Individual health plan application

Fax Completed Application to 503-488-5597

Please print legibly in black or blue ink and return your completed application via mail, fax or email. Faxed and scanned applications must include premium deduction authorization and a voided personal check. **You MUST include a premium check or bank draft information from a personal checking account with this completed application for your application to be processed** as complete.

Please complete all sections of this application. If the application is incomplete or additional information is required, your effective date may be delayed. Illegible and incomplete applications will be returned. We must receive your complete submission including premium prior to the requested effective date.

You are not required to disclose any information on any part of this application about genetic testing or genetic information relating to you or 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. 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.

MAIL: ODS, Attn.: Individual Underwriting, 601 S.W. Second Ave., Portland, OR 97204-3156
FAX: 503-243-3949 **Email:** Scan and send to individualplans@odscompanies.com

SECTION 1 | *Type of application* *(select one)*

Effective dates are assigned by ODS on the 1st of the month following approval and acceptance. For consideration of a particular date in the future (not more than 60 days from the date you signed this form), **please indicate date:** _____ /_____ /_____

- ☐ New enrollment
- ☐ Child-only (ages 0-18) complete a separate form for each child on his or her own plan.
- ☐ Upgrade in coverage
- ☐ Addition of a dependent to an existing policy *(if you check this box, please complete the information at right)*

If you are adding dependents to an existing policy, please provide the following information:

Existing policyholder: _____
ID# of policy: _____
Spouse/date of marriage: _____
Registered domestic partner (RDP)/date of registration: _____
Newborn/date of birth: _____
Child or children/date of birth: _____
Adopted child/date of placement or custody: _____
Other: _____

SECTION 2 | *Select a plan*

You must reside in the state of Oregon for at least 30 days prior to submitting an application and live in Oregon at least six months out of the year in order to be eligible for coverage. In order to be eligible to enroll in the ODS individual dental plan rider, you must enroll in an ODS individual medical plan. The only time you can enroll in an ODS dental plan rider is when you first enroll in an ODS individual medical plan.

As of September 23, 2012, you may access the Summary of Benefits and Coverage (SBC) and Uniform Glossary for the plan you have applied for on the ODS website at www.odscompanies.com. Once on the ODS website, click on the individual and family plan shopping link and select the plan you are applying for. You may also obtain a free paper copy of the SBC or Uniform Glossary by contacting the ODS individual sales and service team.

Apex
- ☐ $1,000*
- ☐ $2,500

Beneficial Value
- ☐ $1,000 ☐ $2,500
- ☐ $5,000 ☐ $7,500

Optional Rx Rider:
- ☐ Yes ☐ No

WellConnect
- ☐ $1,500
- ☐ $3,000

DENTAL PLAN RIDER
- ☐ Delta Dental Fortify dental plan rider
- ☐ Delta Dental Premier dental plan rider
- ☐ Delta Dental PPO dental plan rider
- ☐ **NO,** I do not want the ODS dental plan rider. I understand that by declining the dental coverage available to me, the "one-time only" enrollment period will expire and I will not be allowed to enroll in the dental plan rider at a later date.

Foundation
- ☐ $5,000
- ☐ $10,000

HSA Value
- *Individual:* ☐ $2,800
- *Family:* ☐ $5,600

Maximizer
- ☐ $1,000 ☐ $2,500
- ☐ $5,000

** Eligible plan for medical premium subsidy through the Family Health Insurance Assistance Program (FHIAP).*

SECTION 3 | *Applicant information*

ODS invites you to use the younger spouse/RDP as the primary applicant if it would help you to receive a lower premium.

Applicant's last name	First	M.I.		
Applicant's Social Security no.	Gender ☐ Female ☐ Male	Marital status ☐ Single ☐ Married ☐ RDP	Date of birth	Age
Applicant's height	Applicant's weight	Home telephone no.	Business telephone no.	
Residence address	Street/P.O. box	City	State	ZIP code (+4)
Mailing address *(if different from residence)*	Street/P.O. box	City	State	ZIP code (+4)
Email address	Primary language ☐ English ☐ Spanish ☐ Other _____			

LIST ALL FAMILY MEMBERS TO BE COVERED *(Children under 26 years old)*

Last name of family member	First name	Height	Weight	Gender	Age	Date of birth	Social Security no.
Spouse/RDP							
Child							
Child							
Child							
Child							
Explain relationship to the applicant for any member listed above whose last name is different from the applicant:							

Attach additional copy of this page, if necessary, to list other family members to be included on this application.

SECTION 4 | *Insurance history*

Has any insurance company within the past five years declined, postponed, refused, restricted or increased the premium for health reasons for life or health insurance coverage for you or anyone listed on this application? ☐ Yes ☐ No

If yes, name the insurance company and the person affected: _____

Please indicate the reason for declination by the insurance company and the date the declination occurred: _____

Do you or any family members have other active health or medical coverage, Medicare, Medicare Advantage or Medicare supplemental coverage? ☐ Yes ☐ No

If yes, name of insurance company: _____

Effective date of current medical coverage: ____/____/____ Termination date of current medical coverage: ____/____/____

If anyone listed on this application has had health coverage through ODS within the last five years, list their name and ODS ID number:

As part of the underwriting review, ODS may review any claims history for applicants for the last five years from prior ODS coverage.

Do you or any family members work for an employer who offers health benefits to employees? ☐ Yes ☐ No

Are you or any family members enrolled? ☐ Yes ☐ No

If no, why? _____

SECTION 5 | *Health history statement*

Please clearly mark "yes" or "no" for each item between questions 1 and 53e (for you and any family members). **You must provide details on page 5, under Section 6: Health Statement, to any questions you answer with "yes" between questions 1 and 53e.** Within the past 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 had any illness, ailment, injury, health problem, symptoms, physical impairment, surgery or hospital confinement related to any of the following conditions? (For the purpose of these questions, chronic means persistent, continuous or periodic, or a combination of any of these terms.)

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

SECTION 5 | *Health history statement* *(continued)*

49. Has any person on this application used tobacco products in any form within the past five years? ☐ Yes ☐ No

Name: _____ Type of product: _____

Name: _____ Type of product: _____

Name: _____ Type of product: _____

50. Please provide the following information for each **female** on this application: (details on page 5)

Family member's name:				
a. Initial menstrual cycle begun?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b. Date of last menstrual period: (mm/dd/yy)	____/____/____	____/____/____	____/____/____	____/____/____
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 the answer to **d** is "yes," please explain:				
f. Date of last Depo-Provera shot?				
g. Abnormal Pap smears?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
h. Prior Cesarean section or miscarriage?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Please mark "yes" or "no" for each item below for questions 51 through 53e and give details to any "yes" answers on page 5.

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.
You must provide details on page 5 to any questions you answer with "yes" between questions 53a and 53e.

Within the past 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 healthcare professional, or had any illness, ailment, injury, health problem, symptoms, physical impairment, surgery or hospital confinement not already indicated on this application? ☐ Yes ☐ No
If yes, please indicate question 53a on page 5 and explain.

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 healthcare 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 of applicant	Medication	Prescribed by (Dr.'s name/address/phone)	Date prescribed

SECTION 6 | *Health statement*

You **must** provide specific details below to any question answered "yes" on pages 3 and 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 healthcare provider or clinic/hospital. You may attach a separate sheet of paper if necessary.

Name	Question number	Start to end dates	Condition *(specific illness or injury)*	Treatment *(including medications)*	Final result, ongoing or resolved *(circle one)*	Attending physician/healthcare provider/hospital
					O/R	
					O/R	
					O/R	
					O/R	
					O/R	
					O/R	
					O/R	
					O/R	
					O/R	
					O/R	
					O/R	
					O/R	

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

_____

_____

SECTION 7 | *Prior coverage credit*

If you have had prior health 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. Note: Effective date must be within 63 days of end of prior plan. You must provide a certificate of creditable coverage in order to receive prior coverage credit. This is not required of applicants under the age of 19.

Enter prior coverage information and attach a copy of your certificate of creditable coverage.

Insurance company	Policy no./Identification no.	
Employer name	Effective date of coverage	Termination of coverage
List any coverage before this *(if above coverage was in force less than six months)*		

Do you have 12 months of prior dental insurance with no more than a 90-day break in coverage? ☐ Yes ☐ No

If yes, please provide the following:

Name of individual enrolled in prior plan: _____

Carrier name: _____

Carrier telephone number: _____ Effective: ____/____/____ Termed: ____/____/____

SECTION 8 | *Issuance alternative*

Would you accept a downgrade? ☐ Yes ☐ No

(Downgrade: Insurance carrier may limit the individual health benefit plans in which the individual may elect to enroll because of one or more pre-existing conditions.)

An issuance alternative is determined on a case-by-case basis, and is not guaranteed to be offered in all situations. If you receive an alternative offer, you must sign and return the amendment to put the policy into force indicating your acceptance based on the terms stipulated by the offer. A downgrade offer cannot be issued to a FHIAP applicant.

SECTION 9 | *Agent of record section* *(to be completed by agent 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 ODS, and provided Oregon Disclosure Information required.

In order for you to become the Agent of Record, you must be actively appointed with ODS. Please sign and date below.

I certify that the information supplied to me by the applicant has been truly and accurately recorded here.

Agent name: Doug Ellsworth 20-8047918

Agency name: Health Benefits Solution, Inc Phone no.: 503-922-2903

Street address: 5200 SW Meadows Road, Suite 150

City: Lake Oswego State: Oregon ZIP: 97035

I affirm all health information provided to me has been accurately reflected on this application I disclose to ODS.

Agent's signature (required): _____ Date: ____/____/____

NOTE TO AGENT: COLLECT PREMIUM WITH APPLICATION.

SECTION 10 | *Authorization section*

Be sure to sign and date the application below. A spouse's or RDP's signature is required if applicable. The signature applies to both "Certification of Completeness and Correctness" and "Conditional Authorization to Use/Disclose Protected Health Information":

CERTIFICATION OF COMPLETION AND CORRECTNESS

I affirm that the answers given in this "Oregon Standard Health Statement" are complete and correct. I have provided these answers as part of the application procedure required by ODS to enroll in its insurance coverage. I understand that if this application contains any intentional misrepresentations of material fact ODS may deny coverage, modify or cancel the contract, or take other legal action. I will promptly inform ODS 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 ODS. If approved, coverage will be in force as of the effective date determined by ODS. ODS 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.

MUST LIST EACH APPLICANT FOR COVERAGE, INCLUDING DEPENDENTS (please print):

To list more applicants, please attach another copy of this page with additional dependents and signature of dependent's representative.

CONDITIONAL AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION	
Applicant:	Applicant:
Applicant:	Applicant:
Applicant:	Applicant:

I (We) authorize any physician, healthcare provider, hospital, insurance or reinsurance company to use and disclose a copy of my protected health information to ODS Health Plan, Inc. for the purpose of enrollment determination or eligibility, claim payments 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), including records concerning alcohol and/or chemical dependency, reproductive health (including abortion), sexually transmitted diseases, HIV, AIDS, psychiatric disorders, mental illness and any other personal or medical information related to the purpose of this authorization. Information obtained with this authorization will be used for the purpose defined above and will be limited to the minimum necessary information to achieve that purpose.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected under federal law. 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. Any uses or disclosures already made with my permission cannot be taken back. Unless revoked, this authorization shall be in force and effect for 24 months from the date of the signature below.

To revoke this authorization, please send a written statement to ODS Health Plan, Inc., Privacy Office, 601 S.W. Second Ave., Portland, OR 97204 and state that you are revoking this authorization. This authorization is a condition of your enrollment in our health plan or your eligibility for benefits. If you decide not to sign this authorization, we may decline to enroll you in our health plan and decline to provide benefits and payment for treatment.

I (We) have reviewed and I (we) understand this authorization.

Signature of applicant, parent or legal guardian if applicant is under age 18 X	Relationship*	Date
Print name of parent or legal guardian for minors on this application X		
Signature of applicant's legal spouse, if applying for coverage X	Date	
Signature of dependent(s) age 18 and older, if applying for coverage X	Date	
Signature of dependent(s) age 18 and older, if applying for coverage X	Date	

**If not parent, please attach legal documentation if you are the legal guardian or Holder of Power of Attorney.*

MAIL: ODS, Attn.: Individual Underwriting, 601 S.W. Second Ave., Portland, OR 97204-3156
FAX: 503-243-3949 **Email:** Scan and send to individualplans@odscompanies.com

If you have questions, please contact Customer Service at 503-243-3973 or toll-free at 877-277-7073.

www.odscompanies.com

Insurance products in Oregon provided by Oregon Health Plan, Inc.

SECTION 11 | *Payment options*

INITIAL PAYMENT (SELECT ONE)

Please select a payment preference for your initial premium:*

☐ I would like ODS to draft the initial monthly or quarterly premium and begin billing statements for subsequent billings. I've attached a photocopy of a "voided" personal check from the account to be drafted. **Please fill out the Auto Pay authorization agreement.**

☐ I've attached a personal check for one month's premium and do not wish ODS to draft the initial premium.

Please make checks payable to ODS. Any payment received or draft authorization must be from a personal (not business) checking account.**

NOTE: Sending in a check does not guarantee coverage. The first month's or quarterly premium amount will not be credited to your account until your application for individual health insurance coverage has been approved by ODS Underwriting. You will be notified in writing of your application status no later than 60 days from receipt. If your application is approved, the coverage effective date will be the first day of the month following approval. If your application is not approved, you will be notified in writing and your check will be returned to you. ODS may change or amend the policy or premiums, upon approval by the Oregon Insurance Division, by giving a 30-day notice before the change is effective.

SUBSEQUENT PAYMENTS (SELECT ONE)

Please select your payment preference for subsequent premiums:

☐ **AUTO PAY (EFT)**
Upon acceptance, the initial premium will be deducted via Auto Pay (please fill out the Auto Pay authorization agreement below). After the initial draft, funds transfer automatically around the fifth calendar day of each month. If you prefer, you may attach a personal check for your first month's premium and Auto Pay will begin the following month.

☐ **MONTHLY BILLING STATEMENT**
A $5 monthly administration fee is required with this payment method. You will receive a bill every month.

☐ **QUARTERLY BILLING (EVERY THREE MONTHS)**
A $5 quarterly administration fee is required with this payment method. You will receive a bill every three months.

☐ **FAMILY HEALTH INSURANCE ASSISTANCE PROGRAM (FHIAP) APPLICANTS**
You do not need to include a premium, but you must submit a signed copy of your FHIAP Certificate of Eligibility with your application.

AUTO PAY AUTHORIZATION AGREEMENT

Instructions:

1. Complete and sign below as account holder for monthly automatic bank deduction of insurance premium.

2. Attach a photocopy of your voided personal check from the account to be drafted.

3. Submit the completed application and appropriate documents with your application.

Applicant: _____ Account holder: _____

I (or we, if this is a joint account) authorize ODS to charge my (our) checking account for monthly insurance premiums for the above named individual. I also authorize my bank named here to honor these monthly charges. This authority will remain in effect until I give my bank a reasonable chance to act upon it. I can stop payment by notifying my bank before my account has been charged.

Name of bank: _____

Signature of account holder: _____ Date: _____

You may be billed for the premium payment necessary to begin electronic deductions. If you wish to cancel your bank deductions,we must receive written notice 15 days before the next deduction date.

BILLING WORKSHEET

Billing option		MONTHLY	QUARTERLY
Medical plan monthly premium		$_____	$_____
Rx rider (if applicable)	+	$_____	$_____
Dental plan monthly premium	+	$_____	$_____
Total due to ODS	=	$_____	$_____

* *If no billing option is selected, then you are agreeing, by default, to a monthly billing statement with a $5 monthly administration fee.*

** *Individual benefit plans are not intended for sale as an employer-sponsored health benefit for employees. For this reason, an individual policy cannot be paid with a business check and must be drawn on personal accounts not affiliated with a business. For information on small employer health benefit plans, contact the ODS Sales and Account Services department at 503-243-3948 or 800-578-1402.*