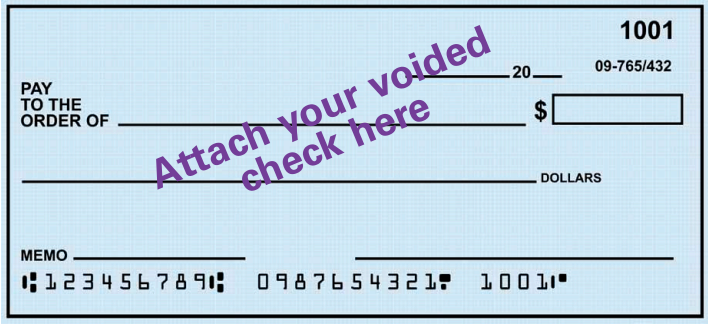
Policyholder's Name (please print) Signature of Bank Account Holder

_____ _____

Policyholder's ID Date

Important details about the automatic withdrawal of your monthly premiums:

- New accounts take 30 days to set up. If your policy is approved and coverage starts sooner than your automatic withdrawal is set up, you may need to pay by check until the funds transfer is in place.
- Transfers occur on the 5th of each month. If the 5th falls on a weekend or a holiday, the transfer will occur on the next business day.
- Transfers will be made for the premium balance due.



9. Certify, Authorize, and Sign

Be sure to sign and date the application on the following page. Your spouse's or domestic partner's signature is also required (if applicable) as is the signature of any child over the age of 18. Your signature applies to both the "Certification of Completeness and Correctness" and "Authorization for Release of Information."

Certification of Completeness and Correctness

I affirm that the answers given in this application are complete and correct. I am providing these answers as part of the application procedure required by PacificSource to enroll in their insurance coverage. I understand that if this application contains any intentional misrepresentation of material fact, PacificSource 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 further understand that if the misrepresentation amounts to fraud, PacificSource may deny coverage, modify or cancel the contract, or take other legal action available to it by law even after the first two years of coverage. I will promptly inform PacificSource in writing if anything happens before my coverage takes effect that makes the information I have provided on this application incomplete or incorrect. I understand and agree that no coverage will be in force until approved by PacificSource. If approved, coverage will be in force as of the effective date determined by PacificSource. A representative of PacificSource may contact me to clarify answers on this application. Representations made by the applicant are deemed to be representations made on behalf of each person covered under this policy. However, changes to the application will not be effective until approved in writing by the applicant. An application received by PacificSource requiring alterations will be modified by amendment and sent to the applicant for signature. As the applicant, I understand I have the right to inspect the information in my file.

Authorization for Release of Information

Names of all applicants:_____

ID # or Social Security # for all applicants:_____

I (We) authorize any physician, healthcare provider, hospital, insurance or reinsurance company, or the Medical Information Bureau, Inc., to use and disclose a copy of my protected health information to PacificSource Health Plans, PO Box 7068, Springfield, Oregon 97475 for the purpose of enrollment determination or eligibility and policy underwriting.

My protected health information includes medical records, emergency and urgent care records, billing statements, diagnostic imaging reports, transcribed hospital reports, clinical office chart notes, laboratory reports, dental records, pathology reports, physical therapy records, hospital records (including nursing records and progress notes), and any personal or medical information related to the purpose of this authorization. Information obtained with this authorization will be used solely for the purpose defined above and will be limited to the minimum necessary information needed to achieve that purpose.

If the information to be disclosed contains any of the types of records or information listed immediately below, additional laws relating to use and disclosure of the information may apply. I (We) understand and agree that such information will be disclosed if I place my initials in the applicable space next to the type of information to be included with the disclosure:

I understand I have the right to refuse to initial this authorization. My refusal to initial this authorization could affect my enrollment in a health plan, eligibility for health benefits, and claims payment.

_____HIV/AIDS test or result information and related records

_____Mental health information

_____Drug/alcohol diagnosis, treatment, or referral information

_____Genetic testing information

I have the right to revoke this authorization in writing at any time. If I revoke this authorization, the information described above will no longer be used or disclosed for the reasons covered by this written authorization except to the extent that action has been taken in reliance on this authorization. Any uses or disclosures already made with my permission cannot be taken back. I understand that revocation of this authorization could affect my enrollment in a health plan, eligibility for benefits, and payment of claims.

To revoke this authorization, please send a written statement to PacificSource Health Plans, Compliance Department, PO Box 7068, Springfield, Oregon 97475, and state that you are revoking this authorization.

I (We) understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I (we) also understand that federal or state law may restrict re-disclosure of HIV/AIDS test or result information, mental health information, genetic information, and drug/alcohol diagnosis, treatment, or referral information.

Unless revoked, this authorization shall be in force for the purpose of enrollment or eligibility determination or policy underwriting for a period not to exceed 24 months. Once an enrollment or eligibility determination has been made, this authorization to use or disclose this protected health information expires.

Each of us authorize you, on behalf of ourselves and the listed family members, to give medical information (including alcohol, chemical dependency, mental treatment, or HIV treatment) you have about us to PacificSource or its representatives.

An insurer offering an insurance contract accepts significant financial risk. Complete information is necessary concerning all health conditions, however minor, to determine whether coverage will be offered. The questions on the application are intended to reveal any and all significant health conditions. Please take the time to give complete and accurate responses, as the insurer may rely solely upon your answers. Any material mistake could completely invalidate (void) the policy at any time within the next two years, even after claims are approved and paid.

I (We) have reviewed and I (we) understand this authorization and the "Certification of Correctness" above.

Applicant's Signature _____ Date _____

Spouse's/Domestic Partner's Signature (if applying for coverage) _____ Date _____

Signature of child age 18 or older (if applying for coverage) _____ Date _____

Signature of child age 18 or older (if applying for coverage) _____ Date _____

Required if applicant is a minor:

Signature of (check one) _____ Date _____ Printed Name of Parent or Guardian _____

☐ Parent ☐ Guardian

This application must be signed and dated no more than **60 days prior to the requested effective date.** *All fields must be completed for this authorization to be valid. If approved, PacificSource will provide the policyholder with a copy of this completed form with the policy.*

10. Are You Ready to Submit?

- ☐ Are all sections filled in completely?
- ☐ Did you include the full contact information for each applicant's current healthcare provider in case we need to contact them?
- ☐ Have you attached any requested paperwork (such as guardianship documentation, Certificate of Coverage, etc.)?
- ☐ Have you selected a payment option and attached a voided check if needed?
- ☐ Did you select a policy effective date on page 2?

11. Submit

Send your signed, completed application and attachments to us by:

Mail: PacificSource Health Plans
PO Box 7068
Springfield, OR 97475-0068

Fax: (541) 225-3646

Email: individual@pacificsource.com

Thank you for your application!

12. Producer Authorization

I, the insurance producer, have not made any representations to the applicant about any provisions, benefits, conditions, or limitations of the policy except through written material furnished by PacificSource. The applicant has been informed that the effective date of coverage is assigned only by PacificSource. I hereby certify that information supplied to me by the applicant has been truly and accurately recorded hereon.

Doug Ellsworth
Producer's Name (printed)

P00096401
PacificSource Producer Number

Producer's Signature

Date

Office use only