

Questions? Call us at CDA Insurance LLC:
1-800-884-2343 or 541-434-9613

Regence Application

Tips for completing the application :

1. Please read everything carefully and answer all questions honestly. This document becomes part of your health insurance contract.
2. Please complete all sections to the best of your ability. Please pay special attention to Section 5. By including the specific details to questions you answered 'yes" to, the processing of your application will be expedited. Be sure to include:

- The specific name and date of the diagnosis or condition and correct spelling.
- The treatment(s) that were done, including the last time you visited the doctor for this condition and medications that were prescribed and medications that are currently being taken.
- Final result refers to the status of the condition. If it has been treated and your doctor has not requested any follow-ups, please state so. If you are still seeing the doctor, please state so.
- Complete name, address and phone number of the doctor .

Prior Insurance?

Yes:

Please make a photocopy of your health insurance card(s) or contact your insurance carrier and request a "Certificate of Credible Coverage." Include this with your application.

No:

If your application is approved, when the policy is sent to you, there will be a form that will need to be signed and returned to us stating that you understand there is a 6 month waiting period on pre-existing conditions before you will be covered for conditions that you been diagnosed with or seen a doctor for before the policy is effective.

Payment:

The payment options are monthly or quarterly.

Monthly:

Please complete Authorization section carefully and attach a voided check. (deposit slip does not work!) If you wish to be billed monthly Simply check that box instead.

Quarterly:

Simply check the corresponding box and you are done.

Final check list before mailing:

- All sections completed?
- Copy of Insurance Card or Certificate of Credible Coverage
- Signed and Dated
- Voided check if selecting the automated monthly withdrawal

Send Completed Application to:

CDA Insurance, LLC, PO Box 26540, Eugene, Oregon 97402



Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueCross BlueShield of Oregon
 100 SW Market Street
 Portland, Oregon 97207-1271
 Mail form to: PO Box 1106, MS-LB1
 Lewiston, ID 83501

Individual Application

Please read carefully and make sure all sections of the application are answered completely. Use ink to complete, sign and date the application to avoid having it returned to you.

SECTION 1 - ELIGIBLE TO APPLY FOR COVERAGE?

1. If you are currently eligible for Medicare, or will be on the requested effective date of coverage for which you are applying, you are not eligible for private individual or family health coverage and should not fill out this application.
2. **You must be a permanent Oregon resident.** A photocopy of a valid Oregon state driver's license, identification card, or similar proof of residency acceptable to Regence BlueCross BlueShield of Oregon may be requested.

For more information please contact your producer or call our Sales department toll-free at 1-888-REGENCE (1-888-734-3623).

SECTION 2 - EFFECTIVE DATE

Your application is subject to review and approval by Regence BlueCross BlueShield of Oregon. Complete applications received in our office by 5:00 PM Pacific Time on the last business day of the month will be eligible for an effective date of the first of the following month, unless otherwise indicated. Incomplete applications may receive a later effective date.

Requested Effective Date _____

SECTION 3 - TYPE OF APPLICATION (check one)

- New enrollment** (applying to become a new Regence member)
- Addition of a spouse/domestic partner and/or child to my existing policy**
- Change to existing individual plan or deductible** (existing Regence member applying to change benefit plans)

Note: Your policy must be paid current in order for a plan change to be made. If your policy cancels due to non-payment, you will need to reapply by submitting a new Individual Application.

SECTION 4 - ENROLLMENT INFORMATION

List all eligible family members to be covered. Eligible family members include a spouse/domestic partner, and/or any child who is under age 26 or who is medically certified as disabled. Copy of certification required.

Last Name	First Name, MI	Relationship to Subscriber	Gender	Age	Height	Weight	Birthdate	Social Security Number
		Subscriber						
		<input type="checkbox"/> Spouse <input type="checkbox"/> Certified Domestic Partner <input type="checkbox"/> Non-Certified Domestic Partner*						

*Non-Certified Domestic Partners must submit an Affidavit of Domestic Partnership



SECTION 5 - ADDRESS AND PHONE NUMBER

Residence Street Address		Mailing Address (if different than residence street address)	
City, State, ZIP Code	County	E-Mail Address (will not be disclosed outside of the company)	
Home Phone Number ()	Cell Phone Number ()	Work Phone Number ()	

SECTION 6 - MEMBER CARD (check one)

- Family Level Card (all members listed on the same card)
 Member Level Card (each member on a separate card)

SECTION 7 - PLAN SELECTION (Detailed benefit information can be found online at regence.com)**MEDICAL PLANS (check one):****Evolve Core**

Deductibles are per member (3 individual deductibles satisfy the family deductible)

- \$1,000 \$2,500 \$5,000 \$7,500 \$10,000

Evolve Plus

Deductibles are per member (3 individual deductibles satisfy the family deductible)

- \$1,000 \$2,500 \$5,000 \$7,500

Evolve HSA**Self-Only Deductibles**

- \$1,500 with 50% coinsurance
 \$1,500 with 80% coinsurance
 \$3,500 with 50% coinsurance
 \$3,500 with 80% coinsurance

Family Deductibles

- \$3,000 with 50% coinsurance
 \$3,000 with 80% coinsurance
 \$7,000 with 50% coinsurance
 \$7,000 with 80% coinsurance

Evolve HSA 100

- \$5,000 self-only deductible \$10,000 family deductible

DENTAL OPTIONS (check one)

- No Dental
 Dental Option 1 - 100/80/50; \$750 annual maximum benefit that may increase over time to \$1,500
 Dental Option 2 - 100% of first \$200 and 50% of next \$1,100 (\$750 annual maximum benefit)



SECTION 8 - OTHER COVERAGE INFORMATION

1. Do you or any family members have other active health or medical coverage?..... Yes No
 If yes, do you intend to replace your current plan with this contract?..... Yes No
2. Do you or any family members work for an employer who offers health benefits to employees?..... Yes No
 Are you or any family members enrolled?..... Yes No
 If no, why? _____
3. Are you currently enrolled in an Regence BlueCross BlueShield of Oregon Individual medical plan and wish to cancel that coverage?..... Yes No

If you answered yes, please sign the statement below:

I wish to terminate my current individual medical coverage from Regence BlueCross BlueShield of Oregon on the effective date of this new individual policy.

Signature _____ Date _____

Regence BlueCross BlueShield of Oregon Individual Plans contain a 6-month pre-existing condition limitation period. The pre-existing waiting period may not apply to any members under the age of 19. Please provide the following information for all applicants, and attach a copy of your Certificate of Coverage from your current or prior carrier or a similar document showing the beginning and ending dates of your current coverage, if applicable. If current coverage is still active, the Certificate of Coverage can be provided at a later date.

Name (First, Last)	Insurance Company	Policy Number	Dates of Coverage		Type of Coverage
			Date Coverage Began mm/dd/yyyy	Date Coverage Ended (indicate active if you are currently covered) mm/dd/yyyy	
1.					◆ Employer Group ◆ Individual ◆ Medicare ◆ COBRA ◆ High Risk Pool ◆ Other (describe)
2.					
3.					



SECTION 9 - 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.

Regence BlueCross BlueShield of Oregon may review its claims history for the last five years for anyone who has had insurance with Regence BlueCross BlueShield of Oregon during that time. List the names and Regence BlueCross BlueShield of Oregon identification numbers of anyone on this application who has had insurance with Regence BlueCross BlueShield of Oregon during the last five years. _____

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", indicate name of person affected, reason for action, and name of insurance company _____

Please mark "Yes" or "No" for each item (for you and any family members.) Provide details on Page 6 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 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:

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



SECTION 9 - OREGON STANDARD HEALTH STATEMENT (continued)

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(s):				
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. mm/dd/yyyy				
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? mm/dd/yyyy				
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 on page 4 & 5? 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



SECTION 9 - OREGON STANDARD HEALTH STATEMENT (continued)

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

Name	Medications (frequency & dosage REQUIRED)	Prescribed by (name/address/telephone number)	Date prescribed

Please provide specific details below to each question answered "yes" on pages 4 & 5. 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 health care provider, or clinic/hospital.

HEALTH HISTORY DETAILS

Name	Question Number	Start to end dates	Condition	Treatment including medications	Final result Ongoing or Resolved Please check	Attending physician/health care 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	
					<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(s) with current medical record/history:



SECTION 10 – PREMIUM BILLING OPTIONS (if application is approved)**BILLING ADDRESS** (Complete only if billing should be sent to an address other than the Residence Street or Mailing Address listed in Section 5 of the application.)

Name (First, Last)

Address

City, State, ZIP Code

EMPLOYER CONTRIBUTION Yes No Is your employer reimbursing or paying for any portion of this policy's premium? Individual benefit plans are not intended for sale as an employer-sponsored health benefit plan for employees.**PAYMENT OPTIONS** (check one):

If no payment option is checked, your policy will automatically default to Monthly Billing.

 FHIAP ID# _____ (please attach to this application a copy of the signed FHIAP Certificate of Eligibility listing all eligible parties) Monthly Billing Surepay (premium is automatically deducted from your bank account on the 5th of each month).

It may take 45 - 90 days from the approval of your application to set up Surepay. To cover initial month(s) you will receive an invoice and need to make your payment by check in order to keep your account paid current.

If selecting the **Surepay** option:

1. Complete the following **Authorization To My Bank** section.
2. Write 'void' on one of your checks and return your voided check with this application (not a deposit slip). *For savings account, please provide proof of ownership of the account.*

AUTHORIZATION TO MY BANK

As a convenience and on behalf of the Account Holder identified below, I/we hereby request and authorize you to pay and charge to the account identified below, checks or electronic debits drawn on the account by and payable to the order of Regence BlueCross BlueShield of Oregon, Portland, Oregon. I/we agree that your rights to each such check or electronic debit shall be the same as if it were an actual check drawn on you and signed by me/us. This authority is to remain in effect until revoked by me/us in writing, and until you actually receive such notice, I/we agree that you shall be fully protected in honoring any such check. I/we further agree that if any checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. A photocopy of this executed authorization shall be as valid as the original.

Financial Institution or Bank Name**Transit/Routing Numbers****Account Number****Check One:** Checking Account Savings Account

Account Holder's Name (please print)

Account Holder's Signature (as it appears on bank records)

Date

SECTION 11 - PRODUCER CERTIFICATION

If you have a producer, that producer may receive bonuses, commissions, administrative service fees, or other compensation, including non-cash compensation, from Regence BlueCross BlueShield of Oregon. Incentives may be based on any of several factors, including the products you buy, your producer's volume of business with Regence BlueCross BlueShield of Oregon, and the other services your producer provides you. These incentives may have an indirect impact on your rates. For more information, please contact your producer.

FOR PRODUCER USE ONLY

I, (the producer) certify I have explained the eligibility provisions to the applicant. I have not made any statements about benefits, conditions or limitations of the contract except through written material furnished by Regence BlueCross BlueShield of Oregon. I have informed the applicant that the effective date of coverage is assigned only by Regence BlueCross BlueShield of Oregon and provided the 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)

Dann Loewenthal

Regence Producer Number

0103197-0002

Producer's Mailing Address

PO Box 26540, Eugene, OR 97402

Producer's E-mail Address

dann@lowinsure.com

Producer's Phone Number

541.434.9613

Producer's Signature (Required)

X

Date (Required)



SECTION 12 - CERTIFICATION, AUTHORIZATION AND SIGNATURE

Be sure to **sign** and **date** this application. Spouse/Domestic Partner and/or child's (age 18-25) signature is required, if applicable. Signature applies to both "Certification of Completion and Correctness" and "Authorization for Use and Disclosure of Protected Health Information".

Certification of Completion and Correctness

I affirm that the answers given in this application are complete and correct. I have provided these answers as part of the application procedure required by Regence BlueCross BlueShield of Oregon to enroll in its insurance coverage. I understand that if this application contains any intentional misrepresentations of material fact, Regence BlueCross BlueShield of Oregon 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, Regence BlueCross BlueShield of Oregon 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 Regence BlueCross BlueShield of Oregon 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 Regence BlueCross BlueShield of Oregon. If approved, coverage will be in force as of the effective date determined by Regence BlueCross BlueShield of Oregon. Regence BlueCross BlueShield of Oregon 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. I further affirm that I received a disclosure statement from Regence BlueCross BlueShield of Oregon or its authorized insurance producer.

Authorization for Use and Disclosure of Protected Health Information

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the application form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits, or as required by law.

Health information requested or disclosed may be related to treatment or services performed by:

- ◆ a physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- ◆ a clinic, hospital, long-term care or other medical facility;
- ◆ any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or;
- ◆ an insurance carrier or health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). **This authorization may not be used for psychotherapy notes** (notes recorded and separately maintained by a mental health professional documenting or analyzing the contents of a conversation during a counseling session). A separate authorization will be required.

* For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Regence Consumer Privacy Notice. A copy is available on our Web site at **regence.com** or by telephone request at **1 (800) 365-3155**.

SIGNATURES

Signature of applicant, parent or legal guardian if applicant is under 18 years of age or legally incompetent *	Relationship	Date
X		
Signature of applicant's legal spouse or eligible domestic partner *		Date
X		
Signature of child between 18 and 25 years of age *		Date
X		
Signature of child between 18 and 25 years of age *		Date
X		

* If signature by a personal representative of the member/enrollee please complete the following:

Personal Representative's Name (please print) _____
 Relationship to Individual _____ (Attach legal documentation if other than parent of a minor child)

If additional health information is required to qualify you or a family member for coverage, we may send you a separate authorization form for the purpose of obtaining medical information.

