



Post Office Box 9
2909 Daggett Ave #275
Klamath Falls, OR 97601

541.312.0018 Deschutes County
541.882.1466 Klamath County
800.303.8680 All Other Areas
541.882.1447 Fax

Individual Policy Application Form

(Please type or print neatly in black or dark blue ink; please attach additional pages if necessary.)

Please complete all sections of this application.

If the application is incomplete, it will be returned to you and, if approved, your effective date may be delayed.

We must receive your application by the 15th of the month for the next month's effective date.

Applications received after the 15th will be processed for the subsequent month's effective date.

Do not send in a check or cash with this application;

Preferred Health will mail you a premium billing statement if approved for coverage.

Section One - Purpose of Application

I am applying for:

- 1) Requested Effective Date: _____ Note: Must be the 1st day of the month, not to exceed 60 days from date application was signed.
- 2) New Enrollment
- 3) Addition of a dependent to an existing policy
 - New Spouse - Date of Marriage _____
 - Newborn - Date of Birth _____
 - Adopted child - Date of Placement in my custody _____
 - Other _____
- 4) To delete family member(s) (complete only section two for those members remaining on coverage, sign and date the application in section seven.)
 - Name: _____ Reason for deletion: _____ Date of event: _____
 - Name: _____ Reason for deletion: _____ Date of event: _____
- 5) Upgrade in coverage to: _____ Current Policy Number: _____
- 6) Other: _____

Section Two - Applicant Information

List all family members to be insured. Only your legal spouse and dependent children are eligible.

Last Name	First Name, Middle Initial	Height	Weight	Sex	Birth Date	Social Security Number
Applicant						
Spouse						
Child						
Child						
Child						
Child						
Child						

What is your marital status? Single Married Separated

Explain the relationship to you of any person listed above whose last name is different from yours. If spouse, attach copy of marriage certificate. If guardian, attach copy of documentation. _____

If you or any other person listed on this application are not approved for coverage, do you want a policy issued for those who are approved for coverage?

Yes No

Comments: _____

Address Information

Last Name	First Name	Middle Initial
Residence Address (No P.O. Box Numbers)	City	State
Mailing Address (If different from residence address)	City	State
E-Mail Address	Home Phone	
Employer	Work Phone	

Will your employer pay any portion of your premium? Yes No Preferred Health individual policies may not be used for an employer based plan if the employer pays or reimburses any part of the premium.

Section Three - Requested Benefits

You must be a resident of the state of Oregon in order to be eligible for coverage. All optional benefits are subject to underwriting approval. Occupational Coverage requires an Occupational Coverage Request Form to be completed.

RX Buy-Up and Dental Options are available only for those enrolled in the Individual Medical Plan, with an Individual Deductible amount of \$5,000 or less.

The Dental Option is available during the initial enrollment of the Individual Medical Plan, as a "one-time only" enrollment period. You will not be allowed to enroll in the dental plan at a later date.

Preferred Health may change or amend the policy or premiums, upon approval by the OR Insurance Division, by giving a 30-day notice before the change is effective.

Plan A	Plan B	Plan C	Plan D	Plan H *
Deductible:	Deductible:	Deductible:	Deductible:	Deductible:
<input type="checkbox"/> \$500	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$1,000 - \$2,000
<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$2,500	<input type="checkbox"/> \$2,500	<input type="checkbox"/> \$2,500	<input type="checkbox"/> \$2,650 - \$5,250
<input type="checkbox"/> \$2,500	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$5,000	
<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$7,500	<input type="checkbox"/> \$7,500	<input type="checkbox"/> \$7,500	
	<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$10,000	
			<input type="checkbox"/> \$15,000	
Optional Benefits:	Optional Benefits:	Optional Benefits:	Optional Benefits:	Optional Benefits:
<input type="checkbox"/> RX Open Option	<input type="checkbox"/> RX Open Option	<input type="checkbox"/> RX Open Option	<input type="checkbox"/> RX Open Option	
<input type="checkbox"/> RX Closed Option	<input type="checkbox"/> RX Closed Option	<input type="checkbox"/> RX Closed Option	<input type="checkbox"/> RX Closed Option	
<input type="checkbox"/> Dental Option	<input type="checkbox"/> Dental Option	<input type="checkbox"/> Dental Option	<input type="checkbox"/> Dental Option	<input type="checkbox"/> Dental Option
<input type="checkbox"/> Alcoholism Option	<input type="checkbox"/> Alcoholism Option	<input type="checkbox"/> Alcoholism Option	<input type="checkbox"/> Alcoholism Option	<input type="checkbox"/> Alcoholism Option
<input type="checkbox"/> Occupational Coverage Option	<input type="checkbox"/> Occupational Coverage Option	<input type="checkbox"/> Occupational Coverage Option	<input type="checkbox"/> Occupational Coverage Option	<input type="checkbox"/> Occupational Coverage Option

* Note: If you are applying for Plan H (HSA Plan), do you plan to open an account with HSA Bank? Yes No

Section Four - Insurance History

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.

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

If yes, name the insurance company: _____

Effective date of current medical coverage: _____

Termination date of current medical coverage: _____

- ◆ Have you had coverage with Preferred Health within the past five years? Yes No

If yes, please list ID#, Group # and name of insured policyholder:

- ◆ Do you or any family member work for an employer who offers health benefits to employees? Yes No

Are you or any family members enrolled: Yes No

If no, why? _____

If you have had prior health coverage and you are applying within 63 days of prior coverage termination, you may be eligible for credit towards any pre-existing condition limitations, maternity benefits, and specified conditions may be reduced under this plan.

Prior Coverage Information - Attach a copy of prior plan ID card or Certificate of Creditable Coverage.

Insurance Company Name and Phone Number	Policy Number/ID Number
Name of Employer	Effective Dates of Coverage: From: _____ To: _____
List names of individuals covered under a current or prior policy:	

Section Five - Oregon Standard Health Statement

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, 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?

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

49. Has any person on this application used tobacco products in any form within the last five 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:				
Date of last DEPO Provera shot?				
Abnormal Pap smears?	<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
Prior Cesarean section or miscarriage?	<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:

- Had any medical advice, diagnosis, care or treatment, including prescribed medication, recommended or received from a licensed healthcare professional, or 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? Yes No
- 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)	Date prescribed

Current medication list continued:

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

Section Five - Oregon Standard Health Statement (continued). Please provide specific details below to each question answered yes on pages three and four. 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 or other healthcare provider, or clinic hospital.

Name	Question Number	Start to End Dates	Condition	Treatment Including Medications	Final Result: Ongoing or Resolved (circle one)	Attending physician / healthcare provider or hospital (name/address/telephone)
					ONGOING or RESOLVED	
					ONGOING or RESOLVED	
					ONGOING or RESOLVED	
					ONGOING or RESOLVED	
					ONGOING or RESOLVED	
					ONGOING or RESOLVED	
					ONGOING or RESOLVED	
					ONGOING or RESOLVED	
					ONGOING or RESOLVED	
					ONGOING or RESOLVED	
					ONGOING or RESOLVED	
					ONGOING or RESOLVED	
					ONGOING or RESOLVED	
					ONGOING or RESOLVED	

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

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

Section Six- Oregon Medical Insurance Pool (OMIP)

If an applicant is denied coverage or offered a plan other than what was selected, that Applicant may apply for coverage under the Oregon Medical Insurance Pool (OMIP). Contact Preferred Health Marketing Department for more information.

Section Seven - Authorization Section

Be sure to sign and date the application below. Spouse's signature is required if applicable. Signature applies to both "Certification of Completeness and Correctness" and "Authorization for Release of 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 Preferred Health to enroll in its insurance coverage. I understand that if this application contains any material misstatements or omissions, Preferred Health may, within the first two years of coverage, deny coverage, modify or cancel the contract, or take other legal action. I will promptly inform Preferred Health 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 Preferred Health. If approved, coverage will be in force as of the effective date determined by Preferred Health. Preferred Health 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.

CONDITIONAL AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

Applicant:	_____	Social Security #	_____
Applicant:	_____	Social Security #	_____
Applicant:	_____	Social Security #	_____
Applicant:	_____	Social Security #	_____

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 Preferred Health Plan, Inc., P.O. Box 9, Klamath Falls, OR 97601 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 statement, 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:

- _____ HIV/AIDS test or result information and related records
- _____ Mental health information
- _____ Genetic testing information
- _____ Drug/alcohol diagnosis, treatment, or referral information

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

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 Preferred Health Plan, Inc., P.O. Box 9, Klamath Falls, OR 97601, 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 Preferred Health or its representatives.

An insurer offering an insurance contract accepts significant financial risk. Complete information is necessary concerning all health condition, 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 Preferred Health 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 Signature (if applying for coverage)

Date

Signature of child age 18 or over (if applying for coverage)

Date

Required if applicant is a minor:

Signature of (check one) Parent Guardian

Date

Printed Name

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, Preferred Health will provide the policyholder with a copy of this completed form with the policy.

Section Eight - 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 Preferred Health. The applicant has been informed that the effective date of coverage is assigned only by Preferred Health. **I hereby certify that information supplied to me by the applicant has been truly and accurately recorded hereon.**

Producer's Name (printed)

Preferred Health Producer Number

Producer's Signature

Date

COLLECT NO PREMIUM WITH APPLICATION

Please mail contract to: Policyholder Producer

Electronic Funds Transfer Authorization



Thank you for choosing to pay your Preferred Health Individual Policy premium by electronic funds transfer (EFT). We think you will appreciate the convenience and security of EFT.

- ◆ New policies become eligible for EFT after they have been effective for one month. **The first premium payment on a new policy cannot be paid by EFT.**
- ◆ Once your EFT is set up, we will notify you by letter of the date the first premium draft will occur. Until then, you must make any premium payments by check or your account will become past due and your policy could be subject to cancellation. On occasion, the second month's premium is due before the first draft occurs.
- ◆ Transfers can only be made for the monthly premium currently due.
- ◆ Transfers occur on the 5th of each month (when the 5th falls on a weekend or holiday, the transfer occurs on the next business day).
- ◆ If you have any questions, you are welcome to contact our Individual Marketing Department at (541) 312-0018 in Descutes County, (541) 882-1466 in Klamath County or (800) 303-8680 from all other areas.

INSTRUCTIONS

- ◆ Complete the form below.
- ◆ Attach a voided check if deduction is to be from checking account; or attach a deposit slip if deduction is to be from savings account.
- ◆ Return this form and attached check to:
Individual Marketing Department
Preferred Health Plan, Inc.
PO Box 9
Klamath Falls, OR 97601

AUTHORIZATION

First premium payment must be by check; account must be paid to date before EFT may be activated.

I/We authorize and direct Preferred Health Plan, Inc. to withdraw funds as follows:

Amount of monthly withdrawal: Monthly premiums.

Withdrawals are made on the 5th of each month (when the 5th falls on a weekend or holiday, the transfer occurs on the next business day).

Select one: Begin transfers on the next available date Delay transfers until _____ (month)

Bank Information:

Bank Name: _____ Account Number: _____

Bank Routing Number: _____

Account Type: Checking – attach a voided check Savings – attach a voided savings deposit 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 migration of policyholder, this authorization will automatically be amended to authorize withdrawal of an amount equal to the new premium payment.

Policyholder's Name (please print)

Signature of Bank Account Holder

Policyholder's ID Number or Social Security Number

Date