



SECTION 1 – INSTRUCTIONS

- Please read carefully
- Please type or print neatly in ink and sign this application.
- Make sure all sections of the application are answered completely. Please be advised that incomplete applications or requests for medical records may cause a delay in the processing of your application.
- If you need assistance completing this application, please contact your insurance agent or call our Individual Sales Department toll-free at (888) 684-5585.

SECTION 2 – PLAN SELECTION

This application is (check one):

- For new coverage for me and my eligible family member(s) listed below.
- To change my existing coverage in a PacificSource Individual plan. Current policy ID # _____
- To add my eligible family member(s) to my existing PacificSource Individual plan. Current policy ID # _____
Reason for addition: _____ Date: _____
- For my dependent child (ren) only. Complete a separate form for each child on his or her own plan. If on a separate plan, dependent children age 18 or older must complete their own application.

Choose a plan and a deductible:

Preferred	Value	HSA	Uniform
<input type="checkbox"/> \$ 1,000 Deductible	<input type="checkbox"/> \$ 5,000 Deductible	<input type="checkbox"/> \$ 3,000 Deductible	<input type="checkbox"/> \$ 1,000 Deductible
<input type="checkbox"/> \$ 2,500 Deductible	<input type="checkbox"/> \$ 7,500 Deductible	<input type="checkbox"/> \$ 6,050 Deductible	
<input type="checkbox"/> \$ 5,000 Deductible	<input type="checkbox"/> \$10,000 Deductible		

Are you applying for conversion coverage? Yes No

If yes, date your coverage through PacificSource group health plan ended or ends? _____

Requested effective date: (no more than 60 days after the signature date) 1st 15th _____ **Month/Year**

Will your employer pay any portion of your premium? Yes No *PacificSource individual policies may not be used for an employer-based plan. If the employer pays or reimburses any part of the premium or if the health plan is treated as part of a plan or program for the purposes of section 106 or 162 of the Internal Revenue Code of 1986. PacificSource does not accept premium payment from employers for individual policies.*

SECTION 3 – APPLICANT INFORMATION

Last Name		First Name		Middle Initial	Height	Weight
Mailing Address (Street or PO box)			City	State	Zip	County
Home Address (if different)			City	State	Zip	County
Home Phone		E-mail Address		Marital Status		
Birth Date (mo/day/year)		Gender	Social Security Number		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partnership* <i>* Affidavit of Domestic Partnership Required</i>	
		<input type="checkbox"/> Male <input type="checkbox"/> Female				

List all family members to be insured. Only your legal spouse, domestic partner, and dependent children are eligible.

Last Name	First name, middle initial	Height	Weight	Gender	Birth Date	Social Security No.
Spouse/Domestic Partner						
Child						
Child						
Child						
Child						

Explain the relationship to you of any person listed whose last name is different from yours. If guardian, attach copy of documentation: _____

SECTION 4 – OTHER INSURANCE INFORMATION

Do you or any family members have other active health or medical coverage, Medicare, Medicare Advantage, or Medicare supplement coverage? Yes No

If yes, provide insurance company's name in the box below.

Do you or any family members work for an employer who offers health benefits to employees? Yes No

If yes, are you or any family members enrolled? Yes No

If no, why? _____

PacificSource may review its claims history for the last five years for anyone who has had insurance with PacificSource during that time. If anyone listed on this application has had health coverage through PacificSource within the last five years, list his or her name and PacificSource ID number or social security number: _____

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 who is listed on this application? Yes No

If yes, please provide the name of the person affected, reason for action, and name of insurance company:

How did you hear about PacificSource? Insurance Agent Mailing TV Web site Other _____

The policy's exclusion periods for pre-existing conditions and specified conditions may be reduced if you or a family member had creditable coverage to within 63 days of the effective date of this policy. To reduce the exclusion periods, you must demonstrate creditable coverage. You may do that by attaching a Certificate of Coverage issued by the prior insurance company or group policyholder, or by presenting evidence of creditable coverage through other documents, records, third party statements, or other means. If you are currently covered under another health policy, or are requesting credit toward the exclusion periods for prior coverage, please complete the following:

List current or prior insurance coverage here:		
Names of individuals covered under a current or prior policy:		
Name and address of other insurance company (include phone no. if available):		
Effective dates of coverage: From _____ To _____	Policy no.:	If group insurance, name of group policyholder:

SECTION 5 – 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 any insurance company that is based on a genetic test or on genetic information.

Please mark either "Yes" or "No" for each item for you and any family members. 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 healthcare professional or had any illness, ailment, injury, health problem, symptoms, physical impairment, surgery, or hospital confinement related to any of the following conditions:

- | | |
|--|---|
| <p>1. AIDS, ARC, HIV positive <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Alcohol/chemical/drug abuse/habit <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Anemia/chronic fatigue <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Appendicitis/chronic abdominal pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Autism Spectrum Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Back/neck/spine <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Birth defect/congenital deformities <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>8. Bladder/urinary tract <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Blood/circulatory <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Bone/orthopedic <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Brain disease or injury/concussion <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Breast (lumps or masses) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Chemotherapy/radiation treatment <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|--|---|

15. a. Colon/rectum/intestine/bowel Yes No
 b. Blood in stool Yes No
16. Convulsion/seizures/epilepsy Yes No
17. Diabetes/sugar in urine..... Yes No
18. Chronic ear/nose/throat/tonsil condition/disease/disorder..... Yes No
19. Eating disorders such as, but not limited to, anorexia or bulimia..... Yes No
20. Emphysema/asthma/chronic lung disease (COPD)..... Yes No
21. Endocrine/gland/hormone system Yes No
22. Disease or injury of eye/ cataract/glaucoma Yes No
23. Gallbladder/pancreatic disease Yes No
24. Chronic headaches/migraines Yes No
25. Heart/chest pain/angina..... Yes No
26. Hernia Yes No
27. High cholesterol (if "Yes," record date of last reading and results on page 4) Yes No
28. High blood pressure (if "Yes," record date of last reading and results on page 4) Yes No
29. Kidney/kidney stones..... Yes No
30. Knee/shoulder/hip/other joints Yes No
31. Liver condition/hepatitis Yes No
32. Lupus, chronic muscle pain, muscle injury or disease, or fibromyalgia..... Yes No
33. a. Mental/emotional condition/ depression..... Yes No
 b. Therapy/counseling within last five years (if "Yes," record date of last session on page 4) Yes No
34. Neurological condition/disease/injury Yes No
35. Phlebitis/blood clot..... Yes No
36. Osteoarthritis/osteoporosis/osteopenia Yes No
37. Prostate/elevated PSA/prostatitis Yes No
38. Reproductive system disorder/infertility.... Yes No
39. Chronic respiratory/lung condition..... Yes No
40. Rheumatoid arthritis Yes No
41. Sexually transmitted diseases Yes No
42. Skin condition, abnormal or cancerous moles, or eczema/cysts/cancer Yes No
43. Sleep apnea/chronic sleep disorder Yes No
44. Stomach disorders/ulcer/acid reflux Yes No
45. Stroke/paralysis/seizures..... Yes No
46. Tumors..... Yes No
47. TMJ/jaw joint..... Yes No
48. Weight fluctuation (+/- 20 lbs.)..... Yes No
49. Cosmetic surgery/implants, use of prosthetic devices/limbs Yes No
50. 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: _____

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:

- a. Had any medical advice, diagnosis, care, or treatment, including prescribed medication, 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? 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 healthcare provider (at a future date)? Yes No
- e. Taken any prescription medication on a regular basis? Yes No

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

Name	Medications (include dosage and frequency of use)	Prescribed by (name/address/telephone)	Date prescribed

Please provide specific details below to each question answered "Yes" on pages 2 through 4. 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.

Health History Details:						
Please provide details below to any questions answered "Yes" on pages 2 through 4:						
Name	Question number	Start to end dates	Condition	Treatment Including Medications	Final result	Attending physician/healthcare 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	

Health History Details, continued:

Name	Question number	Start to end dates	Condition	Treatment Including Medications	Final result	Attending physician/healthcare 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).

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

SECTION 6 – SINGLE COVERAGE FOR APPLICANT UNDER AGE 19 ONLY

Complete this section only if the applicant is under age 19 and is applying for single coverage. The information provided will be used to determine applicant's eligibility for a state or federal children's insurance program.

Earned income – complete for all family members in the household and list every employer for each adult. Earned income is defined as monthly income before taxes are taken out of your wages.

Name	Employer	Earned Income (per month)

Total Earned Income per month: \$ _____

Dependent care expenses (daycare, etc.) are paid for how many persons in the household? _____

Unearned income – list all sources of unearned income for the family (child support, unemployment, workers compensation, etc).

Name	Source	Unearned Income (per month)

Total Unearned Income per month: \$ _____

SECTION 7 – CERTIFICATION AND DECLARATION

Certification of Completeness and Correctness

I affirm that the answers given in this application are complete and correct. I am providing these answers as part of the application procedure required by PacificSource to enroll in their insurance coverage. I understand that if this application contains any intentional misrepresentation of material fact, PacificSource may, within the first two years of coverage, deny coverage, modify or cancel the contract, and/or take any other legal action available to it by law. I further understand that if the misrepresentation amounts to fraud, PacificSource may deny coverage, modify or cancel the contract, or take other legal action available to it by law even after the first two years of coverage. I will promptly inform PacificSource 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 will be in force until approved by PacificSource. If approved, coverage will be in force as of the effective date determined by PacificSource. A representative of PacificSource may contact me to clarify answers on this application. Representations made by the applicant are deemed to be representations made on behalf of each person covered under this policy. However, changes to the application will not be effective until approved in writing by the applicant. An application received by PacificSource requiring alterations will be modified by amendment and sent to the applicant for signature. As the applicant, I understand I have the right to inspect the information in my file.

**SECTION 8 – CONDITIONAL AUTHORIZATION TO USE/
DISCLOSE PROTECTED HEALTH INFORMATION**

Names of all applicants: _____

ID# or Social Security #: _____

I (We) authorize any physician, healthcare provider, hospital, insurance or reinsurance company, or the Medical Information Bureau, Inc., to use and disclose a copy of my protected health information to PacificSource Health Plans, PO Box 7068, Springfield, Oregon 97475 for the purpose of enrollment determination or eligibility and policy underwriting.

My protected health information includes medical records, emergency and urgent care records, billing statements, diagnostic imaging reports, transcribed hospital reports, clinical office chart notes, laboratory reports, dental records, pathology reports, physical therapy records, hospital records (including nursing records and progress notes), and any personal or medical information related to the purpose of this authorization. Information obtained with this authorization will be used solely for the purpose defined above and will be limited to the minimum necessary information needed to achieve that purpose.

If the information to be disclosed contains any of the types of records or information listed immediately below, additional laws relating to use and disclosure of the information may apply. I (We) understand and agree that such information will be disclosed if I place my initials in the applicable space next to the type of information to be included with the disclosure:

- | | |
|--|-----------------------------------|
| _____ HIV/AIDS test or result information and related records | _____ Mental health information |
| _____ Drug/alcohol diagnosis, treatment, or referral information | _____ Genetic testing information |

I understand I have the right to refuse to sign this authorization. My refusal to sign this authorization could affect my enrollment in a health plan, eligibility for health benefits, and claims payment.

I have the right to revoke this authorization in writing at any time. If I revoke this authorization, the information described above will no longer be used or disclosed for the reasons covered by this written authorization except to the extent that action has been taken in reliance on this authorization. Any uses or disclosures already made with my permission cannot be taken back. I understand that revocation of this authorization could affect my enrollment in a health plan, eligibility for benefits, and payment of claims.

To revoke this authorization, please send a written statement to PacificSource Health Plans, Compliance Department, PO Box 7068, Springfield, Oregon 97475, and state that you are revoking this authorization.

I (We) understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I (we) also understand that federal or state law may restrict re-disclosure of HIV/AIDS test or result information, mental health information, genetic information, and drug/alcohol diagnosis, treatment, or referral information.

Unless revoked, this authorization shall be in force for the purpose of enrollment or eligibility determination or policy underwriting for a period not to exceed 24 months. Once an enrollment or eligibility determination has been made, this authorization to use or disclose this protected health information expires.

Each of us authorize 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 PacificSource or its representatives.

