

# Oregon Individual Enrollment Application

Please read all accompanying materials before completing this application. **All questions must have complete and accurate answers.** Omissions or incomplete answers will result in the return of your application and may cause a delay in processing your coverage. Please **PRINT**, sign and date in blue or black ink. **Applications that contain correction fluid or tape will not be accepted.** You must be a resident of the state of Oregon and not eligible for Medicare to apply.

**SECTION 1 – TYPE OF APPLICATION. Must be received 10 days prior to requested effective date.**

- New Enrollment Application: Requested effective **Month:** \_\_\_\_\_ **Day:**  1st  15th (no more than 60 days after the signature date)
- Plan Change (**from and to a current LifeWise Plan**): Member ID# \_\_\_\_\_ (first of the month effective date only)
- Adding Legally Recognized Spouse / Registered Domestic Partner: Member ID# \_\_\_\_\_  
Date of Marriage / Registered Domestic Partnership: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (Signature of spouse/registered domestic partner required on page 7)
- Adding Child: Member ID# \_\_\_\_\_  Newborn  Adoption Date of Birth / Placement: \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- Adding Child: Legal Ward/Guardianship/Medical Child Support Order Date of Order: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (attach copy of court order or placement papers)

**SECTION 2 – SUBSCRIBER & DEPENDENT INFORMATION (attach additional page(s) if necessary)**

Name—Last, First, Middle Initial (as it will appear on your ID card. Only the first 26 characters will be displayed.)	If last name is different than applicant, explain relationship	Social Security #	Height (ft. in.)	Weight	Gender	Date of Birth (MM/DD/YYYY)
Self: ▶					<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /
Legally Recognized Spouse / Registered Domestic Partner: ▶					<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /
Dependent Child (under 23 only): ▶					<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /
Dependent Child (under 23 only): ▶					<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /
Dependent Child (under 23 only): ▶					<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /
Home Address (not P.O. Box) required		City / State / ZIP		County	Home Telephone Number ( )	
Mailing Address (if different from Home Address)		City / State / ZIP		County	Work Telephone Number ( )	
Billing Address (if different from Mailing Address)		City / State / ZIP		County	Cell Telephone Number ( )	
E-mail Address of Primary Applicant						

**SECTION 3 – BENEFIT PLAN SELECTION**

Check one box to indicate your family’s plan selection and deductible option:

- 1. WiseEssentials™ Deductible Options:  \$1,500  \$2,500  \$5,000  \$7,500
- 2. WiseChoices™ Deductible Options:  \$500  \$1,000  \$2,500  \$5,000
- Health Savings Account (HSA) Qualified Plans**
- 3. WiseSavings™ (Individual) Deductible Options:  \$3,000
- 4. WiseSavings™ (Family) Deductible Options:  \$6,000
- Optional Benefit**
- 5. Alcoholism Endorsement  \$4,500 limit per 24 month period

**SECTION 4 – ELIGIBILITY**

To be eligible for coverage, applicants:

- Must be a resident of and continue to remain a resident of Oregon state. We may require proof of residency.
- Must not be entitled to Medicare (including entitlement due to disability).
- Must be under 65 years of age.

**SECTION 5 – RATE/BILLING INFORMATION**

**DO NOT SEND PAYMENT with this application.**

**PAYMENT OPTIONS—Select One:**  Monthly Billing (by mail)  Monthly Automatic Funds Transfer (complete Section 6.)

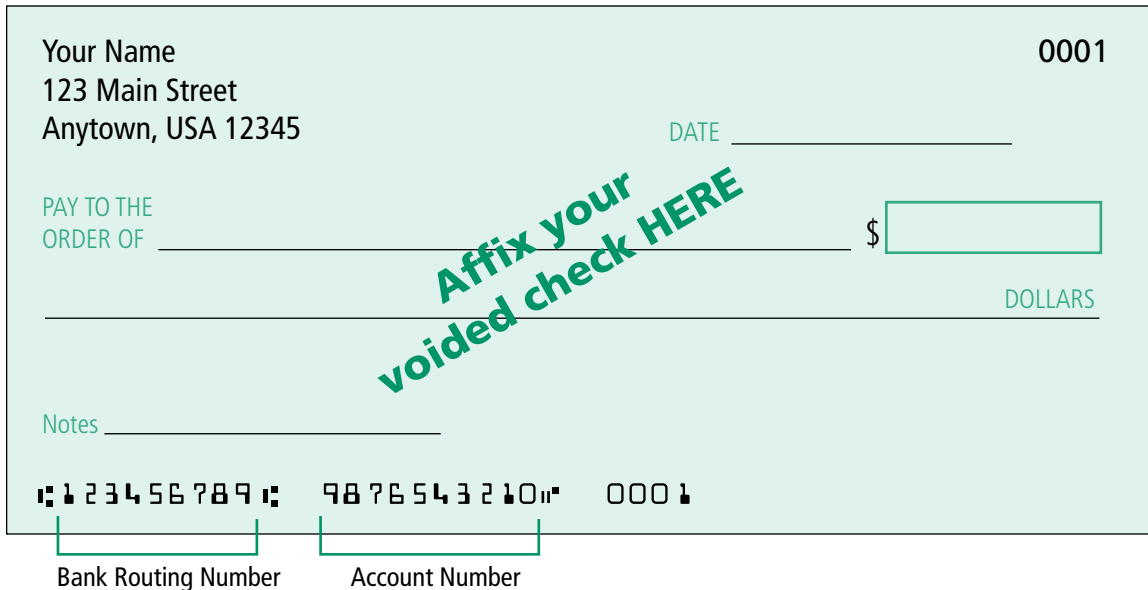
**SECTION 6 – AUTOMATIC FUNDS TRANSFER AUTHORIZATION**

I have selected the Automatic Funds Transfer (AFT), and I hereby authorize LifeWise Health Plan of Oregon (LifeWise) to initiate funds transfer from the bank or depository financial institution account indicated below. I authorize my financial institution to honor these transfers.

Financial Institution or Bank Name:	<input type="checkbox"/> Checking <input type="checkbox"/> Savings
Account Holder’s Name (print):	
City, State, ZIP:	
Bank Routing Number*:	Account Number:**

\* The bank routing number is the 9-digit number at the bottom of check (for checking account) or deposit slip (for savings account). See example, below.  
 \*\* Your account number is to the right of the bank routing number. See example, below.

**Please attach a voided check (for checking account) or deposit slip (for savings account) from the account TO BE DEDUCTED in the space provided below.**



**Additional Terms and Conditions:**

- Premium payments will be deducted each month on the **3rd working (business) day**, or as soon thereafter as practical. The deduction will also include any outstanding balance on my account.
- I have the right to stop payment of a transfer from my bank account to LifeWise. I must notify LifeWise no later than the **20th of the month** to be effective for the following month’s automatic withdrawal.
- I agree to indemnify and hold harmless LifeWise for any claim arising out of transfers or deductions from my account pursuant to this agreement.
- I understand there may be a delay in processing this authorization through my bank. I agree that, until then, I will continue to submit the monthly premium payment directly to LifeWise.

**I affirm that premiums for this policy are not paid or sponsored by an employer** (please initial): \_\_\_\_\_

Signature of Account Holder: **X** \_\_\_\_\_ Date (MM/DD/YYYY): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**SECTION 7 – INSURANCE INFORMATION**

1. 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?

No

Yes—Name of affected person: \_\_\_\_\_  
Name of Insurance Company: \_\_\_\_\_  
Reason: \_\_\_\_\_

2. List name and Social Security Number of anyone on this application who is currently insured or has previously been insured by LifeWise:

\_\_\_\_\_

3. Do you or any family members have other active health or medical coverage, Medicare, Medicare Advantage or Medicare supplement coverage?

No

Yes—Name of insurance company: \_\_\_\_\_  
Effective date of current medical coverage: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Termination date of current medical coverage: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

4. Do you or any family member work for an employer who offers health benefits to employees?

No

Yes—Are you or any family members enrolled?  No  Yes If "No," why?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Are you applying within 63 days of the termination of any prior health coverage?

No

Yes—You may be eligible for prior coverage credit towards pre-existing or other coverage limitations on these plans.

**PLEASE COMPLETE INFORMATION BELOW TO RECEIVE PRIOR COVERAGE CREDIT.**

Name and address of other insurance company: \_\_\_\_\_  
\_\_\_\_\_

Policy Number: \_\_\_\_\_ Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

Name of Policyholder: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Social Security Number: \_\_\_\_\_

List first name(s) of all persons covered on that policy: \_\_\_\_\_

Will you terminate current coverage upon approval of LifeWise plan?  No  Yes

Does the other plan provide medical coverage?  No  Yes

Effective Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Termination Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**SECTION 8 – HEALTH QUESTIONNAIRE**

**NOTICE TO APPLICANT:** You are not required to disclose any information on any part of this application about genetic testing or genetic information relating to you or to any blood relative. You are not required to disclose any decision by an insurance company that is based on a genetic test or on genetic information.

Please mark “Yes” or “No” for each item (for you and any family members requesting coverage). Provide details on page 6 to any questions answered “Yes.” **(For the purpose of these questions, chronic means persistent, continuous, periodic or a combination of any of these terms.)**

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

Please check each item either Yes or No	Yes	No
1. AIDS, ARC, HIV positive	<input type="checkbox"/>	<input type="checkbox"/>
2. Alcohol/chemical/drug abuse/habit	<input type="checkbox"/>	<input type="checkbox"/>
3. Anemia/chronic fatigue	<input type="checkbox"/>	<input type="checkbox"/>
4. Appendicitis/chronic abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>
5. Back/neck/spine	<input type="checkbox"/>	<input type="checkbox"/>
6. Birth defect/congenital deformities	<input type="checkbox"/>	<input type="checkbox"/>
7. Bladder/urinary tract	<input type="checkbox"/>	<input type="checkbox"/>
8. Blood/circulatory	<input type="checkbox"/>	<input type="checkbox"/>
9. Bone/orthopedic	<input type="checkbox"/>	<input type="checkbox"/>
10. Brain disease or injury/concussion	<input type="checkbox"/>	<input type="checkbox"/>
11. Breast (lumps or masses)	<input type="checkbox"/>	<input type="checkbox"/>
12. Cancer	<input type="checkbox"/>	<input type="checkbox"/>
13. Chemotherapy/radiation treatment	<input type="checkbox"/>	<input type="checkbox"/>
14 a. Colon/rectum/intestine/bowel	<input type="checkbox"/>	<input type="checkbox"/>
14 b. Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>
15. Convulsion/seizures/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
16. Diabetes/sugar in urine	<input type="checkbox"/>	<input type="checkbox"/>
17. Chronic ear/nose/throat/tonsil condition/disease/disorder	<input type="checkbox"/>	<input type="checkbox"/>
18. Eating disorders such as, but not limited to, anorexia or bulimia	<input type="checkbox"/>	<input type="checkbox"/>
19. Emphysema/asthma/chronic lung disease (COPD)	<input type="checkbox"/>	<input type="checkbox"/>
20. Endocrine/gland/hormone system	<input type="checkbox"/>	<input type="checkbox"/>
21. Disease or injury of eye/cataract/glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
22. Gallbladder/pancreatic disease	<input type="checkbox"/>	<input type="checkbox"/>
23. Chronic headaches/migraines	<input type="checkbox"/>	<input type="checkbox"/>
24. Heart/chest pain/angina	<input type="checkbox"/>	<input type="checkbox"/>
25. Hernia	<input type="checkbox"/>	<input type="checkbox"/>

Please check each item either Yes or No	Yes	No
26. High cholesterol <b>(if “Yes,” record last reading on page 6)</b>	<input type="checkbox"/>	<input type="checkbox"/>
27. High blood pressure <b>(if “Yes,” record last reading on page 6)</b>	<input type="checkbox"/>	<input type="checkbox"/>
28. Kidney/kidney stones	<input type="checkbox"/>	<input type="checkbox"/>
29. Knee/shoulder/hip/other joints	<input type="checkbox"/>	<input type="checkbox"/>
30. Liver condition/hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
31. Lupus, chronic muscle pain, muscle injury or disease, or fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
32 a. Mental/emotional condition/depression	<input type="checkbox"/>	<input type="checkbox"/>
32 b. Therapy/counseling within last 5 years <b>(if “Yes,” record date of last session on page 6)</b>	<input type="checkbox"/>	<input type="checkbox"/>
33. Neurological condition/disease/injury	<input type="checkbox"/>	<input type="checkbox"/>
34. Phlebitis/blood clot	<input type="checkbox"/>	<input type="checkbox"/>
35. Osteoarthritis/osteoporosis/osteopenia	<input type="checkbox"/>	<input type="checkbox"/>
36. Prostate/elevated PSA/prostatitis	<input type="checkbox"/>	<input type="checkbox"/>
37. Reproductive system disorder/infertility	<input type="checkbox"/>	<input type="checkbox"/>
38. Chronic respiratory/lung condition	<input type="checkbox"/>	<input type="checkbox"/>
39. Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>
40. Sexually transmitted disease(s)	<input type="checkbox"/>	<input type="checkbox"/>
41. Skin condition, abnormal or cancerous moles or eczema/cysts/cancer	<input type="checkbox"/>	<input type="checkbox"/>
42. Sleep apnea/chronic sleep disorder	<input type="checkbox"/>	<input type="checkbox"/>
43. Stomach disorders/ulcer/acid reflux	<input type="checkbox"/>	<input type="checkbox"/>
44. Stroke/paralysis/seizures	<input type="checkbox"/>	<input type="checkbox"/>
45. Tumors	<input type="checkbox"/>	<input type="checkbox"/>
46. TMJ/jaw joint	<input type="checkbox"/>	<input type="checkbox"/>
47. Weight fluctuation (+/-20 lbs.)	<input type="checkbox"/>	<input type="checkbox"/>
48. Cosmetic surgery/implants, use of prosthetic devices/limbs	<input type="checkbox"/>	<input type="checkbox"/>

(continued)

**Please provide details on page 6 to any questions answered “Yes.”**

**SECTION 8 – HEALTH QUESTIONNAIRE (continued)**

49. Has any person on this application used tobacco products in any form within the last 5 years?

No

Yes—Name \_\_\_\_\_ Type of Product \_\_\_\_\_

Name \_\_\_\_\_ Type of Product \_\_\_\_\_

Name \_\_\_\_\_ Type of Product \_\_\_\_\_

50. Please provide the following information for each female, age 13 and over, listed on this application:

	Family member name: ▶	Family member name: ▶	Family member name: ▶	Family member name: ▶
a. Initial menstrual cycle begun?	<input type="radio"/> No <input type="checkbox"/> Yes	<input type="radio"/> No <input type="checkbox"/> Yes	<input type="radio"/> No <input type="checkbox"/> Yes	<input type="radio"/> No <input type="checkbox"/> Yes
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="radio"/> No <input type="checkbox"/> Yes	<input type="radio"/> No <input type="checkbox"/> Yes	<input type="radio"/> No <input type="checkbox"/> Yes	<input type="radio"/> No <input type="checkbox"/> Yes
e. If (d) is yes, please explain:				
f. Date of last DEPO Provera	/ /	/ /	/ /	/ /
g. Abnormal Pap smears?	<input type="radio"/> No <input type="checkbox"/> Yes	<input type="radio"/> No <input type="checkbox"/> Yes	<input type="radio"/> No <input type="checkbox"/> Yes	<input type="radio"/> No <input type="checkbox"/> Yes
h. Prior Cesarean section or miscarriage?	<input type="radio"/> No <input type="checkbox"/> Yes	<input type="radio"/> No <input type="checkbox"/> Yes	<input type="radio"/> No <input type="checkbox"/> Yes	<input type="radio"/> No <input type="checkbox"/> Yes

51. Is any person on this application now pregnant?

No  Yes

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?

No  Yes

If "Yes," Name \_\_\_\_\_ Due date / /

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

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

(continued)

**SECTION 8 – HEALTH QUESTIONNAIRE (continued)**

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

Name	Medications (including milligrams and daily dosage)	Prescribed by (name/address/telephone)	Date prescribed

**HEALTH HISTORY DETAILS**

**Please provide specific details below to each question answered “Yes” in Section 8.** Include insured/applicant’s name; the number of the question to which you answered “Yes;” the condition, treatment and date; the result of treatment, including any medications; and the name, address and telephone number of the attending physician, other health care provider or clinic/hospital.

Name	Question number	Start to end dates	Condition/Diagnosis	Treatment Including Medications	Final result: Ongoing or Resolved	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	
					<input type="checkbox"/> Ongoing <input type="checkbox"/> Resolved	

Attach additional pages, if necessary.

I have attached \_\_\_\_\_ page(s).

**Please provide the name, telephone number and address of the medical provider with your current medical records/history:**

Name of Medical Provider	Telephone Number (       )
Address (City / State / ZIP)	

**SECTION 9 – IMPORTANT INFORMATION**

- ✓ It is an eligibility requirement of these plans that the applicant is, and continues to remain, an Oregon resident.
- ✓ The application must be signed by both the applicant and legally recognized spouse/registered domestic partner, no more than 60 days prior to the requested effective date of coverage.
- ✓ The application must be received a minimum of **10 days prior** to the effective date of coverage.
- ✓ The premiums for this policy are not paid or sponsored directly by my employer.
- ✓ Please be advised that an improperly completed application or requests for medical records may cause delays in the processing of this application.
- ✓ I understand that if I/we are declined for the Plan requested on this application I/we may be offered a Plan(s) for which I/we would be accepted.
- ✓ I understand that this application becomes a part of the policy if issued.

**SECTION 10 – 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 this insurance carrier to enroll in its insurance coverage. I understand that if this application contains any material misstatements or omissions, the insurance carrier may, within the first two years of coverage, deny coverage, modify or cancel the contract, or take other legal action. **I will promptly inform the insurance carrier 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 the insurance carrier. If approved, coverage will be in force as of the effective date determined by the carrier. The carrier 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.

**AUTHORIZATION FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION**

**TYPE OF INFORMATION TO BE DISCLOSED:** I (We) authorize: any physician; health care provider; hospital; insurance or reinsurance company; or the Medical Information Bureau, Inc. (MIB) to disclose a copy of my (our) personal health information, including any and all diagnostic, procedural, treatment, claim, prescription or other health related information including records concerning alcohol and/or chemical dependency, reproductive health (including abortion), sexually transmitted diseases, HIV, AIDS, psychiatric disorders, mental illness and genetic testing to LifeWise Health Plan of Oregon or its representative.

**PURPOSE OF DISCLOSURE:** I (We) understand that personal information will be used for underwriting, evaluating enrollment in the health plan, determining eligibility for benefits and paying claims.

**TIMEFRAME OF RELEASE:** Unless I revoke it, this release will remain valid for twenty-four (24) months from the date of my signature below.

**REVOCAION OF RELEASE:** I understand that I may change my mind and revoke this release at any time. I will do this by letting LifeWise know of my decision. Any change will be effective five (5) business days after LifeWise receives my written notice at the address listed on this form. I understand that some or all of this information may already have been used by LifeWise to make decisions, which will not be affected by its revocation.

**REDISCLASURE:** LifeWise Health Plan of Oregon may be required to redisclose this information to another party that is not subject to state and federal privacy rules.

**EFFECT OF DECLINING TO SIGN 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 or to give you benefits.

**I/we authorize separate policies issued to any combination of family members approved, even if coverage for the main applicant is declined.**  Yes  No

**Be sure to sign and date the application. Legally recognized spouse's/registered domestic partner's signature is required if applicable. Signature applies to both "Certificate of Completeness and Correctness" and "Authorization for Release of Information." All persons listed on the application who are 18 years of age or older must sign and date below.**

<b>X</b>		/ /
Signature of Applicant/Policyholder* (policyholder must sign if adding legally recognized spouse/registered domestic partner or child)	Printed Name	Signature Date (mm/dd/yy)

<b>X</b>		/ /
Signature of Legally Recognized Spouse/Registered Domestic Partner	Printed Name	Signature Date (mm/dd/yy)

<b>X</b>		/ /
Signature of child age 18 or over	Printed Name	Signature Date (mm/dd/yy)

<b>X</b>		/ /
Signature of child age 18 or over	Printed Name	Signature Date (mm/dd/yy)

\*If not the applicant, I am the  Parent  Holder of Power of Attorney  Legal Guardian (If you are the legal guardian or holder of a power of attorney for the applicant, attach legal documentation.)

**DO NOT SEND PAYMENT WITH THIS APPLICATION.**

**SECTION 11 – AGENT USE ONLY**

I (the Agent) certify that I have explained the eligibility provisions to the applicant. I have not made any statements about benefits, conditions or limitations of the policy except through written material furnished by LifeWise. I have informed the applicant that the effective date of coverage is assigned only by LifeWise, and provided Oregon Disclosure information required.

**I CERTIFY THAT THE INFORMATION SUPPLIED TO ME BY THE APPLICANT HAS BEEN TRULY AND ACCURATELY RECORDED HERE.**

Agent Name (Please print or type)		Agent No.	
Agency Name (If applicable)		Telephone Number (       )	
Street Address	City	State	ZIP
Agent's Signature		Date /      /	

**FOR INTERNAL USE ONLY**


**LifeWise Health Plan of Oregon**

815 SW Bond Street  
P.O. Box 7709  
Bend, Oregon 97708-7709

Individual Plan Sales: 1-800-290-1278

Customer Service: 1-800-596-3440

**[www.lifewiseor.com](http://www.lifewiseor.com)**