

Nonrenewable Short Term Medical Policy Application



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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 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 at (541) 684-5442, or toll-free at (866) 695-8684.

SECTION 2 – PLAN SELECTION

Policy length: <input type="checkbox"/> Daily (30 to 185 days): _____ <input type="checkbox"/> Monthly (1 to 6 months): _____	Plan type: <input type="checkbox"/> \$500 deductible <input type="checkbox"/> \$1,000 deductible <input type="checkbox"/> \$2,000 deductible <input type="checkbox"/> \$2,500 deductible	Requested effective date: _____ / _____ / _____ (month/day/year) If no date is requested and this application for coverage is accepted, the effective date will be the day after the postmark date of the application.
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I request that optional alcoholism treatment be attached to my policy for an additional charge: Yes No
(Call (866) 695-8684 for more information)

SECTION 3 – APPLICANT INFORMATION *(Must be the oldest person in the family unit)*

To qualify for coverage, all persons listed on this application must be at least 30 days of age, less than 65 years of age, a U.S. citizen or permanent resident, and not eligible for Medicare while this policy is in effect.

Last Name	First Name	MI	Birth Date (mo/day/yr)	Social Security No.	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Permanent Address (Street or PO box)		City	State	Zip	
Mailing Address (if different)		City	State	Zip	
Home Number			E-mail Address		

DEPENDENT INFORMATION *(Must be legal dependents of the applicant)*

First Name and Middle Initial	Last Name	Sex	Birth Date (mo/day/yr)	Social Security No.
Spouse/Domestic Partner		<input type="checkbox"/> M <input type="checkbox"/> F		
Child*		<input type="checkbox"/> M <input type="checkbox"/> F		
Child		<input type="checkbox"/> M <input type="checkbox"/> F		
Child		<input type="checkbox"/> M <input type="checkbox"/> F		
Child		<input type="checkbox"/> M <input type="checkbox"/> F		
Child		<input type="checkbox"/> M <input type="checkbox"/> F		

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

**If you are applying for a policy for children only (no parent on the policy), you must submit a separate application for each child. A sibling cannot be considered a dependent. The premium for each policy is based on the individual child's age and should include a separate application fee.*

SECTION 4 – PAYMENT OPTIONS

Daily Plan Type

Premium is due in a single payment with application submission.

- Total premium (+ \$25 nonrefundable application fee)

Enclosed: \$ _____

$$\text{Daily Premium: } \frac{\text{_____}}{\text{(rate)}} \times \frac{\text{_____}}{\text{(days)}} = \frac{\text{_____}}{\text{(premium)}}$$

Premium + \$25 nonrefundable application fee = Total Due

Monthly Plan Type

Premium can be paid all at once or by automatic bank withdrawal.

- Total premium (+ \$25 nonrefundable application fee)

Enclosed: \$ _____

$$\text{Monthly Premium: } \frac{\text{_____}}{\text{(rate)}} \times \frac{\text{_____}}{\text{(months)}} = \frac{\text{_____}}{\text{(premium)}}$$

Premium + \$25 nonrefundable application fee = Total Due

- Automatic bank withdrawal. Please submit the first **two** full months' premium (+ \$25 nonrefundable application fee) by check, and include a separate voided check. Subsequent withdrawals will draw one full calendar month's premium. Please sign below to authorize future withdrawals.

Automatic Bank Withdrawal Authorization: This authorization will remain in effect until policy termination by either party. *Please note that a full month's premium will be charged regardless of your effective date.*

Bank Account Holder's Name (please print) _____

Signature of Bank Account Holder _____

Date _____

SECTION 5 – MEDICAL INFORMATION

Please answer the following questions. If any question is answered yes, this policy cannot be issued.

- Does any person listed on this application have hospital, medical, Medicare, or Medicaid coverage that will remain in force beyond the requested effective date listed on this application? Yes No
- Is any person listed on this application now pregnant, responsible for a current pregnancy, or is an expectant mother or father through birth or adoption? Yes No
- Is any person listed on this application currently admitted to any hospital or healthcare facility for any reason? Yes No
- 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:
 - AIDS, ARC, HIV positive? Yes No
 - Alcohol/chemical/drug abuse/habit Yes No
 - Cancer Yes No
 - Diabetes/sugar in urine Yes No
 - Heart/chest pain/angina Yes No
 - Kidney disorder Yes No
 - Liver condition/hepatitis Yes No
 - Stroke/paralysis/seizures Yes No

SECTION 6 – IMPORTANT INFORMATION

I UNDERSTAND THAT:

- If this application for coverage is accepted, the effective date will be 12:01 a.m. 1) the day after the postmark date of the application or 2) the requested effective date, whichever is later. **Initials:** _____
- This policy is designed to provide medical coverage on a temporary basis to fill a temporary need. It cannot be renewed and is not intended to replace permanent coverage. However, if the temporary need continues, the applicant may apply for one new policy within a 12-month period. **Initials:** _____
- This policy does not exceed six months, including renewals. **Initials:** _____
- If this application for coverage is not accepted, any premium paid will be promptly refunded. However, the application fee is nonrefundable. **Initials:** _____
- This is not a continuation of any previous medical plan, including any prior short-term medical plan. Any condition which may have existed or occurred under one policy will be a pre-existing condition under the subsequent policy, and therefore, will not be covered under the subsequent policy. **Initials:** _____

- ***This insurance will not cover pre-existing conditions or prescription drugs for pre-existing conditions. Pre-existing conditions are defined as any sickness or injury for which any medical advice, treatment, service, supply, or prescription drug has been received, or for which symptoms have been shown, during the five years immediately preceding the effective date of this coverage.***Initials: _____
- Under no circumstances will the applicant or dependents make changes once the policy goes into force, except as outlined in the policy.Initials: _____
- This policy will not cover services or supplies for treatment of illness or injury due to or in the course of employment or self-employment for wages or profit, whether or not the expense for the service or supply is paid under workers' compensation.Initials: _____
- Upon notice from PacificSource, coverage may be terminated or the policy rescinded for fraud or material misrepresentation of the applicant or the applicant's representative in the applying or use of this policy.Initials: _____
- I may terminate my policy at any time, and refunds are limited as outlined in the policy.Initials: _____

SECTION 7 – ACKNOWLEDGEMENT AND DECLARATION

I acknowledge and understand that, from time to time, my health plan may request or disclose health information about me or my dependents (those listed for benefits coverage on this enrollment form) for the purpose of facilitating healthcare treatment or payment, for business operations necessary to administer healthcare 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 healthcare practitioner
- A clinic, hospital, long-term care, or other medical facility
- Any other institution providing care, treatment, consultation, pharmaceuticals, or supplies.
- An insurance carrier or group 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 acknowledgement does not apply to obtaining information regarding psychotherapy notes.
A separate authorization will be used for this information.*

I affirm that the answers given in this application are complete and correct. I am providing these answers as part of the application process required by PacificSource to enroll in insurance coverage. I understand and agree that no coverage will be in force unless, and until, a policy is issued. If approved, coverage will be in force as of the effective date determined by PacificSource.

APPLICANT SIGNATURE* _____ **DATE:** _____

SPOUSE/DOMESTIC PARTNER SIGNATURE: _____ **DATE:** _____

DEPENDENT (AGE 18 & OVER) SIGNATURE: _____ **DATE:** _____

**If this signature is that of a personal representative of the member/enrollee, please complete the following:*

Personal representative's name: _____
 Relationship to individual: Parent Legal Guardian (attach legal document) Holder of Power of Attorney (attach legal document)

SECTION 8 – PRODUCER AUTHORIZATION

I, the insurance producer, have not made any representations to the applicant about any provisions, benefits, conditions, or limitations of the policy except through written material furnished by PacificSource. The applicant has been informed that the effective date of coverage is assigned only by PacificSource. I hereby certify that information supplied to me by the applicant has been truly and accurately recorded hereon.

Producer's Name (printed): _____ PacificSource Producer No: _____

Producer's Signature: _____ Date: _____