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®

PacifiCare Life Assurance Company

How to Apply for PacifiCare Individual and Family Plans

Here are the steps to follow to ensure your application is processed as quickly as possible.

1. Application, Plan and Payment Information

Be sure to answer all questions completely and provide all the requested information. Incomplete information may result in a processing delay.

- ***Print clearly using black ink.*** Please don't type on your form.
- ***Select the date you wish coverage to become effective.*** PacifiCare allows effective dates beginning on the 1st of the month. Please submit your application by the 20th of the month to be considered for the 1st of the following month. Actual effective dates are determined by PacifiCare. **Do not cancel any existing coverage until you are notified by PacifiCare that you have been accepted.**
- ***Select a method of payment for your first month's premium.***
  - **Check.**
  - **Credit Card.** (For this payment method you must enclose your completed Credit Card Payment Authorization Form.)
- ***Select a method of payment for your recurring monthly payments.***
  - **Easy Pay.** We will automatically deduct your monthly premium from your checking account each month. If you prefer this option, please submit a completed Easy Pay Form (enclosed).
  - **Monthly Payment.** Send us a check by the 1st of each coverage month.
- ***Applicant Information.*** Please list yourself as the Primary Applicant. If married, include your spouse as a Dependent (if the spouse is also applying). If the parent/guardian is applying for a child only, list the child's name as the Primary Applicant.
- ***Enrollment Information.*** Please answer all the questions in this section for each family member applying.

2. Oregon Standard Health Statement

Answer every question in full. Otherwise, your application may be returned to you, resulting in a delay in processing.

- ***Be sure to mark "yes" or "no" for each item listed for yourself and all family Members listed on the application.*** Even if your application is approved, any omissions or false statements may result in future claims being denied and/or termination of your coverage.
- ***Include all requested details and explanations.*** If you need to include additional information or explanations, simply attach an extra sheet.

3. Send Your Completed Application to PacifiCare

- ***Review your application to be sure it is complete.***
- ***Be sure to disclose all health history on the Oregon Standard Health Statement for all family members listed on the application.*** Even if your application is approved, any omissions or false statements may result in future claims being denied and/or termination of your coverage.
- ***Sign and date your application.*** You, your Spouse (if applying) and any listed Dependent age 18 or over must sign and date the application.
- ***Enclose your first premium check or your completed Credit Card Payment Authorization Form.***
- ***Mail your application to:***

  PacifiCare Individual Plans
Individual Underwriting
M/S # CY24-155
P.O. Box 3069
Cypress, CA 90630-9962

After reviewing your Oregon Standard Health Statement, PacifiCare will notify you if your application has been approved or declined for coverage. We will also contact you should we need additional information.

Upon acceptance of your Oregon Standard Health Statement, your policy will be effective the 1st of the month following the approval date. You may change your coverage election and reapply for a replacement election within 10 days of original acceptance.

If your application for coverage is declined, your original premium check will be returned to you with a declination letter.

Before sealing the envelope, be sure to enclose:

- Your completed Enrollment Application
- Your first premium check or Credit Card Payment Authorization form
- Your Easy Pay Form if you choose to automatically deduct monthly premium from your checking account

Please note: Coverage does not become effective under any circumstances until an application has been underwritten and approved by PacifiCare.

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

PacifiCare®

PacifiCare Life Assurance Company

Individual Plan Application

IMPORTANT: PLEASE PRINT IN BLACK INK. *Every* question must be answered completely by applicant or guardian. Application must be signed to be valid.

Application, Plan and Payment Information

A. Please check one: ❑ Applying for Coverage ❑ Adding Dependents to ❑ Changing my Plan

B. Requested Effective Date: 1st of ______ – ______ (mm yy)

Note: Your requested effective date is not guaranteed. Actual effective date is determined by PacifiCare.

C. Select ONE plan:

PacifiCare SignatureFreedom℠ (SDHP PPO)
❑ SDHP PPO 80-60%/$1,500 ❑ Include Alcoholism Rider
❑ SDHP PPO 80-60%/$3,000 ❑ Include Alcoholism Rider

PacifiCare SignatureFreedom℠ Elect (SDHP EPO)
❑ SDHP EPO 70%/$3,000 ❑ Include Alcoholism Rider

PacifiCare SignatureOptions℠ (PPO)
❑ PPO 80-60%/$5,000 ❑ Include Alcoholism Rider

Dental
❑ PacifiCare SignatureSavings Discount Dental and Vision Program

PacifiCare Dental and
Vision Administrators
PO Box 25187
Santa Ana, CA 92799
1-800-228-3384

D. Choose your payment method for:

First Month's Payment (please select one option)
❑ Check enclosed: amount of $ __________
❑ Credit Card (Enclose your completed Credit Card Authorization Form – payment will be deducted only if application is approved.)

Recurring Monthly Payment (please select one option. Credit Card payment is not available for recurring monthly payments.)
❑ Monthly bill
❑ Monthly Easy Pay (Enclose your completed Easy Pay form and a voided check.)

Individual benefit plans are not intended for sale as an employer-sponsored health benefit plan for employees. For information on small employer health benefit plans, contact the Oregon Sales department at 1-800-922-1444.

Applicant Information

Primary Applicant's Name

Last	First	MI

Home Address *(P.O. Box not acceptable)*

Street	Apt. #	City	County	State	ZIP

Mailing Address *(If different from home address)*

Street	Apt. #	City	State	ZIP

Phone Number

Home	Work	E-mail

Marital Status
❑ Single ❑ Married

Preferred Language (optional) ❑ English ❑ Spanish

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

Enrollment Information

List yourself and all eligible family members applying for coverage.

Relationship	Last Name	First Name	M.I.	Gender	Social Security #	Height	Weight	Birth Date (Mo/Day/Yr)	Age
Applicant				❑ M ❑ F					
Spouse				❑ M ❑ F					
Child				❑ M ❑ F					
Child				❑ M ❑ F					
Child				❑ M ❑ F					
Child				❑ M ❑ F					

Explain relationship to applicant for any member listed above whose last name is different from the applicant: ______________________

*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.

Oregon Standard Health Statement

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 question for you and any family members requesting coverage. Provide details on Page 4 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 4) ❑ Yes ❑ No
27. High blood pressure (if "Yes," record last reading on page 4) ❑ 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 4) ❑ 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

Oregon Standard Health Statement (continued)

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

Other Insurance Information

Has any insurance company declined, postponed, refused, restricted or increased premium for health reasons, for life or health insurance coverage for you or any of your dependents listed on this application within the last five years?

❑ Yes ❑ No If yes, give the name of the person and the reasons: ____

____

Do you or any family members listed on this application have other active health or medical coverage (Medicare, Medicare Advantage or Medical Supplement Coverage)? If so and you are applying within 63 days of the termination of that coverage, you may be eligible for prior coverage credit toward pre-existing or other coverage limitations on these plans.

❑ Yes ❑ No Name of Family Member: ____

Name of Insurance Company: ____

Effective Date: ____________________ Termination Date: ____________________

Additional Space for Medical History

Please provide specific details below to each question answered Yes on the previous page.

Last Name	First Name	MI

Question Number	Dates Treated

Condition and Treatment *(including medications)*	Final Result (please check one) ☐ Ongoing ☐ Resolved

Attending Physician/Hospital Name	Street Address

City	State	ZIP	Phone No.

Last Name	First Name	MI

Question Number	Dates Treated

Condition and Treatment *(including medications)*	Final Result (please check one) ☐ Ongoing ☐ Resolved

Attending Physician/Hospital Name	Street Address

City	State	ZIP	Phone No.

Additional Space for Medical History (continued)

Last Name		First Name		MI
Question Number	Dates Treated			
Condition and Treatment *(including medications)*			Final Result (please check one)	☐ Ongoing ☐ Resolved
Attending Physician/Hospital Name		Street Address		
City		State	ZIP	Phone No.

Last Name		First Name		MI
Question Number	Dates Treated			
Condition and Treatment *(including medications)*			Final Result (please check one)	☐ Ongoing ☐ Resolved
Attending Physician/Hospital Name		Street Address		
City		State	ZIP	Phone No.

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

Certification and Authorization

Be sure to sign and date the application. Your spouse's and/or adult dependent's signature is required if applicable. The signatures apply to both the Certification of Completion and Correctness and the Authorization for Release of Information.

Certification of Completeness and Correctness

I affirm that the answers given in this Oregon Standard Health Statement are complete and correct. I have provided these answers as a 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 upon 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 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 PacifiCare 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.

Revocation of Release I understand that I may revoke this authorization at any time before I become a PacifiCare member, except for instances that PacifiCare has already taken action based on the authorization, by mailing my written revocation to: **PacifiCare Individual Plans, Individual Underwriting, M/S # CY24-155, P.O. Box 3069, Cypress, CA 90630-9962.**

Effect of Declining to Sign This Application 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.

Terms and Conditions

- 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 legal spouse, no more than 60 days prior to the 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.

Signatures

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

If I/We do not medically qualify for the plan requested, I/We authorize PacifiCare to enroll me in an alternate plan for which I/We are medically qualified, if available. ❑ Yes ❑ No

Signature	Date
Signature of Applicant/Parent or Legal Guardian *(Required)*	Date *(Required)*
Signature of Applicant's Spouse *(Required if applying)*	Date *(Required)*
Signature of Applicant's Dependent Age 18 or over *(Required if applying)*	Date *(Required)*
Signature of Applicant's Dependent Age 18 or over *(Required if applying)*	Date *(Required)*

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.

For Agent's Use Only

Agent Name	Agency Name	License No.	Tax I.D. No.

Payee: ❑ Agent ❑ Firm

Is Payee currently contracted with PacifiCare? ❑ Yes ❑ No *(If no, submit a copy of Payee's license)*

Street Address	City	State	ZIP

Phone No.	Fax No.	E-mail

Is this the Payee's first individual application with PacifiCare? ❑ Yes ❑ No

Are you aware of any information not disclosed in the Oregon Standard Health Statement which may have a bearing on this risk?

❑ Yes ❑ No If yes, explain: ______________________________

Did you provide the applicant(s) with information regarding the Oregon Standard Health Statement, disclosures and eligibility provisions exactly as set forth in this application?

❑ Yes ❑ No If no, explain: ______________________________

Was the Oregon Standard Health Statement completed by the applicant? ❑ Yes ❑ No

Were you present at the time the application was completed? ❑ Yes ❑ No

Agent's Signature	Date

PacifiCare Use Only

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

PacifiCare Individual and Family Plans
Individual Underwriting
M/S CY24-155
P.O. Box 3069
Cypress, CA 90630

Individual Sales:
800-922-1444
www.pacificare.com

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POR147393-002

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):	$__________

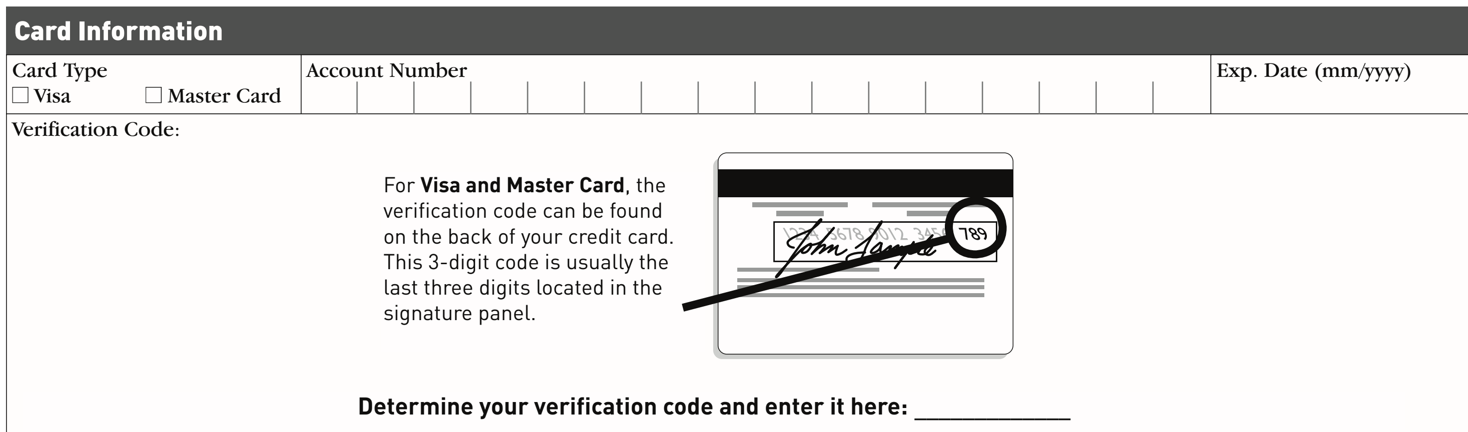
Applicant's Information

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

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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PEW147083-000