Oregon Individual Enrollment Application
LifeWise Adult Health Plan (for individuals age 19 or older)

January 1, 2015
LifeWise Health Plan of Oregon

This application is for alternative care, hearing, vision and dental coverage for adults (individuals who are 19 years of age or older).

Please print your answers clearly in ink so we can process your application quickly. Be sure to return all pages to us. Omissions or incomplete answers will result in the return of your application and may cause delay in the effective date of your coverage.

1 My Enrollment Information

- ☐ I am a new applicant and 19 years of age or older (Please go to Section 2)
- ☐ I am a current member. 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.

NOTE: Dependents must be 19 years of age or older to be eligible for this plan.

Changing Plans?

You may change plans only during the Open Enrollment period or if you are eligible for Special Enrollment. This application must be received by the end of the Open Enrollment period or the end of the Special Enrollment period.

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 Adult Health Plan if you are:

- A resident of and continue to remain a resident of the state of Oregon. We may require proof of residency.
- Be 19 years of age or older
- Not enrolled in federal Medicare A or B (including entitlement due to disability), or a Medicare Choice or Medicare Advantage plan.

Eligible dependents that can enroll on your plan include:

- Your spouse or registered same-sex domestic partner (age 19 or older)
- Your natural or legally adopted child(ren), legal ward or foster child(ren) age of 19 or older

Open Enrollment Period

Individuals may apply for enrollment in a LifeWise plan during an open enrollment period. An open enrollment period is the timeframe set by the state of Oregon when applicants can enroll. Please refer to lifewiseor.com for the dates of the open enrollment period. The completed enrollment application must be postmarked or received electronically before the end of the open enrollment period.

Special Enrollment

Individuals can apply for enrollment outside of an open enrollment period if they qualify for a special enrollment period. To qualify for a special enrollment period, you must experience a qualifying event.

3 I want to enroll my…

Name	Social Security Number / Date of Birth	Gender
Self—age 19 or older (Last, First, Middle Initial)*	Social Security Number (optional)	Gender: ☐ M ☐ F
	Date of Birth / /	
Legally Recognized Spouse/Registered Same-Sex Domestic Partner—age 19 or older only (Last, First, Middle Initial)* (If last name is different than applicant, explain relationship)	Social Security Number (optional)	Gender: ☐ M ☐ F
	Date of Birth / /	
Dependent Child—age 19 or older only (Last, First, Middle Initial)* (If last name is different than applicant, explain relationship)	Social Security Number (optional)	Gender: ☐ M ☐ F
	Date of Birth / /	
Dependent Child—age 19 or older only (Last, First, Middle Initial)* (If last name is different than applicant, explain relationship)	Social Security Number (optional)	Gender: ☐ M ☐ F
	Date of Birth / /	
Dependent Child—age 19 or older only (Last, First, Middle Initial)* (If last name is different than applicant, explain relationship)	Social Security Number (optional)	Gender: ☐ M ☐ F
	Date of Birth / /	
Dependent Child—age 19 or older only (Last, First, Middle Initial)* (If last name is different than applicant, explain relationship)	Social Security Number (optional)	Gender: ☐ M ☐ F
	Date of Birth / /	

Address	City / State / ZIP	County
Home Address (not P.O. Box) **required**	City / State / ZIP	County
Mailing Address (if different from Home Address)	City / State / ZIP	County
Billing Address (if different from Mailing Address)	City / State / ZIP	County

Home Telephone Number	Work Telephone Number	Cell Telephone Number
( )	( )	( )

E-mail Address of Primary Applicant

Primary Language(s), if other than English (Primary Applicant)

* Only the first 26 characters will be displayed on the ID card(s)

4 Selecting my plan

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 1 day before your desired effective date.)

Alternative Care, Hearing, Vision and Dental Plan (for adults age 19 or older)
Note: You are not eligible to select an Adult Health Plan if you have selected the HSA medical plan option.

☐ Yes, I want to enroll in a LifeWise Adult Health Plan (select one):

☐ LifeWise Adult Health Package 50 ☐ LifeWise Adult Health Package 50

This plan provides benefits for alternative care, hearing, vision and dental services to adults age 19 or older. There is a 12 month waiting period for all major dental services.

5 Paying for my health plan (select one) **Don't send payment**

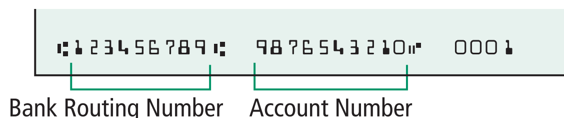
We do not accept premium payments from third party payers including employers, providers and not-for-profit agencies, except as required or allowed by law.

☐ Monthly paper bill by mail (move on to Section 6)

☐ 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.

Account Holder's Name (print)	Financial Institution or Bank Name	
Financial Institution/Bank City, State, ZIP		☐ Checking ☐ Savings
Bank Routing Number (see picture below, number cannot begin with a "5")	Account Number (see picture below)	



Routing Number

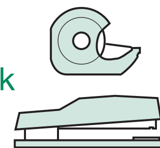
We can't set up automatic withdrawals with bank routing numbers that begin with a "5." If your routing number begins with a "5," call your bank to get the correct bank routing number.

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.
- I affirm that my premiums are not paid or sponsored by my employer, not-for-profit agency, a provider or any other third-party, except as required or allowed by law.

Account Holder Signature X ______________________ Date of Signature ____ / ____ / ____

Attach your **voided** check HERE



6 Basic Terms of Enrollment

1) I understand and agree that this application is not an offer of coverage, and coverage does not begin until: a) This application is received, reviewed, and accepted by LifeWise and an effective date of coverage is assigned; and b) My complete and correct payment is received. Submission of this application does not guarantee I will receive coverage.
2. I understand and agree that this application becomes part of my policy and to the extent that the application is inconsistent with the plan, the plan will govern.
3. I understand that acceptance for coverage is dependent on: a) Persons listed on this application must be residents of the state of Oregon in order to apply for and maintain coverage under this plan, and b) No one on this plan is enrolled in Medicare A or B.

   "Resident" means a person who lives in the state of Oregon, and intends to live in the state permanently or indefinitely. In no event will coverage be extended to an applicant who resides here for the primary purpose of obtaining health care coverage. The confinement of a person in a nursing home, hospital or other medical institution shall not by itself be sufficient to qualify such a person as a resident. LifeWise may require proof of residency from time to time. Such proof shall include, but not be limited to, the street address of the individual's residence and not a post office box.
4. I understand and agree that only LifeWise may: a) Make or modify the terms of the application or contract; or b) Waive any of the LifeWise rights or requirements. I understand that I may receive benefits which are less than the amount billed by my provider when treatment is not received from a contracted provider.
5. I understand and agree that this coverage is issued as individual coverage for adults age 19 or older and there is a 12 month waiting period for all major dental services. I further understand that coverage is not sold or issued for use as a government or third party sponsored health plan, and is not partially or fully paid for by an employer, not-for-profit agency, provider or any other third party payer, either directly or indirectly, except as required or allowed by law.
6. I understand and agree that if I cancel my LifeWise individual medical plan or lose coverage for any reason, My LifeWise Adult Health Package plan will end at the same time.
7. I understand that if this application contains any intentional misrepresentations of material fact regarding required information, 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.**

7 Notice of Information Use and Disclosure

Type of Information to be Disclosed: With the exception of genetic information, I (we) authorize: any physician; healthcare provider; hospital; insurance or reinsurance company; pharmacy benefit manager, third party benefits administrator 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 as allowed by law.

Purpose of Disclosure: I (We) understand that personal information will be used for evaluating enrollment in the health plan and 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 Not Authorizing: 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 Note: You or your authorized representative will receive a copy of this authorization.

8 My final checklist:

Omissions or incomplete answers will result in the return of your application and may cause a delay in the effective date of your coverage.

Did I remember to:

- ☐ Provide documentation for my qualifying event (If applying outside Open Enrollment).
- ☐ Choose an effective date in Section 4?
- ☐ Attach a voided check and sign at the bottom of Section 5 if you want to pay your bill with automatic bank withdrawal?

Remember to have all applicants sign and date this application in ink in the next section (Section 9)

9 Signatures

I hereby apply for enrollment with LifeWise Health Plan of Oregon for myself and family members listed on this application for coverage under the Individual contract indicated on this form. I understand I will have the right to examine and return the contract within 10 days of its delivery to me. I certify that:

- I have read the form, agree to its terms and I have supplied all of the required information on this form
- I have received and read a product information packet containing plan summaries and understand that a complete list of exclusions and limitations is detailed in the contract. If there is a conflict, the terms of the contract prevail
- I declare that, to the best of my knowledge, all of the information on all forms necessary for enrollment is true and complete, and that all of the persons for whom I am requesting enrollment are eligible for coverage. I understand that if I have made false, incomplete or misleading statements or answers on behalf of myself or any family members, all entitlements to benefits are void and this contract may be cancelled or modified retroactively to its effective date. I further understand that it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Important!

Signatures are required for all applicants.

Approved applications postmarked or received by the 14th day of the month will be effective on the 15th of the month. A prorated subscription charge will apply for the partial month of coverage. Approved applications postmarked or received by the last day of the month will be effective on the first day of the following month. This does not apply to applicants enrolling during open enrollment.

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

Mail completed application before your requested effective date to:

LifeWise Health Plan of Oregon | PO Box 91120, MS 295 | Seattle, WA 98111-9220
Or fax application to: 888-773-6372

877-203-5851
lifewiseor.com

LifeWise

Marketing Authorization

LifeWise Health Plan of Oregon continuously strives to provide products and services to meet the needs of its members. Please sign this form to allow LifeWise to use your contact information to send you information about products and services offered by us and other companies that could provide you with additional financial protection such as critical illness, accident and life insurance.

I understand that:

1. I may change my mind and cancel this authorization at any time by sending written notice to LifeWise. After LifeWise receives my notice, they will cancel this Authorization within ten (10) business days. My notice will not have an effect on any actions taken prior to LifeWise receiving my revocation.
2. If information is shared with third parties, it may no longer be protected by HIPAA and other privacy rules.
3. I understand that this release is voluntary. It does not affect my enrollment in a health plan, eligibility for benefits or payment of claims.
4. Unless revoked by me, this release will remain valid for 1 year after my coverage with LifeWise terminates.

Name of subscriber: ______________________ Date of birth: ____ / ____ / ____

Signature of subscriber: ______________________ Date signed: ____ / ____ / ____

Please return this page.

10 Your Household Information (optional)

The following information is collected for statistical purposes only, and is not used to determine your eligibility for coverage.

Total Number Of Individuals In Household (includes those not applying for coverage): ________

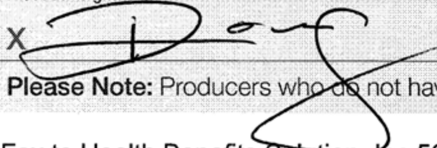
Household Income (check one):

☐ $0 to $19,999 ☐ $20,000 to $39,999 ☐ $40,000 to $59,999
☐ $60,000 to $74,999 ☐ $75,000 to $99,000 ☐ $100,000 or more

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.

Agency Name	
Health Benefits Solution, Inc	
Producer Name	**LifeWise Producer Number**
Doug Ellsworth	2341 A
Producer Address	
5200 SW Meadows Rd, Suite 150	
Producer Telephone Number	**Producer E-mail Address**
(503) 922-2903	Doug@HBS247.com
Producer Signature	**Date**
X 	/ /

Please Note: Producers who do not have a current appointment with LifeWise are not authorized to offer LifeWise products.

Fax to Health Benefits Solution, Inc 503-488-5597, or Scan to doug@hbs247.com

Mail completed application to: LifeWise Health Plan of Oregon
PO Box 91120, MS 295
Seattle, WA 98111-9220

Fax: 888.773.6372
lifewiseor.com

If you are applying for the first time and have questions, please contact Individual Plan Sales at **877.203.5851**.
If you are an established member with LifeWise Health Plan, please contact Customer Service at **800.596.3440**.