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: PacifiCare

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...

PacifiCare®

PLEASE UNFOLD BEFORE COMPLETING FORM

PacifiCare SignatureValue℠ Individual Application

Part A

This application must be completed in full and must be received by the 20th of the month.
If accepted, coverage will begin the first of the following month. An incomplete or illegible application will be returned and cause a delay in processing. Please see your plan brochure for instructions.

Requested Effective Date The first of: (mm/yy)	**I am** ❑ applying for coverage ❑ changing information ❑ adding dependents
Please check the plan you are requesting ❑ Plan I ❑ Plan II Plan options are offered by PacifiCare of Oregon, Inc.	**Payment Choice** ❑ Monthly (through bank withdrawal – enclose your completed Easy Pay form and a voided check) ❑ Monthly (billed)

PLEASE NOTE: Appropriate premium must accompany this application. Partial payments will be returned and full payment required. Please check the Plan Packet for more information.

❑ PacifiCare SignatureSavings℠ Discount Dental and Vision Program PacifiCare SignatureSavings is a discount dental and vision access program offered by PacifiCare Dental and Vision Administrators and is not a health maintenance organization or insurance product.	PacifiCare Dental and Vision Adminstrators P.O. Box 25187, Santa Ana, CA, 92799 1-800-228-3384

Applicant's Name		Marital Status ❑ Single ❑ Married	
If applying for coverage for child only, Parent or Legal Guardian's Name	Ethnicity (Optional) ❑ Caucasian ❑ Black or African American ❑ Hispanic or Latino ❑ Asian, Native Hawaiian, other Pacific Islander ❑ American Indian or Alaskan Native ❑ Not provided by member	Preferred Language (Optional) ❑ English ❑ Spanish	
Home Address	City	State	ZIP
County	Home Phone	Work Phone	
Mailing address (if different from residence address)	City	State	ZIP
Do you or any family members have other active health or medical coverage, Medicare, Medicare Advantage, or Medical Supplement Coverage? ❑ Yes ❑ No		If yes, name of insurance company	
Duration of Coverage	Effective date of coverage	Termination date of current medical coverage	

Do you or your 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?

Part B

Has any insurance company declined, postponed, refused, restricted or increased premium for health reasons, for life or health insurance coverage on you or any of your dependents within the last five years?
❑ Yes ❑ No If yes, name of person affected and name of insurance company:

List all family members to be covered and select a Medical Group/Primary Care Physician (PCP) for each family member, using the Physician Code from the PacifiCare SignatureValue (MCO) Provider Directory. This section must be completed in full.

	Last name of Family Member	First Name, Middle Initial	Height	Weight	Sex	Social Security Number	Date of Birth	Physician Name	PCP Code #	Current Patient Y/N
Subscriber										
Spouse										
Child										
Child										
Child										

Explain relationship to the subscriber for any person listed above whose last name is different from the subscriber:

PacifiCare Use Only

Check #	Check Amount	Ach	Void Check	Received	
Approved Date	Received Date	Effective Date	Group #	ID#	PMG

PCO-IDAPP-05-A

Questions? Call the Oregon Sales Department at 1-800-922-1444.

POR144593-002
PO /96364

White - PacifiCare Yellow - PacifiCare Pink - Applicant

Oregon Standard Health Statement

Please mark "Yes" or "No" for each Item (for you and any family members requesting coverage). Provide details on Page 3 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:

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

49. Has any person on this application used tobacco products in any form within the last five years? ❑ Yes ❑ No. If yes:
Name ____________________ type of product _______________ 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				
a. Initial menstrual cycle begun?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
b. Date of last menstrual period				
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 (d) Is yes, please explain:				
Date of last Depo-Provera shot?				
Abnormal Pap smears?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Prior cesarean section or miscarriage?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

51. Is any person on this application now pregnant? ❑ Yes ❑ No If yes, name ________________ due date ____/____/____
52. Is any person on this application, including male applicants and dependent males or females, responsible for a current pregnancy? ❑ Yes ❑ No If yes, name ________________ due date ____/____/____

53. Please provide the following information for each person on this application. Within the last five years, has any person on this application:
   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? ❑ Yes ❑ No
   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 health care provider? ❑ 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	Medications	Prescribed by (name/address/telephone)	Date prescribed

Health History Details

Please provide specific details below to any questions answered "Yes" on Oregon Standard Health Statement.

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

Name	Question Number	Start to End Dates	Condition	Treatment Including Medications	Final Result (circle one) Ongoing or Resolved	Name, Address, Phone Number of attending physician or hospital
					O / R	
					O / R	
					O / R	
					O / R	
					O / R	

Be sure to sign and date the application. Spouse's signature is required if married. Signature applies to both "Certificate of Completion 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 am providing these answers as part of the application procedure required by this insurance carrier to enroll in their insurance coverage. I understand that if this application contains any material misstatements or omissions, the insurance carrier may, within the
f
law. 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 phone 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 Release of Information

To any physician; health care provider; hospital; insurance or reinsurance company; the Medical Information Bureau, Inc. (MIB), or other insurance information exchange: Each of us authorizes 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 any authorized carrier, or its representatives. This authorization takes effect on the dates shown below. This authorization shall be valid for 30 months from the date following my/our signature(s) below. A photocopy of this authorization is as valid as the original. You may revoke this authorization at any time before you become a PacifiCare member, except for instances that PacifiCare has already taken action based on the authorization. Your revocation must be mailed to, PacifiCare Individual and Family Plans, Individual Underwriting, M/S # CY24-155, PO Box 3069, Cypress, CA 90630-9962

Signature of Subscriber	Date	Signature of custodian or representative (if applicable)	Date
Signature of Spouse	Date	Signature of custodian or representative (if applicable)	Date
Agent name	Agent #	Agency name	Phone #
Street Address		City	ZIP
Signature of Agent		Date	

PacifiCare compensates Agents/Brokers for the sale of certain products. Your premium is the same if you purchase coverage directly from PacifiCare or if you use an Agent/Broker. Please contact your Agent/Broker, if applicable, regarding the amount of compensation. In addition, you may request information regarding broker commissions attributable to your policy by contacting PacifiCare Membership Accounting.

PacifiCare®

Credit Card Payment Authorization

Payment Option

First Month's Premium (due at time of application)		One-Time Credit Card Charge	
☐ Premium Payment Amount:	$____________	☐ Premium to be Charged to Card:	$____________
☐ Application Fee (TX/OK):	$25	☐ Total Fees (if applicable):	$____________

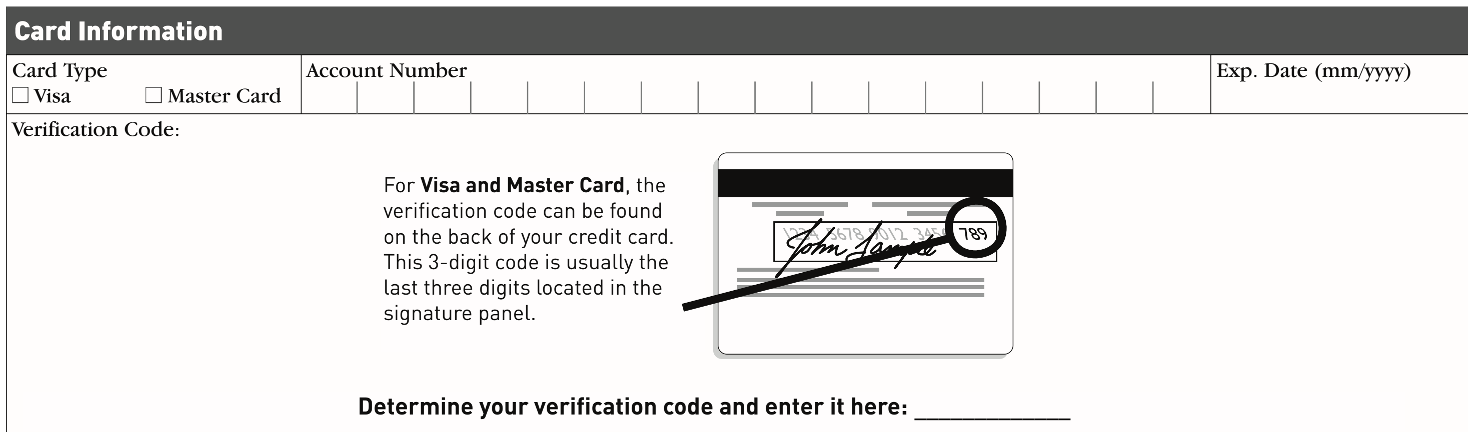
Applicant's Information

Applicant's First Name	Applicant's Middle Name	Applicant's Last Name

Cardholder's Information

Cardholder's First Name (as it appears on card)	Cardholder's Middle Initial	Cardholder's Last Name	Cardholder's Phone #

Cardholder's Billing Address	City	State	ZIP



Card Information

Card Type ☐ Visa ☐ Master Card	Account Number	Exp. Date (mm/yyyy)

Verification Code:

For **Visa and Master Card**, the verification code can be found on the back of your credit card. This 3-digit code is usually the last three digits located in the signature panel.

Determine your verification code and enter it here: ____________

Authorization

As a convenience, I request and authorize PacifiCare to charge my credit card account, identified above, for the payment of my health plan premium and/or any applicable fees (application, returned payment, reinstatement, etc.) for the payment option(s) designated above. I understand that the initial premium for my Policy may be adjusted based on my medical condition (or that of any dependent to be covered under the policy) and agree that the additional amount(s) required may be charged to this account. I further agree that should this card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, PacifiCare will attempt to contact me by mail, but shall be under no liability whatsoever, including any fees imposed by the card issuer even though such dishonor may ultimately result in forfeiture of coverage.

Signature of Credit Card Account Holder (as it appears on the credit card)	Date

For PacifiCare Office Use Only

Authorization Date	Transaction #	ID #

Return this form to:
PacifiCare Individual Plans
Individual Underwriting
M/S/ CY24-155
P.O. Box 3069
Cypress, CA 90630-9962

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