LIFEWISE | HEALTH PLAN OF OREGON

Oregon Individual Enrollment Application

Effective April 1, 2012

Please print your answers clearly in blue or black ink so we can process your application quickly. Applications that contain correction fluid or correction tape cannot be accepted.

1 I'm filling out this application because…

☐ **I am a new applicant.** (Please go to Section 2)

☐ **I am a current member and my policyholder ID # is:** _____ (see your ID card)

- ☐ I want to add my legally recognized spouse or registered same-sex domestic partner: _____ (date of marriage or registered same-sex domestic partnership)
- ☐ I want to add my newborn/adopted child: _____ (date of birth or adoption; attach placement papers for adoptions)
- ☐ I want to add a child (legal ward/ guardianship/medical child support order): _____ (date of order; attach court order or placement papers)
- ☐ I want to change my plan.

Changing Plans?

If you're changing plans, your new plan will take effect on the first of the month following receipt of this application.

2 Am I Eligible?

You're eligible to apply for a LifeWise plan if you are:

- A resident of and continue to remain a resident of the state of Oregon. We may require proof of residency.
- Not entitled to Medicare (including entitlement due to disability).
- Under 65 years of age.

Eligible dependents that can enroll on your plan include:

- Your spouse or registered same-sex domestic partner
- Your natural or legally adopted child(ren) under the age of 26
- Child(ren) under the age of 26 and you are their legal guardian

3 Date my coverage should begin

I want this plan to begin on the ☐ 1st **or** ☐ 15th of _____ (enter month)

(No more than 60 days after the signature date. We must receive your application at least 10 days before your desired effective date.)

4 I want to enroll my…

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					☐ Male ☐ Female	/ /
Legally Recognized Spouse / Registered Same-Sex Domestic Partner					☐ Male ☐ Female	/ /
Dependent Child (under 26 only)					☐ Male ☐ Female	/ /
Dependent Child (under 26 only)					☐ Male ☐ Female	/ /
Dependent Child* (under 26 only)					☐ Male ☐ 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
			( )
Email Address of Primary Applicant			

* See page 8 to enroll additional dependents.

5 Selecting my health plan (select one)

WiseValue Plus

- ☐ $2,500 (generics-only drug coverage)
- ☐ $5,000 (generics-only drug coverage)

WiseValue Plus Rx

- ☐ $1,000 (generics and brand drug coverage)
- ☐ $2,500 (generics and brand drug coverage)
- ☐ $5,000 (generics and brand drug coverage)
- ☐ $7,500 (generics and brand drug coverage)
- ☐ $10,000 (generics and brand drug coverage)

WiseOptimum

- ☐ $1,000 (generics and brand drug coverage)
- ☐ $2,500 (generics and brand drug coverage)
- ☐ $5,000 (generics and brand drug coverage)

WiseHSA

- ☐ $3,000 Individual/$6,000 Family (generics and brand drug coverage)
- ☐ $5,950 Individual/$11,900 Family (generics-only drug coverage)

☐ Optional Supplemental Alcoholism Endorsement

6 Paying for my health plan (select one)

☐ Monthly paper bill by mail (move on to Section 7)

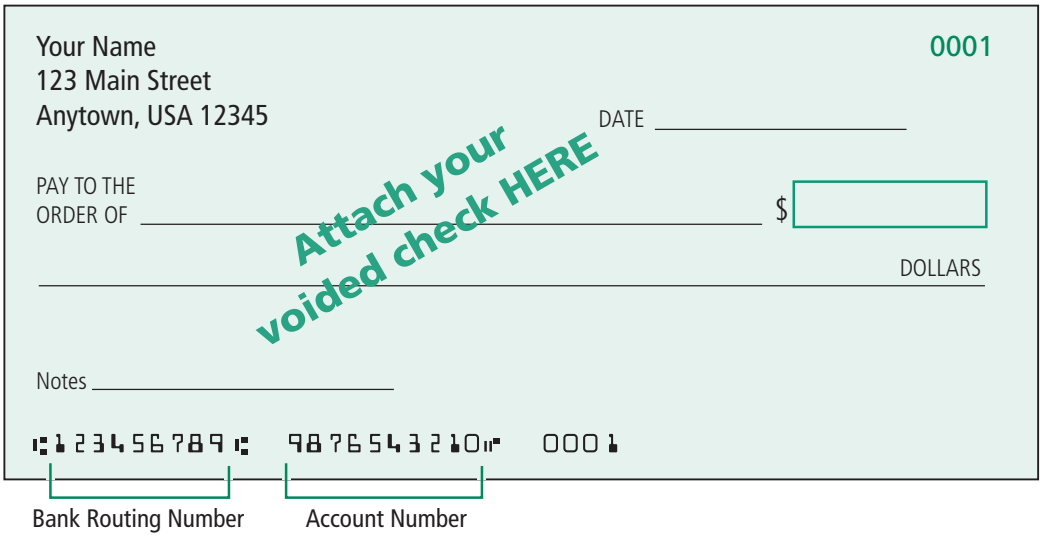
☐ Automatic monthly withdrawal from my bank account. Here's my account information:

I have selected automatic monthly withdrawal and I hereby authorize LifeWise to initiate funds transfer from the bank or financial institution account indicated below. I authorize my financial institution to honor these transfers.

No Money Now

Do not send payment with this application. Please choose one of the options on the left to pay for your health plan.

Account Holder's Name (print)	Financial Institution or Bank Name
Financial Institution/Bank City, State, ZIP	☐ Checking ☐ Savings
Bank Routing Number (see picture below)	Account Number (see picture below)



Routing Number

We can't set up automatic withdrawals with bank routing numbers that begin with a "5." If your routing number begins with a "5," call your bank to get the correct bank routing number.

Additional Terms and Conditions:

- Funds are transferred on the 3rd business day of each month to pay for that month's coverage. (For example, the deduction on February 3rd pays for coverage in February.) 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.
- It may take as long as 45 days to set up the funds transfer. I may receive a paper bill to cover the initial month(s) while the transfer is being set up.

Account Holder Signature X _____ **Date of Signature** ____ / ____ / ____

7 My prior health coverage

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 anyone for whom coverage is requested?**

   ○ **No**

   ☐ **Yes**—Name of affected person: _____

   Name of Insurance Company: _____

   Reason: _____

2. **LifeWise Health Plan of Oregon may review its claims history for the last five years for anyone who is currently insured or was insured with LifeWise within the last 5 years. List name and Social Security Number of anyone on this application who is currently insured or was previously insured during this time period:**

   _____

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: ____/____/____

8 My health information (within the past 5 years)

Notice to Applicants: It is important for you to completely and accurately provide the information requested below. Although a person under the age of 19 may not be denied enrollment from coverage under an individual health benefit plan because of health reasons, coverage could be rescinded if information is intentionally misrepresented on this health statement. 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 anyone for whom coverage is requested. Provide details on page 7 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** for whom coverage is requested had any medical advice, diagnosis, care, or treatment, including prescribed medications, recommended or received from a licensed healthcare 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	Y	N
2.	Alcohol/chemical/drug abuse/habit	Y	N
3.	Anemia/chronic fatigue	Y	N
4.	Appendicitis/chronic abdominal pain	Y	N
5.	Back/neck/spine	Y	N
6.	Birth defect/congenital deformities	Y	N
7.	Bladder/urinary tract	Y	N
8.	Blood/circulatory	Y	N
9.	Bone/orthopedic	Y	N
10.	Brain disease or injury/concussion	Y	N
11.	Breast (lumps or masses)	Y	N
12.	Cancer	Y	N
13.	Chemotherapy/radiation treatment	Y	N
14 a.	Colon/rectum/intestine/bowel	Y	N
14 b.	Blood in stool	Y	N
15.	Convulsion/seizures/epilepsy	Y	N
16.	Diabetes/sugar in urine	Y	N
17.	Chronic ear/nose/throat/tonsil condition/ disease/disorder	Y	N
18.	Eating disorders such as, but not limited to, anorexia or bulimia	Y	N
19.	Emphysema/asthma/chronic lung disease (COPD)	Y	N
20.	Endocrine/gland/hormone system	Y	N
21.	Disease or injury of eye/cataract/glaucoma	Y	N
22.	Gallbladder/pancreatic disease	Y	N
23.	Chronic headaches/migraines	Y	N
24.	Heart/chest pain/angina	Y	N
25.	Hernia	Y	N

Please check each item either Yes or No		Yes	No
26.	High cholesterol **(if "Yes," record last reading on page 7)**	Y	N
27.	High blood pressure **(if "Yes," record last reading on page 7)**	Y	N
28.	Kidney/kidney stones	Y	N
29.	Knee/shoulder/hip/other joints	Y	N
30.	Liver condition/hepatitis	Y	N
31.	Lupus, chronic muscle pain, muscle injury or disease, or fibromyalgia	Y	N
32 a.	Mental/emotional condition/depression	Y	N
32 b.	Therapy/counseling within last 5 years **(if "Yes," record date of last session on page 7)**	Y	N
33.	Neurological condition/disease/injury	Y	N
34.	Phlebitis/blood clot	Y	N
35.	Osteoarthritis/osteoporosis/osteopenia	Y	N
36.	Prostate/elevated PSA/prostatitis	Y	N
37.	Reproductive system disorder/infertility	Y	N
38.	Chronic respiratory/lung condition	Y	N
39.	Rheumatoid arthritis	Y	N
40.	Sexually transmitted disease(s)	Y	N
41.	Skin condition, abnormal or cancerous moles or eczema/cysts/cancer	Y	N
42.	Sleep apnea/chronic sleep disorder	Y	N
43.	Stomach disorders/ulcer/acid reflux	Y	N
44.	Stroke/paralysis/seizures	Y	N
45.	Tumors	Y	N
46.	Temporomandibular joint/jaw joint	Y	N
47.	Weight fluctuation (+/-20 lbs.)	Y	N
48.	Cosmetic surgery/implants, use of prosthetic devices/limbs	Y	N

49. Has any person for whom coverage is requested 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 _____

8 My health information (within the past 5 years, continued)

50. Please provide the following information for each female for whom coverage is requested:

	Family member name:	Family member name:	Family member name:	Family member name:
a. Initial menstrual cycle begun?	○ No ☐ Yes	○ No ☐ Yes	○ No ☐ Yes	○ No ☐ Yes
b. Date of last menstrual period:	mm / dd / yyyy	mm / dd / yyyy	mm / dd / yyyy	mm / dd / yyyy
c. If (b) is more than 35 days ago, please explain:				
d. Excessive or absent menstrual bleeding?	○ No ☐ Yes	○ No ☐ Yes	○ No ☐ Yes	○ No ☐ Yes
e. If (d) is yes, please explain:				
f. Date of last DEPO Provera shot:	/ /	/ /	/ /	/ /
g. Abnormal Pap smears?	○ No ☐ Yes	○ No ☐ Yes	○ No ☐ Yes	○ No ☐ Yes
h. Prior Cesarean section or miscarriage?	○ No ☐ Yes	○ No ☐ Yes	○ No ☐ Yes	○ No ☐ Yes

51. Is any person for whom coverage is requested now pregnant?
○ **No** ☐ **Yes.** If "**Yes,**" Name _____ Due date ____/____/____

52. Is any person for whom coverage is requested, 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 for whom coverage is requested. 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 healthcare 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 healthcare provider at a future date? . . . . . ○ No ☐ Yes

e. Taken any prescription medication on a regular basis? . . . . . ○ No ☐ Yes

54. List all medications currently being taken by any person for whom coverage is requested:

Name	Medications	Dose—how much medication you take daily (required)	Prescribed by (name/address/telephone)	Date prescribed
		_____ **mg** **ml** (circle one) _____ times per day		
		_____ **mg** **ml** (circle one) _____ times per day		
		_____ **mg** **ml** (circle one) _____ times per day		
		_____ **mg** **ml** (circle one) _____ times per day		

9 Details on my health conditions (within the past 5 years)

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 healthcare provider or clinic/hospital.

Name	Question number	Start to end dates	Name of Condition	Treatment **Including Medications**	Final result: **Ongoing or Resolved**	Attending physician/healthcare provider or hospital (name/address/telephone)
					☐ Ongoing ☐ Resolved	
					☐ Ongoing ☐ Resolved	
					☐ Ongoing ☐ Resolved	
					☐ Ongoing ☐ Resolved	
					☐ Ongoing ☐ 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:

Your Medical Provider	Telephone Number ( )
Address (City / State / ZIP)	
Medical Provider for your **legally recognized spouse/registered same-sex domestic partner**	Telephone Number ( )
Address (City / State / ZIP)	
Medical Provider for your **child(ren)**	Telephone Number ( )
Address (City / State / ZIP)	

10 My final checklist

To avoid any delays in processing your application, please make sure you've completed this entire application including:

- ☐ Attaching placement papers if you are adding an adopted or court-placed child as required in Section 1.
- ☐ Choosing an effective date in Section 3. (We must receive your application at least 10 days before your desired effective date.)
- ☐ Attaching a voided check and signing at the bottom of Section 6 if you want to pay your bill with automatic bank withdrawal.
- ☐ Answering questions 1–54 in Section 8 based on the past 5 years of medical history for all applicants.
  - ☐ If you answered "yes" to any question in Section 8, did you provide additional detail in Section 9?
- ☐ Providing contact information for each applicant's medical provider in Section 9.

Remember to have all applicants, age 18 and over, sign and date this application in ink in the next section (Section 11).

If you are the legal guardian or holder of a power of attorney for the applicant, attach legal documentation.

If you want to enroll additional dependents and ran out of space in Section 4, please add your other dependents below:

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)
Dependent Child (under 26 only) ▶					☐ Male ☐ Female	/ /
Dependent Child (under 26 only) ▶					☐ Male ☐ Female	/ /
Dependent Child (under 26 only) ▶					☐ Male ☐ Female	/ /

11 Certification and Authorization

Certification of Completion and Correctness

As part of the underwriting review, I understand that LifeWise Health Plan of Oregon will review any claims history for the last five years from my prior LifeWise Health Plan of Oregon coverage. 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 to enroll in health insurance coverage. I understand that if this application contains any intentional misrepresentations of material fact, LifeWise may, within the first two years of coverage, deny coverage, modify or cancel the contract, or take other legal action. I further understand that if the misrepresentation amounts to fraud, LifeWise may deny coverage, modify or cancel the contract, or take other legal action even after the first two years of coverage. **I will promptly inform LifeWise in writing if anything happens before my coverage takes effect that makes the information I have provided on this application incomplete or incorrect.** I understand and agree that no coverage shall be in force until approved by LifeWise. If approved, coverage will be in force as of the effective date determined by LifeWise. LifeWise may contact me to clarify answers on this application. I understand I have the right to inspect the information in my file. I understand that this application becomes part of the contract if issued.

Authorization for Collection, Use and Disclosure of Personal Information

Type Of Information To Be Disclosed: With the exception of genetic information, I (we) authorize: any physician; healthcare 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 and mental illness 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.

Revocation 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.

Redisclosure: 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.

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

I affirm that premiums for this plan are not paid or sponsored by my employer.

Be sure to sign and date the application. Legally recognized spouse's/registered same-sex 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 for whom coverage is requested and who are 18 years of age or older must sign and date below.

Important!
Signatures are required for all applicants, 18 years of age or older.

X		/ /
Signature of applicant/policyholder* (policyholder must sign if adding legally recognized spouse/registered same-sex domestic partner or child)	Printed Name	Signature Date (mm/dd/yyyy)
X		/ /
Signature of legally recognized spouse/registered same-sex domestic partner	Printed Name	Signature Date (mm/dd/yyyy)
X		/ /
Signature of child age 18 or over	Printed Name	Signature Date (mm/dd/yyyy)
X		/ /
Signature of child age 18 or over	Printed Name	Signature Date (mm/dd/yyyy)

*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.)

12 Producer use only

I (the Producer) 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.

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

FOR INTERNAL USE ONLY

LifeWise Health Plan of Oregon
P.O. Box 7709
Bend, OR 97708-7709

Fax Number: 888-773-6372

If you are applying for the first time and have questions,
please contact Individual Plan Sales at 800-290-1278.

If you are an established member with LifeWise Health Plan of Oregon,
please contact Customer Service at 800-596-3440.

lifewiseor.com