



# Health Net Health Plan of Oregon, Inc. Oregon Standard Health Statement Individual & Family Plan Application

**PLEASE COMPLETE IN INK**

I am applying to Health Net Health Plan of Oregon, Inc. for an individual medical-surgical-hospital policy, with benefits selected as follows:

**Participating Provider Policy requested:** (Mark policy and deductible)

Classic Plans	Value Plans	HMO Plan	HSA Plan
<input type="checkbox"/> PPO 80%/60% <input type="checkbox"/> \$500 Deductible <input type="checkbox"/> \$1,000 Deductible <input type="checkbox"/> \$2,500 Deductible <input type="checkbox"/> \$5,000 Deductible  <input type="checkbox"/> PPO 80%/50% <input type="checkbox"/> \$500 Deductible <input type="checkbox"/> \$2,500 Deductible  Preventive Care Benefit for Children <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> PPO 80%/50% <input type="checkbox"/> \$500 Deductible <input type="checkbox"/> \$1,500 Deductible <input type="checkbox"/> \$5,000 Deductible  <input type="checkbox"/> \$1,000 Deductible <input type="checkbox"/> \$2,500 Deductible <input type="checkbox"/> \$10,000 Deductible  Preventive Care Included	<input type="checkbox"/> \$25 copayment HMO Plan (Available in select counties)  Preventive Care Included	<input type="checkbox"/> Single <input type="checkbox"/> Family  Preventive Care Included

You may choose an effective date of the 1<sup>st</sup> or 15<sup>th</sup> of the month. If the application is postmarked or received after the requested effective date, your effective date will be automatically changed to the next available effective date. Requested Effective Date is: \_\_\_\_\_

My initial premium of \$ \_\_\_\_\_ is enclosed. Enclose ½ months premium for the 15<sup>th</sup> of the month effective date.

Bill me for my initial premium upon acceptance. **Note:** Premium must be received before your coverage will become effective.

**Future payment choice for plans:**  Mail-in premium payment  Simple Pay Option (automatic premium withdrawal)

**GENERAL – The oldest family member to be enrolled must be the applicant and will be the policy Subscriber.**

Applicant's Name _____				Social Security # _____	
Residence Address _____		City _____	State _____	Zip _____	County _____
P.O. Box (if applicable) _____		City _____	State _____	Zip _____	
Home Telephone Number ( ) - _____	Sex M/F	Height	Weight	Birth Date	Primary Care Provider (Last, First Name)(HMO Plan Enrollees Only)

All HMO Plan enrollees must designate a Primary Care Provider (PCP). Each family member may choose a different PCP.

**COMPLETE SPOUSE/DEPENDENT SECTION ONLY IF THEY ARE TO BE COVERED.**

Dependent children must be under 23 years old and unmarried

Spouse's Full Name (Last, First, Initial) / Social Security Number	Sex M/F	Height	Weight	Birth Date	Primary Care Provider (HMO Plan)
Dependent's Full Name (Last, First, Initial) / Social Security Number	Sex M/F	Height	Weight	Birth Date	Primary Care Provider (HMO Plan)
	M/F				
	M/F				

If last name of a dependent differs from yours, explain relationship:

If any of the person listed above are entitled to Creditable Coverage toward the exclusion periods for pre-existing conditions, other specified conditions and transplant exclusion periods, indicate the period of Creditable Coverage. (See last page for definition.) Include additional sheets if necessary. Please include a copy of your Certificate of Prior Coverage.

Prior Carrier Name \_\_\_\_\_ Telephone # \_\_\_\_\_

Applicant's Name \_\_\_\_\_ Creditable Coverage from \_\_\_\_\_ to \_\_\_\_\_

Applicant's Name \_\_\_\_\_ Creditable Coverage from \_\_\_\_\_ to \_\_\_\_\_

Incomplete applications will be returned. The effective date will be delayed until the completed application has been received.

**FOR OFFICE USE ONLY**

Check #	Amount	Agent #	Group #	Premium amount

## HEALTH HISTORY STATEMENT

Please mark either "Yes" or "No" for each item listed for yourself and any family members requesting coverage. Provide details on page three to any questions answered "Yes." Within the last **five** years, has anyone listed on this application had any diagnosis, treatment, or advice relating to any of the following:

- |   |  |   |  |
|---|--|---|--|
| 1. AIDS, ARC, HIV positive.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 27. High blood pressure.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Alcohol/Chemical/Drug abuse/habit...                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | If "Yes", current reading<br>_____/_____  |  |
| 3. Anemia/Chronic fatigue .....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 28. Kidney/Kidney stones .....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Appendicitis/chronic abdominal pain...                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | 29. Knee/Shoulder/Hip/Other joints .....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Back/Neck/Spine.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 30. Liver condition /Hepatitis .....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Birth defect/Congenital deformities...                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | 31. Lupus, chronic muscle pain, muscle<br>injury or disease, or fibromyalgia .....                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Bladder/Urinary tract.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 32. A. Mental/Emotional condition/<br>Depression.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Blood/Circulatory.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 32. B. Therapy/Counseling within last 5 years<br>(if "Yes," record date of last session on<br>page 3) ..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Bone/Orthopedic.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 33. Neurological condition/Disease/Injury...  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Brain disease or injury/concussion .....                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 34. Phlebitis/Blood clot.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Breast (lumps or masses) .....  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 35. Osteoarthritis/Osteoporosis/ Osteopenia   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Cancer.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 36. Prostate/Elevated PSA/Prostatitis.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Chemotherapy/Radiation treatment....                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | 37. Reproductive system disorder/<br>Infertility.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. A. Colon/Rectum/Intestinal/Bowel.....                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | 38. Chronic respiratory/Lung condition...   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. B. Blood in stool .....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 39. Rheumatoid Arthritis.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 15. Convulsion/Seizures/Epilepsy.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 40. Sexually transmitted disease(s).....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16. Diabetes/Sugar in urine.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 41. Skin condition, abnormal or cancerous<br>moles or eczema/cysts/cancer.....                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 17. Chronic ear/Nose/Throat/Tonsil<br>condition/Disease/Disorder.....         | <input type="checkbox"/> Yes <input type="checkbox"/> No | 42. Sleep apnea/Chronic sleep disorder ...  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 18. Eating disorders such as, but not limited<br>to, Anorexia or Bulimia..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 43. Stomach disorders/Ulcer/Acid Reflux...  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 19. Emphysema/Asthma/Chronic lung disease<br>(COPD) .....                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | 44. Stroke/Paralysis/Seizures.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 20. Endocrine/Gland/Hormone system.....                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | 45. Tumors .....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 21. Disease or injury of<br>Eye/Cataract/Glaucoma .....                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | 46. TMJ/Jaw joint.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 22. Gallbladder/Pancreatic disease .....                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | 47. Weight fluctuation (+/- 20 lbs.).....   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 23. Chronic headaches/Migraines .....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 48. Cosmetic surgery/Implants, use of<br>prosthetic devices/Limbs .....                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 24. Heart/Chest pain/Angina.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| 25. Hernia.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| 26. High cholesterol .....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| If "Yes", current reading<br>_____/_____                                      |  |   |  |

49. 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:
Name :	Type of product:

50. 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 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? <input type="checkbox"/> Yes <input type="checkbox"/> No | c. Been advised to have or contemplated having an operation or medical procedure not yet performed? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Had chronic cough, fatigue, diarrhea, or enlarged glands? <input type="checkbox"/> Yes <input type="checkbox"/> No  | d. Been scheduled to see a health care provider? <input type="checkbox"/> Yes <input type="checkbox"/> No  |
|  | e. Taken any prescription medication on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No  |

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

Name	Medications	Prescribed by (name/address/telephone)	Date Prescribed

Name	Question Number	Start to end dates	Condition	Treatment Including medications	Final Result <b>Ongoing</b> or <b>Resolved</b> Please check	Attending physician/health care provider or hospital (name/address/telephone)
					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"/>	

Attach additional pages if necessary.  I have attached \_\_\_\_\_ page(s).

<b>Name, address, and telephone number of medical provider with current medical records/history:</b>
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<b>CURRENT OR FORMER HEALTH NET COVERAGE</b>			
Member Name	Group Number	State	Last Date of Coverage

**Continuation of Present Health Coverage:** If you have other health coverage now, will you continue the coverage in addition to the Health Net of Oregon coverage you are applying for?  Yes  No

Name of Company \_\_\_\_\_ Address \_\_\_\_\_ Telephone No. \_\_\_\_\_

Is any person listed on the application receiving or eligible to receive Medicare or Social Security Disability benefits?

Yes  No If Yes, give name: \_\_\_\_\_ Medicare Effective Dates: Part A \_\_\_\_\_ Part B \_\_\_\_\_

Medicare Identification number: \_\_\_\_\_

**Information Practices:** Information about you or an enrolling family member may be obtained from medical records as indicated in the medical information release portion of the application form. Other than from medical records, personal information will not be collected from any sources other than the applicant or individuals proposed for coverage.

**BE SURE TO COMPLETE THE HEALTH HISTORY STATEMENT AND SIGN AND DATE THE BACK PAGE**

<b>FOR UNDERWRITING USE ONLY</b>

**Definition: "Creditable Coverage"** means any of the following coverages: Group coverage (including FEHBP and Peace Corps); Individual coverage (including student health plans); Medicaid; Medicare; CHAMPUS; Indian Health Service or tribal organization coverage; state high risk pool coverage; and public health plans. Creditable coverage does not include coverage only for a specified disease or illness or hospital indemnity (income) insurance. Coverage is Creditable only if there has not been a gap in coverage exceeding 63 days.

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

**CONDITIONAL AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION**

**To any physician; health care provider, including OHSU; hospital, including OHSU; insurance or reinsurance company; the Medical Information Bureau, Inc. (MIB), or other insurance information exchange:**

Each of us authorizes you to give Health Net Health Plan of Oregon, Inc. or its representatives any medical record information (including alcohol, chemical dependency, mental treatment, or HIV treatment) you have about me or my family members. Such information may be used for processing application for coverage, for prior authorizing services or processing claims for benefits, or for purposes of health care provider credentialing, quality assurance, utilization review, case management, peer review, and audit. A photocopy of this authorization is as valid as the original. I understand that I may receive a copy of this authorization upon request.

This authorization takes effect on the date signed and it remains in effect as follows:

- For information used to process this application – 30 months
- For information used for all the other reasons listed above – as long as coverage is in effect or until the completion of processing any claim, whichever is longer.

I affirm that I received a disclosure statement and outline of coverage from Health Net of Oregon or its authorized agent. I understand that a PPO policy will not pay benefits for any loss incurred during the first six months after the effective date on account of a disease or physical condition which I now have or have had in the past. Creditable coverage applies. I understand that if my application for coverage is accepted, I will have ten days after receiving notice of acceptance during which I may either make a replacement election or cancel the policy for a full refund. I affirm that my employer is not paying the premium for this coverage.

**Be sure to sign and date the application. Spouse's signature is required if applicable. Signature applies to both "Certification of Completeness and Correctness" and "Authorization for Release of Information".**

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SIGNATURE OF APPLICANT (PARENT OR LEGAL GUARDIAN  
IF APPLICANT IS UNER 18 YEARS OF AGE OR LEGALLY INCOMPETENT) \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ DATE \_\_\_\_\_

-----  
PRINT NAME OF APPLICANT (PARENT OR LEGAL GUARDIAN  
IF APPLICANT IS UNER 18 YEARS OF AGE OR LEGALLY INCOMPETENT) \_\_\_\_\_

-----  
SIGNATURE OF APPLICANT'S LEGAL SPOUSE (IF APPLYING FOR COVERAGE) \_\_\_\_\_ DATE \_\_\_\_\_

**INSURANCE PRODUCER USE ONLY**

I certify that the information supplied by the applicant(s) has been truly and accurately recorded and that I have made no representation about benefits, condition, or limitation of the policy except through written material furnished by Health Net Health Plan of Oregon, Inc.

Insurance Producer's Signature \_\_\_\_\_ Date \_\_\_\_\_

Insurance Producer's Name (please print) Kevin B Coleman Insurance Producer's Number \_\_\_\_\_

Agency Name \_\_\_\_\_ Insurance Producer's Phone Number \_\_\_\_\_

Agency Address 2160 W 11th, Suite D City Eugene State Oregon Zip 97402

Policy mail Policy to:  Insurance Producer  Member

Health Net Health Plan of Oregon, Inc., 13321 SW 68<sup>th</sup> Parkway, Tigard Oregon 97223 • 888.802.7001 • [www.healthnet.com](http://www.healthnet.com)



# Health Net Health Plan of Oregon, Inc. Individual & Family PPO/HMO Plan Disclosure Statement

This disclosure statement answers questions consumers often ask about health insurance coverage and costs. It highlights some of the important issues that frequently affect consumers. It is intended for your use whether you are purchasing health insurance for the first time or whether you are replacing or adding to your existing coverage.

## General Questions and Answers

1. Does the insurer have a list of doctors or hospitals, or both, under contract that are considered “preferred” or “participating”? **Yes.**
- 2a. May I use doctors or hospitals that are *not* on the list under my IFP PPO Plan? **Yes.**
- 2b. May I use doctors or hospitals that are *not* on the list under my IFP HMO Plan? **No**, except for Urgent and Emergency Care.
3. Will I save money by using the doctors or hospitals on the list instead of others? **Yes.**
4. Will doctors and hospitals on the list accept benefits paid under the policy as full payment and not bill me for the balance (other than for deductibles and copayments)? **Yes.**
5. Pregnancy Benefits (if the coverage offered is comprehensive major medical):
  - a. What are the policy’s benefits and limitations with respect to pregnancy? **Pregnancy benefits apply to any covered member and are only available after a 12-month benefit exclusion period is satisfied.**
  - b. Will the offered policy cover a pregnancy without complications if the pregnancy is in existence at the time of the policy’s issuance? **No. Applicants who are currently pregnant would not be issued a policy.**

## Are You Replacing Coverage?

6. If I replace my current policy with another and there is no lapse or gap in coverage, will my enrollment under the old policy count toward meeting any pre-existing conditions provisions? **Yes, creditable coverage applies toward the benefit exclusion periods for pre-existing conditions, as well as toward the 12-month exclusion period for specified conditions, and the 24-month waiting period for transplant benefits.**
7. Will expenses I incurred under my current policy during the current policy year be credited to the new policy’s deductibles? **No, unless you are transferring from another Health Net of Oregon plan to this plan.**
8. If I have a health condition existing when the offered policy is issued, will that condition be covered as of the date of issuance? **No. Pre-existing health conditions will be covered after a 6-month pre-existing conditions period. Covered transplant benefits will be paid after a 24-month exclusion period. There is also a 12-month exclusion period for specified conditions.**
9. Does the policy contain any dollar limitation on specific benefits? Are there any limits on specific benefits such as hospitalization? **Yes. Refer to the attached benefit summary for a list of benefits that have limitations.**

## Are You Adding Coverage to Your Current Policy?

10. If my coverage under the new policy duplicates coverage under my current policy, will the new policy pay if my current policy also pays? (You should ask the agent or company representative who sold you your current policy whether your current policy will pay if the new policy pays.) **No. The only time that the benefits of the new policy will be paid without regard to other coverage is in the case of another individual policy with an effective date after this policy.**

# Oregon Individual Health Insurance Policy Disclosure Statement

## Are You Considering Replacing Current Coverage?

Before you replace your current policy with another, you should review both policies in order to determine whether replacement is in your best interests. The new coverage may be different in important respects. You should be aware of these differences and whether they are temporary or permanent. If you obtained your current policy from another agent or a representative of another company, be sure to ask that agent or representative any questions you may have about that policy.

## Are You Considering Adding to Your Current Coverage?

Before you add new coverage to your current coverage, you should review both policies to ensure that you are not purchasing unnecessary coverage. If you obtained your current policy from another agent or a representative of another company, be sure to ask that agent or representative any questions you may have about that policy and the need for additional coverage.

## Questions? Ask for Help.

If you have any questions that are not answered by this disclosure statement, be sure to ask your agent or insurer representative.

## Read Your Policy!

If you purchase the offered policy, read it carefully as soon as you receive it. Because it is an individual policy, you will have an opportunity to send it back and obtain a premium refund.

## Fill Out Your Application Carefully!

Be sure to fill out all portions of your application completely and truthfully. If misstatements are made or information about your health is omitted from the application, the insurer may void the policy or deny your claims. We hope this disclosure statement will help you with your insurance purchase. However, please note that the statement is not intended to be a part of the policy and that only the language of the policy issued by the insurer is final and binding.

Kevin Coleman

(Agent's or insurance company representative)

2160 W 11th, Suite D Eugene, OR 97402

(Address)

Completed this statement on \_\_\_\_\_ for \_\_\_\_\_  
(Date) (Applicant)

The policy is underwritten by:

**Health Net Health Plan of Oregon, Inc.**

(Insurance company or health care service contractor)

**13221 SW 68<sup>th</sup> Parkway, Suite 200, Tigard, Oregon 97223**

(Address)

888-802-7001  
www.healthnet.com