



DEPENDENT APPLICATION 2009

You must be a permanent resident of Oregon to be eligible for OMIP
(see resident definition in Section B).

If you are currently enrolled in Oregon Health Plan/Medicaid,
Medicare or a substantially equivalent medical health insurance plan, **STOP**.
You are not eligible for OMIP.

Examples of plans that are not substantially equivalent are:
specified disease or illness-only; long-term or short-term disability; mandatory
student health; hospital-only or confinement policy; or an accident-only policy.

Medical eligibles: OMIP will not pay benefits during the first six months of enrollment
for pre-existing conditions. OMIP may not credit coverage for benefits and services
that your previous health plan did not cover or credit benefits that had not
been satisfied during the previous plan's exclusion period.

Please return this completed application to:

Oregon Medical Insurance Pool

PO Box 1271

Mail Station 5K

Portland, OR 97207-1271

Customer Service: 1-800-848-7280

Fax: (503) 225-5474

A APPLICANT/DEPENDENT INFORMATION

COMPLETE ALL SECTIONS IN INK.

Policyholder's Name Last	First	MI	Age	Birthdate (M/D/Y)
Permanent Physical Address	City	State	Zip	
<input type="checkbox"/> Mailing or <input type="checkbox"/> Billing Address (if different)			County	
Current ID No. (From Insurance Card)	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Home Phone	Work Phone	

Date you want your OMIP insurance to begin? _____. Applications are processed in the order they are received. It may take up to 30 days for processing. However, if you are applying to OMIP because you are medically eligible, your insurance starts the first of the month after we receive a complete (including all required documents) application unless you ask for a future date.

List all dependents you would like to add to your policy:				
Name (Last, first, middle initial)	Gender	Birthdate	Relationship	SSN
Spouse/Domestic Partner (<i>Certified</i>):				
Spouse/Domestic Partner (<i>Non-certified*</i>):				
Child:				
Child:				

*Attach domestic partner affidavit for non-certified domestic partners.

B PROOF OF ELIGIBILITY

Oregon resident: means you must be a permanent resident of Oregon to be eligible for OMIP. A resident is a person who maintains a residence in Oregon, lives there at least 180 days *per benefit enrollment year* and files personal income taxes in Oregon.

Once you enroll in OMIP, you must maintain a principal place of residence in Oregon and physically reside in this state at least 180 days each benefit enrollment year and file personal income taxes in Oregon.

_____ Dependent initial here showing you read and understand the residency requirements
(Parent/legal guardian if dependent is under 18 years of age or legally incompetent)

The applicant must attach a copy of *one* of the following documents showing applicant's name and address:

1. Current Oregon Driver License or Oregon identification card; or
2. Current utility bill (utility bills include, gas, garbage, phone, or electric); or
3. Current rental or lease agreement; or
4. Current FHIAP *Letter of Eligibility* with the date of eligibility and applicant's name.

— OFFICE USE ONLY —

GP NO.	ID NO.	OED	WP CRED	IL	M S	E S	ELG	EH	BC
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C STATISTICAL & ELIGIBILITY INFORMATION

OMIP requires that you complete the following information. The program will use only information about other insurance or employer-based benefits to determine eligibility. OMIP otherwise also uses this data for evaluating future insurance market reform.

In the last six months, have you been insured by any other insurance program (including Medicare or Medicaid/OHP)? Yes No

If yes, answer the following:

Who was listed as the primary insured under the policy? _____

What is that person's social security or ID number? _____

What is the name of the insurance company? _____

What is the policy number? _____ What is the group number? _____

What date did the policy begin? _____ What date did the policy end? _____

Why did the policy end? _____

Was this policy purchased through an agent? If so, please provide the agent's name: _____

Was the insurance group (*through the employer*) or individual insurance?

Group Individual Do not know

If it was group insurance, what is the name of the employer who offered the policy? _____

D AFFIRMATION, UNDERSTANDING & DISCLOSURE AUTHORIZATION

I understand that I am applying to the Oregon Medical Insurance Pool (OMIP), a State of Oregon program located within the Department of Consumer and Business Services, for an individual policy of medical, surgical, prescription and hospital insurance. I also understand that my coverage will become effective on the first of the month following approval and acceptance of the application by OMIP, unless I am eligible for Portability coverage. If eligible for Portability coverage, I understand that my coverage will become effective the date my prior group coverage is terminated. I will be responsible for paying premiums from my effective date forward.

I affirm that the foregoing answers on the application are complete and correct. I understand that no coverage will be in effect until the full initial premium is paid after this application has been approved and accepted by OMIP.

1. Pre-existing conditions will **not** be covered until the OMIP policy has been in effect for six months, unless OMIP waives the pre-existing condition limitation period. A pre-existing condition is a condition for which medical treatment or diagnosis was rendered during the six-month period immediately preceding the OMIP effective date of coverage. Alcoholism and transplants are considered pre-existing conditions.

_____ ***ALL* parties on this application *MUST* Initial here showing you have read & understand the above paragraph.**

(Parent/legal guardian if applicant is under 18 years of age or legally incompetent.)

2. If this application contains any material misrepresentations or omissions or you falsified or concealed residency requirements OMIP may terminate your policy back to the effective date of OMIP coverage. In addition, OMIP will retain your premiums to cover any claims and administration costs OMIP paid retroactive to the date OMIP terminates your policy and recover from you any amounts OMIP paid in excess of the premiums.

_____ ***ALL* parties on this application *MUST* Initial here showing you have read & understand the above paragraph.**

(Parent/legal guardian if applicant is under 18 years of age or legally incompetent.)

INDIVIDUAL AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

On behalf of ourselves and the family member(s) listed on this application, I authorize any physician, health-care provider, hospital, insurance or reinsurance company, or other insurance information exchange to disclose to the Oregon Medical Insurance Pool (OMIP) of the Department of Consumer and Business Services, an agency of the State of Oregon, or its representatives, our health information (including alcohol, chemical dependency, mental treatment, genetic testing or HIV treatment). We acknowledge and understand that this information will be used only for the purpose of determining enrollment, eligibility for benefits, and payment of claims, case management, quality assurance reviews or audits. Health information may include claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

If I choose not to sign this authorization, OMIP may refuse to enroll us in an OMIP health plan or pay future claims that we may incur if we obtain OMIP insurance coverage.

I may cancel this authorization at any time by sending a written request to OMIP. My cancellation of this authorization will not affect any action OMIP took before it received my request.

Federal law requires OMIP to tell me that, if the party to whom OMIP discloses my personal information shares it with anyone else, some state and federal laws may no longer protect it. This excludes alcohol and drug abuse records, which are protected by federal confidentiality rules (42 CFR, Part 2). Federal law prohibits redisclosure of this information without specified written authorization.

My signature on this application authorizes disclosure to OMIP of health insurance coverage, health insurance applications, Medicaid eligibility and medical record information about myself and my family members, listed on this application, if needed to: 1) determine eligibility for coverage; 2) preauthorize or process claims for benefits; 3) perform case management (including concurrent review) or quality assurance reviews; or 4) conduct an audit. OMIP shall not release the medical record information it obtains to anyone else except as allowed by state and federal law.

This authorization takes effect on the date I sign this application and remains in effect for the lifetime of the OMIP coverage or the duration of any claim, whichever is longer.

A photocopy of this authorization is as valid as the original.

<p>Signature of policyholder (or parent/legal guardian if applicant is under 18 years of age or legally incompetent):</p> <p style="text-align: center;">Date</p>
<p>Signature of dependent (or parent/legal guardian if applicant is under 18 years of age or legally incompetent):</p> <p style="text-align: center;">Date</p>
<p>If signed by a personal representative of the applicant, please complete the following:</p> <p>Personal Representative Name (please print) _____</p> <p>Relationship to Individual _____ (attach legal documentation if other than parent)</p>

E PREMIUM PAYMENT

DO NOT SEND PREMIUM PAYMENT WITH THIS APPLICATION

If you are approved, you will receive information regarding your premium payment.

I would like to pay my premium with the following method (check one):

- Monthly automatic payment directly from my bank *(If checked, complete authorization agreement that follows.)*
- Monthly billed directly
- Quarterly billed directly
- FHIAP ID # _____
Please attach a copy of the signed **FHIAP Certificate of Eligibility** listing all eligible parties, to this application.
- CareAssist ID # _____

AUTHORIZATION AGREEMENT FOR MONTHLY AUTOMATIC BANK PAYMENT (SUREPAY)

Name of Applicant or Policy Holder	Social Security Number
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Authorization to my bank: Checking Account Savings Account

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 on behalf of the Oregon Medical Insurance Pool. 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	Transit/Routing Numbers	Account Number

Account Holder's Name (please print)

Account Holder's Authorized Signature(s) – as it appears on bank statement

Date

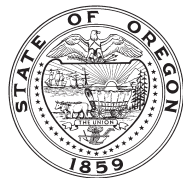
Attach Voided Check Here

DOCUMENT CHECKLIST

Did you remember to:

Yes No

- Answer all questions completely?
- Attach proof of residency? (*Section B on application*)
- Initial residency acknowledgement statement (*Section B on application*)
- Initial the affirmations, understandings and disclosure authorization and then sign and date the application. (*Section D on application*)
- If applying for credit toward the six-month pre-existing condition exclusion, attach *Certificate of Coverage* from prior insurance carrier reflecting your beginning and ending dates of coverage and stating your previous coverage has been terminated?
- If applying through portability eligibility, please attach a COBRA exhaustion letter. This tells us that your COBRA coverage is exhausted and that no portability options are available. Or, attach any of the other required documents reflecting portability eligibility. Please also provide a *Certificate of Coverage* with termination dates to verify that this coverage has been terminated.



Oregon Medical Insurance Pool

