



Life and Health Insurance Company

Independent Licensee of the Blue Cross and Blue Shield Association.

InterMSM APPLICATION
 An Interim Medical Insurance Policy
NON-RENEWABLE

100 SW Market St.
 PO Box 1271, MS E-3A
 Portland, OR 97207-1271
 (503) 721-7161 • (800) 794-5390

NOTE: Coverage begins at 12:01 a.m. on the **later** of the day **after** the postmark date stamped on the application envelope or the date you request. If applying by mail, coverage will take effect only upon receipt of full premium. If applying online, automatic monthly payments to a credit card is available.

Please complete all information on this page and on Page 2, missing information may cause your effective date to be delayed

Applicant's Name (Last, First, Middle)		<input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Requested Effective Date	
Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Married / Domestic Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Single		Telephone Number ()	Email Address	
Home Address & Apt. No./Mailing Address			City	State	Zip

We are always searching for ways to better serve your needs. You can help us by answering the following questions.

1. Are you : Hispanic/Latino Non-Hispanic/Latino

2. How would you describe yourself in terms of your racial heritage? African-American American Indian or Alaskan Native Asian or Pacific Islander Caucasian Two or More Races

You may choose to not answer this question

Dependents to be enrolled: Dependent children must be under 23 years of age and primarily dependent on you for support.

Last Name	First Name	M	SS#	Birth Date	Sex	Relationship (Spouse / Domestic Partner, Child, Child of DP)
Same as above			Same as above	Same as above	M / F	Self
					M / F	
					M / F	
					M / F	
					M / F	
					M / F	

List names as they should appear on your identification card. If enrolling additional dependents, please attach a separate sheet including the information above.

If you are enrolling a non-state certified domestic partner or children of a non-state certified domestic partner please also include the Affidavit of Non-State Certified Domestic Partnership.

DEDUCTIBLE AMOUNT/FAMILY DEDUCTIBLE <input type="checkbox"/> \$250/\$750 <input type="checkbox"/> \$500/\$1,500 <input type="checkbox"/> \$1,000/\$3,000 <input type="checkbox"/> \$2,500/\$7,500		POLICY TERM (30 – 185 DAYS) NO. OF DAYS _____	PREMIUM \$ APP. FEE + \$ <u>20.00</u> TOTAL \$
RATE OF PAYMENT AFTER DEDUCTIBLE <input type="checkbox"/> 80% to \$5,000 <input type="checkbox"/> 50% to \$5,000			
1. Are you, or any person to be insured, age 65 or older?		<input type="checkbox"/> YES <input type="checkbox"/> NO If YES, this policy cannot be issued.	
2. Are you, or any person to be insured, eligible for Medicare?		<input type="checkbox"/> YES <input type="checkbox"/> NO If YES, this policy cannot be issued.	
3. Do you, or any person to be insured, now have any hospital, major medical, group health or medical insurance coverage that will not terminate prior to the beginning of this policy?		<input type="checkbox"/> YES <input type="checkbox"/> NO If YES, this policy cannot be issued.	
4. Are you, or any family member, now pregnant?		<input type="checkbox"/> YES <input type="checkbox"/> NO If YES, this policy cannot be issued.	



Regence

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I understand that:

- 1) if my application for coverage is accepted, the Effective Date will be 12:01 a.m. on the later of the day after the postmark date or the requested effective date;
- 2) if my application for coverage is not accepted, any premium I paid will be promptly refunded;
- 3) this is not a continuation of any previous medical plan, including any prior Short Term Medical Plan;
- 4) this policy is not renewable; and
- 5) this insurance will not cover Pre-Existing Conditions. Pre-Existing Conditions are defined as any sickness or injury for which any medical advice, treatment, service, supply or drug prescription has been received, or for which symptoms have been shown, during the 5 years immediately preceding the Effective Date of this coverage.

I acknowledge and understand Regence Life and Health Insurance Company may request or disclose health information about me or my dependents (persons who are listed for benefit coverage on the enrollment 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:

- 1) a physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- 2) a clinic, hospital, long-term care or other medical facility;
- 3) any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or
- 4) 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).

DISCLOSURE: If you have a broker or agent, they may receive bonuses, commissions, administrative service fees or other compensation, including non-cash compensation, from RLH. Incentives may be based on any of several factors, including the size of group business, the products you buy, your broker or agent's volume of business with RLH and the other services your agent or broker provides to you. These incentives may have a direct or indirect impact on your rates. For more information, please contact your broker or agent.

PLEASE NOTE: InterM is an individual insurance plan and cannot be purchased by employers for their employees.

INSURANCE FRAUD WARNING: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

I represent that each of the above statements and answers are complete and true to the best of my knowledge and belief. I understand that if I have made intentionally false or misleading statements or answers on behalf of myself or any family members that all entitlements to benefits are void and the contract may be canceled or modified retroactively to its effective date.

Insured's Signature	Parent's or Guardian's Signature
Date Signed	<div style="display: flex; justify-content: space-between;"> 2177 Henrik Jahn </div> Agent Number Licensed Agent's Name (Please Print)

*****PLEASE COMPLETE THE AUTHORIZATION ON THE FOLLOWING PAGE *****



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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize any physician, health care provider, hospital, insurance or reinsurance company, or other insurance information exchange to disclose to Regence Life and Health Insurance Company (RLH) or its representatives health information (including alcohol, chemical dependency, mental health treatment, genetic testing or HIV treatment) pertaining to me and/or my eligible dependents. I acknowledge and understand that this information will only be used for the purpose of determining enrollment in the health plan and eligibility for benefits or payment of claims. 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 to not sign this authorization, RLH may be unable to enroll my family or me in the health plan or to pay claims that were incurred while we had insurance coverage with RLH.

I may cancel this authorization at any time by sending a written request to RLH. Cancellation of this authorization will not affect any action RLH took before it received this request. If I do not revoke this authorization, it will automatically expire when I am no longer covered under this policy and all claims arising from the policy have been settled, or in 24 months from the date below, whichever comes first. A photocopy of this authorization is as valid as the original.

Federal law requires RLH to tell me that if the party to whom RLH 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 specific written authorization.

APPLICANT SIGNATURE*: _____ **DATE:** _____

APPLICANT'S NAME: _____ **(Please print)**

*If signature by a personal representative of the Insured, please complete the following:

Personal Representative's Name: _____

Relationship to Insured: Parent Legal Guardian* Holder of Power of Attorney*

*Please attach legal documentation if you are the Legal Guardian or Holder of Power of Attorney.

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

SPOUSE / DOMESTIC PARTNER NAME: _____ **(Please print)**

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 conversation during a counseling session.)



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AFFIDAVIT OF NON-STATE CERTIFIED DOMESTIC PARTNERSHIP

An Affidavit of Non-State Certified Domestic Partnership is required before any domestic partner benefits may be granted for non-state certified domestic partners. One affidavit may be used for any of the insurance benefits available to domestic partners.

Name of Policyholder: _____

Domestic Partner's Name: _____ Date Domestic Partnership Began _____

I certify that (name of Domestic Partner) _____ and I are domestic partners and that we meet the following criteria:

- We are each 18 years of age or older;
- We share a close personal relationship and are responsible for each other's common welfare;
- We are each other's sole domestic partner;
- We share the same regular and permanent residence, with the current intent to continue doing so indefinitely;
- We are jointly financially responsible for "basic living expenses" including food, shelter, and medical expenses;
- We are not legally married to anyone, nor have had another domestic partner within the previous 30 days;
- We are not related by blood closer than would bar marriage in our state of residence; and
- We were both mentally competent to contract when our domestic partnership began.

CHANGE IN DOMESTIC PARTNERSHIP:

I (name of Policyholder) _____ agree to inform Regence Life and Health Insurance Company within 30 days of any change in our domestic partnership status that would make the domestic partner no longer eligible for benefits by filing a *Termination of Non-State Certified Domestic Partnership Statement*.

Upon termination or dissolution of this domestic partnership, the policyholder named herein agrees that he/she cannot file another affidavit for a minimum of 90 days from the date of termination.

ACKNOWLEDGEMENT:

We understand that this information will be held confidential and will be subject to disclosure only upon express written authorization, in any action involving the enrollment or eligibility of the domestic partner, or if otherwise required by law. We understand that this declaration of responsibility for our common welfare may have legal implications under State law. We further understand that a civil action may be brought against us for any losses, including reasonable attorney's fees, arising from false or misleading statements contained in the Affidavit of Non-State Certified Domestic Partnership. We also certify under penalty of perjury, under our State laws, that the foregoing is true and correct.

POLICYHOLDER'S SIGNATURE DATE

DOMESTIC PARTNER'S SIGNATURE DATE

Policyholder and Domestic Partner's Home Address:

ADDRESS

CITY STATE ZIP

Return your signed Affidavit of Non-State Certified Domestic Partnership to Regence Life and Health Insurance Company. Your completed affidavit should accompany any necessary applications.