

Enrolling is Simple. Just Follow These 3 Easy Steps...

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department
at: _____ fax: _____

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly

Step 3

SEND THE COMPLETED APPLICATION TO:

Please make your check payable to: Health Net

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

If you have questions please contact our office at:

Thank you for choosing...





Health Net

Health Net Health Plan of Oregon, Inc. Oregon Standard Health Statement Individual & Family Plan Application

PLEASE COMPLETE IN INK

I am applying to Health Net Health Plan of Oregon, Inc. for an individual medical-surgical-hospital policy, with benefits selected as follows:

Participating Provider Policy requested: (Mark policy and deductible)

Form with columns for Diamond 15, Emerald 40, Topaz First Dollar, Pearl HMO 25, Crystal HDHP (HSA-Qualified), and Value (80%/50%) with various deductible options.

You may choose an effective date of the 1st or 15th of the month. If the application approval process is completed after the requested effective date, your effective date will be automatically changed to the next available effective date after approval. Requested Effective Date is:

My initial payment equal to one month's premium of \$ is enclosed. If my coverage is effective the 15th of the month, my next billing statement may show a prorated premium.

Bill me for my initial premium upon acceptance. Note: Premium must be received before your coverage will become effective.

Future payment choice for plans: Mail-in premium payment Simple Pay Option (automatic premium withdrawal)

GENERAL - The oldest family member to be enrolled must be the applicant and will be the policy Subscriber.

Form for Applicant's Name, Social Security #, Residence Address, City, State, Zip, County, P.O. Box, Home Telephone Number, Sex, Height, Weight, Birth Date, Primary Care Provider.

COMPLETE SPOUSE/DEPENDENT SECTION ONLY IF THEY ARE TO BE COVERED.

Dependent children must be under 23 years old and unmarried

All HMO Plan enrollees must designate a Primary Care Provider (PCP). Each family member may choose a different PCP.

Table with columns for Spouse's/Dependent's Full Name, Social Security Number, Sex, Height, Weight, Birth Date, Primary Care Provider, and Current Patient status.

If last name of a dependent differs from yours, explain relationship:

If any of the persons listed above are entitled to Creditable Coverage toward the exclusion periods for pre-existing conditions, other specified conditions and transplant exclusion periods, indicate the period of Creditable Coverage. (See last page for definition.) Include additional sheets if necessary. Please include a copy of your Certificate of Prior Coverage. You will not receive Pre-existing credit until we receive this document.

Prior Carrier Name Telephone #

Applicant's Name Creditable Coverage from to

Applicant's Name Creditable Coverage from to

Form asking how the applicant heard about Health Net Health Plan of Oregon, Inc. with options: Radio, Mail, Billboard, Newspaper, Yellow Pages, Broker, Internet, Other.

Incomplete applications will be returned. The effective date will be delayed until the completed application has been received.

HEALTH HISTORY STATEMENT

Please mark either "Yes" or "No" for each item listed for yourself and any family members requesting coverage. Provide details on page four to any questions answered "Yes." For the purposes of these questions, chronic means persistent, continuous, or periodic, or a combination of any of these terms.

Within the last **five** years, has anyone listed on this application had any medical advice, diagnosis, care, or treatment, including prescribed medications, recommended or received from a licensed health care professional or had any illness, ailment, injury, health problem, symptoms, physical impairment, surgery or hospital confinement related to any of the following conditions:

- | | | | |
|--|--|--|--|
| 1. AIDS, ARC, HIV positive..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 27. High blood pressure..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Alcohol/Chemical/Drug abuse/habit... | <input type="checkbox"/> Yes <input type="checkbox"/> No | If "Yes", current reading
_____/_____ | |
| 3. Anemia/Chronic fatigue | <input type="checkbox"/> Yes <input type="checkbox"/> No | 28. Kidney/Kidney stones | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Appendicitis/chronic abdominal pain... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 29. Knee/Shoulder/Hip/Other joints | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Back/Neck/Spine..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 30. Liver condition /Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Birth defect/Congenital deformities... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 31. Lupus, chronic muscle pain, muscle injury or disease, or fibromyalgia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Bladder/Urinary tract..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 32. Mental/Emotional condition/Depression..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Blood/Circulatory..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 32. A. Therapy/Counseling within last 5 years (if "Yes," record date of last session on page 3)..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Bone/Orthopedic..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 33. Neurological condition/Disease/Injury... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Brain disease or injury/concussion | <input type="checkbox"/> Yes <input type="checkbox"/> No | 34. Phlebitis/Blood clot..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Breast (lumps or masses) | <input type="checkbox"/> Yes <input type="checkbox"/> No | 35. Osteoarthritis/Osteoporosis/ Osteopenia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Cancer..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 36. Prostate/Elevated PSA/Prostatitis..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Chemotherapy/Radiation treatment.... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 37. Reproductive system disorder/Infertility..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. A Colon/Rectum/Intestinal/Bowel..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 38. Chronic respiratory/Lung condition... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. B Blood in stool | <input type="checkbox"/> Yes <input type="checkbox"/> No | 39. Rheumatoid Arthritis..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 15. Convulsion/Seizures/Epilepsy..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 40. Sexually transmitted disease(s)..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16. Diabetes/Sugar in urine..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 41. Skin condition, abnormal or cancerous moles or eczema/cysts/cancer... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 17. Chronic ear/Nose/Throat/Tonsil condition/Disease/Disorder..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 42. Sleep apnea/Chronic sleep disorder ... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 18. Eating disorders such as, but not limited to, Anorexia or Bulimia..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 43. Stomach disorders/Ulcer/Acid Reflux... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 19. Emphysema/Asthma/Chronic lung disease (COPD) | <input type="checkbox"/> Yes <input type="checkbox"/> No | 44. Stroke/Paralysis/Seizures..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 20. Endocrine/Gland/Hormone system..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 45. Tumors | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 21. Disease or injury of Eye/Cataract/Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | 46. TMJ/Jaw joint..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 22. Gallbladder/Pancreatic disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | 47. Weight fluctuation (+/- 20 lbs.)..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 23. Chronic headaches/Migraines | <input type="checkbox"/> Yes <input type="checkbox"/> No | 48. Cosmetic surgery/Implants, use of prosthetic devices/Limbs | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 24. Heart/Chest pain/Angina..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Hernia..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 26. High cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| If "Yes", current reading _____ | | | |

PAGE 2

49. Has any person on this application used tobacco products in any form within the last 5 years? Yes No

If Yes:

Name :	Type of product:
Name :	Type of product:
Name :	Type of product:

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

Family member	Name:	Name:	Name:	Name:
a. Initial menstrual cycle begun?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Date of last menstrual period.				
c. If (b) is more than 35 days ago, please explain:				
d. Excessive or absent menstrual bleeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. If (d) is yes, please explain:				
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:

- | | |
|--|---|
| <p>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 above? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>b. Had chronic cough, fatigue, diarrhea, or enlarged glands? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> | <p>c. Been advised to have or contemplated having an operation or medical procedure not yet performed? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>d. Been scheduled to see a health care provider? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>e. Taken any prescription medication on a regular basis? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> |
|--|---|

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

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

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)
					<input type="checkbox"/> Ongoing <input type="checkbox"/> Resolved	
					<input type="checkbox"/> Ongoing <input type="checkbox"/> Resolved	
					<input type="checkbox"/> Ongoing <input type="checkbox"/> Resolved	
					<input type="checkbox"/> Ongoing <input type="checkbox"/> Resolved	
					<input type="checkbox"/> Ongoing <input type="checkbox"/> Resolved	

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

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

CURRENT OR FORMER HEALTH NET COVERAGE			
Member Name	Group Number	State	Last Date of Coverage

Continuation of Present Health Coverage: If you have other health coverage now, will you continue the coverage in addition to the Health Net of Oregon coverage you are applying for? Yes No

Name of Company _____ Address _____ Telephone No. _____

Is any person listed on the application receiving or eligible to receive Medicare or Social Security Disability benefits? Yes No
If Yes, give name: _____ Medicare Effective Dates: Part A _____ Part B _____

Medicare Identification number: _____

Information Practices: Information about you or an enrolling family member may be obtained from medical records as indicated in the medical information release portion of the application form. Other than from medical records, personal information will not be collected from any sources other than the applicant or individuals proposed for coverage.

BE SURE TO COMPLETE THE HEALTH HISTORY STATEMENT AND SIGN AND DATE THE BACK PAGE

FOR UNDERWRITING USE ONLY

Definition: "Creditable Coverage" means any of the following coverages: Group coverage (including FEHBP and Peace Corps); Individual coverage (including student health plans); Medicaid; Medicare; CHAMPUS; Indian Health Service or tribal organization coverage; state high risk pool coverage; and public health plans. Creditable coverage does not include coverage only for a specified disease or illness or hospital indemnity (income) insurance. Coverage is Creditable only if there has not been a gap in coverage exceeding 63 days.

CERTIFICATION AND AUTHORIZATION

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 Health Net Health Plan of Oregon, Inc. to enroll in the insurance coverage. I understand that if this application contains any material misstatements or omissions, Health Net may, within the first two years of coverage, deny coverage modify or cancel the contract, or take other legal action. I will promptly inform Health Net in writing if anything happens before my coverage takes effect that makes this incomplete or incorrect. I understand and agree that no coverage shall be in force until approved by Health Net. If approved, coverage will be in force as of the effective date determined by Health Net. Health Net 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 AND DISCLOSE PROTECTED HEALTH INFORMATION

To any physician; health care provider, including OHSU; hospital, including OHSU; insurance or reinsurance company; the Medical Information Bureau, Inc. (MIB), or other insurance information exchange:

Each of us authorizes you to give Health Net Health Plan of Oregon, Inc. or its representatives any medical record information (including alcohol, chemical dependency, mental treatment, or HIV treatment) you have about me or my family members. Such information may be used for processing application for coverage, for prior authorizing services or processing claims for benefits, or for purposes of health care provider credentialing, quality assurance, utilization review, case management, peer review, and audit. A photocopy of this authorization is as valid as the original. I understand that I may receive a copy of this authorization upon request.

This authorization takes effect on the date signed and it remains in effect as follows:

- For information used to process this application – 30 months
- For information used for all the other reasons listed above – as long as coverage is in effect or until the completion of processing any claim, whichever is longer.

I affirm that I received a disclosure statement and outline of coverage from Health Net of Oregon or its authorized agent. I understand that a PPO policy will not pay benefits for any loss incurred during the first six months after the effective date on account of a disease or physical condition which I now have or have had in the past. Creditable coverage applies. I understand that if my application for coverage is accepted, I will have ten days after receiving notice of acceptance during which I may cancel the policy for a full refund. I affirm that my employer is not paying the premium for this coverage.

I understand that if I/we are declined for the plan requested on this application, I/we may be offered an alternate plan(s) for which I/we would be accepted.

Be sure to sign and date the application. Spouse's signature is required if applicable. Signature applies to both "Certification of Completeness and Correctness" and "Authorization for Release of Information".

SIGNATURE OF APPLICANT (PARENT OR LEGAL GUARDIAN IF APPLICANT IS UNER 18 YEARS OF AGE OR LEGALLY INCOMPETENT)	RELATIONSHIP	DATE
--	--------------	------

PRINT NAME OF APPLICANT (PARENT OR LEGAL GUARDIAN
IF APPLICANT IS UNER 18 YEARS OF AGE OR LEGALLY INCOMPETENT)

SIGNATURE OF APPLICANT'S LEGAL SPOUSE (IF APPLYING FOR COVERAGE)	DATE
--	------

INSURANCE PRODUCER USE ONLY

I certify that the information supplied by the applicant(s) has been truly and accurately recorded and that I have made no representation about benefits, condition, or limitation of the policy except through written material furnished by Health Net Health Plan of Oregon, Inc.

Insurance Producer's Signature _____	Date _____
Insurance Producer's Name (please print) _____	Insurance Producer's Number _____
Agency Name _____	Insurance Producer's Phone Number _____
Agency Address _____	City _____ State _____ Zip _____

Health Net Health Plan of Oregon, Inc., 13321 SW 68th Parkway, Tigard Oregon 97223 • 888.802.7001 • www.healthnet.com



Simple Pay Option

Simple Pay Option is a valuable service that guards against a missed payment or possible lapse in coverage. It also saves the expense of postage, check writing, or money orders. Each month, Simple Pay Option automatically deducts your health insurance premium amount directly from an account you select. The premium will be deducted on approximately the fifth day of each month. Your premium payments will be clearly identified on your monthly bank statement.

Automatic Payment Instructions for Individual & Family Plans

- 1. Fill out and sign this form. Please use black ink.
2. Attach a blank check from your personal financial account and write VOID on it. We will use it as a record of your account number. Please do not submit a deposit slip instead of a voided check.
3. We will communicate with your bank regarding this authorization.
4. Send a personal check for the first month's premium.
5. If you are returning this authorization separately from your Individual Enrollment application, please mail to:

Health Net Health Plan of Oregon, Inc.
Individual & Family Enrollment
13221 SW 68th Parkway, Suite 200
Tigard, Oregon 97223

Form with fields for Applicant's Social Security Number, Transit Routing Number, Account Number, Bank Name, Bank Address, City, State, and Zip.

As a convenience, I request and authorize Health Net Health Plan of Oregon, Inc. to pay and charge to the above account checks drawn on that account by and payable to the order of Health Net Health Plan of Oregon, Inc. provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that Health Net's rights in respect to each such check shall be the same as if it were a check written to Health Net and signed personally by me. This authority is to remain in effect until revoked by me in writing and until Health Net actually receives such notice, I agree that Health Net shall be fully protected in honoring any such check. (Note: A 30-day notice is required to discontinue this service due to the time required to initiate this change with your bank.)

I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, Health Net shall be under no liability whatsoever even though such dishonor may result in the forfeiture of health coverage.

Signature of Account Holder

Date



PLEASE INCLUDE YOUR VOIDED CHECK.