

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

***Please type or print neatly in ink.***

**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.

**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 bank draft or direct bill.

**Monthly Bank Draft:**

Please complete Authorization section carefully and attach a voided check.

**Direct Bill:**

Simply check the monthly or quarterly box, you are done.

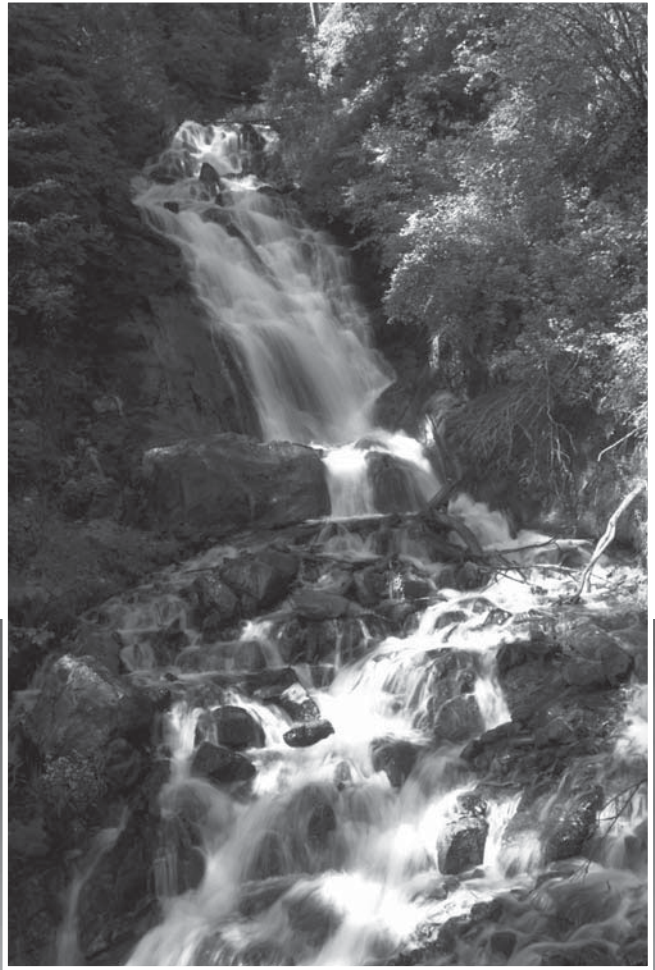
**Final check list before mailing:**

- All sections completed?
- A Copy of your Oregon Drivers License or Utility Bill as proof of Residence
- 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

**OMIP**  
*We're here for you!*



**APPLICATION**  
**2008**



## APPLICATION INSTRUCTIONS

1. If you are currently enrolled in OHP/Medicaid or Medicare, **STOP**. *You are NOT eligible for OMIP*. Your application will be rejected.
2. Review the *Health Plans flyer* to determine which eligibility criteria you meet and which plan best meets your health care needs.
  - a) If you are unable to obtain individual health insurance due to health reasons, you are medically eligible and may select Medical Plans 500, 750, 1000, or 1500.
  - b) If you have exhausted COBRA benefits (or none were available to you) and are not being offered an Oregon portability plan or are moving out of the portability service area, you are portability eligible and may select Portability Plans 750 or 1500.
  - c) If you are eligible for a federal Health Coverage Tax Credit (HCTC) you **must indicate in Section D, number 3** and must select only one of the following medical plans: 500, 750, 1000, or 1500.
3. Determine the number of persons to be covered by the plan.
4. Identify the age of the oldest family member to be covered by the plan. The age of the oldest family member determines the premium for everyone covered by the plan.
5. Determine your monthly cost for your insurance coverage by reviewing the *Rates flyer*.

If you have any questions about completing this application, please call OMIP Customer Service for assistance **1-800-848-7280**.

# A APPLICANT INFORMATION

COMPLETE ALL SECTIONS IN INK.

Applicant's Name Last		First	MI	Age	Birthdate (M/D/Y)
Residence Address			City	State	Zip
<input type="checkbox"/> Mailing or <input type="checkbox"/> Billing Address (if Different than Residence)					
Social Security Number		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Home Phone	Work Phone	
E-mail address:				County	

What date are you requesting your OMIP insurance coverage to begin? \_\_\_\_\_  
 You must allow up to 30 days for OMIP to process your application. Your effective date is determined by the month OMIP receives your completed application.

# B HEALTH PLAN OPTIONS

Select One Type of Coverage:

Individual                     
  Two-Party                     
  Family

Select One Plan:

Medical Plan 500                     
  Medical Plan 750                     
  Medical Plan 1000\*

Medical Plan 1500\*

Portability Plan 750                     
  Portability Plan 1500\*

\*Note - Plan 1000 and Plan 1500 are NOT available if using a FHIAP subsidy

If you are applying for Two Party or Family Coverage, list all dependents you would like to insure:

Name (Last, first, middle initial)	Gender	Birthdate	Relationship	SSN
Spouse/Domestic Partner*:				
Child:				
Child:				

\*Attach domestic partner affidavit.

— OFFICE USE ONLY —

GP NO.	ID NO.	OED	WP CRED	IL	M S	E S	ELG	EH	BC
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# C HEALTH CONDITIONS

Within the last five (5) years, have you (the applicant) had ANY diagnosis, treatment, or professional medical advice relating to any of the following medical conditions? If yes, please check those conditions which apply. If you have one of these conditions and you are an Oregon resident you automatically qualify for OMIP coverage under the Medical Eligibility Criteria without having to apply to a commercial insurance carrier. However, OMIP reserves the right to verify and confirm the presence of the pre-existing condition(s).

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> AIDS                                  | <input type="checkbox"/> Eating Disorders                   | <input type="checkbox"/> Paraplegia                  |
| <input type="checkbox"/> Alcohol Dependence                    | <input type="checkbox"/> Fibromyalgia                       | <input type="checkbox"/> Parkinson's Disease         |
| <input type="checkbox"/> Alzheimer's                           | <input type="checkbox"/> Friedreich's Disease               | <input type="checkbox"/> Pending Surgery             |
| <input type="checkbox"/> Amyotrophic Lateral Sclerosis         | <input type="checkbox"/> Gastric Bypass Surgery             | <input type="checkbox"/> Peripheral Arteriosclerosis |
| <input type="checkbox"/> Aneurysm                              | <input type="checkbox"/> Hemophilia                         | <input type="checkbox"/> Pituitary Gland Disorders   |
| <input type="checkbox"/> Angina Pectoris                       | <input type="checkbox"/> Hepatitis B, C, D, E               | <input type="checkbox"/> Polyarteritis               |
| <input type="checkbox"/> Aplastic Anemia                       | <input type="checkbox"/> HIV +                              | <input type="checkbox"/> Postero-Lateral Sclerosis   |
| <input type="checkbox"/> Arteriosclerosis Obliteran            | <input type="checkbox"/> Hodgkin's Disease                  | <input type="checkbox"/> Polycystic Kidney           |
| <input type="checkbox"/> Artificial Heart Valve                | <input type="checkbox"/> Huntington's Chorea                | <input type="checkbox"/> Polycystic Ovarian Syndrome |
| <input type="checkbox"/> Ascites                               | <input type="checkbox"/> Hydrocephalus                      | <input type="checkbox"/> Pregnant — Currently        |
| <input type="checkbox"/> Barrett's Esophagitis                 | <input type="checkbox"/> Hypertensive Renal Disease         | <input type="checkbox"/> Psychotic Disorders         |
| <input type="checkbox"/> Brain Tumors                          | <input type="checkbox"/> Intermittent Claudication          | <input type="checkbox"/> Pulmonary Fibrosis          |
| <input type="checkbox"/> Cancer                                | <input type="checkbox"/> Joint Replacement                  | <input type="checkbox"/> Quadriplegia                |
| <input type="checkbox"/> Cardiomyopathy                        | <input type="checkbox"/> Kidney Failure                     | <input type="checkbox"/> Rheumatoid Arthritis        |
| <input type="checkbox"/> Celiac Disease                        | <input type="checkbox"/> Lead Poisoning (Cerebral)          | <input type="checkbox"/> Sickle Cell Anemia          |
| <input type="checkbox"/> Cerebral Palsy                        | <input type="checkbox"/> Leukemia                           | <input type="checkbox"/> Silicosis                   |
| <input type="checkbox"/> Chemical Dependency                   | <input type="checkbox"/> Lupus                              | <input type="checkbox"/> Sleep Apnea                 |
| <input type="checkbox"/> Chronic Obstructive Pulmonary Disease | <input type="checkbox"/> Malignant Tumor                    | <input type="checkbox"/> Splenic Anemia              |
| <input type="checkbox"/> Cirrhosis of the Liver                | <input type="checkbox"/> Melanoma                           | <input type="checkbox"/> Still's Disease             |
| <input type="checkbox"/> Congestive Heart Failure              | <input type="checkbox"/> Metastatic Cancer                  | <input type="checkbox"/> Stroke                      |
| <input type="checkbox"/> Coronary Artery Disease               | <input type="checkbox"/> Multiple or Disseminated Sclerosis | <input type="checkbox"/> Syringomyelia               |
| <input type="checkbox"/> Coronary Insufficiency                | <input type="checkbox"/> Muscular Atrophy                   | <input type="checkbox"/> Topectomy & Lobotomy        |
| <input type="checkbox"/> Coronary Occlusion                    | <input type="checkbox"/> Muscular Dystrophy                 | <input type="checkbox"/> Transient Ischemic Attack   |
| <input type="checkbox"/> Crohn's Disease                       | <input type="checkbox"/> Myasthenia Gravis                  | <input type="checkbox"/> Transplants                 |
| <input type="checkbox"/> Cystic Fibrosis                       | <input type="checkbox"/> Myotonia                           | <input type="checkbox"/> Ulcerative Colitis          |
| <input type="checkbox"/> Dermatomyositis                       | <input type="checkbox"/> Obesity (BMI > 30)                 | <input type="checkbox"/> Von Willebrand's Disease    |
| <input type="checkbox"/> Diabetes                              | <input type="checkbox"/> Open Heart Surgery                 | <input type="checkbox"/> Wilson's Disease            |
|  | <input type="checkbox"/> Pancreatitis                       |  |

# D PROOF OF ELIGIBILITY

You must be an Oregon resident in order to be eligible for any of the OMIP plans. You must attach a copy of one of the following:

1. Current Oregon driver license or Oregon identification card, both front and back; or
2. Current Oregon voter registration card; or
3. Current utility bill with the applicant's name and address as the billed party; or
4. Current FHIAP Letter of Eligibility with the date of eligibility and applicant's name.

Please **check** the boxes below that apply:

## 1. Medical Eligibility

- I have one or more of the conditions listed in **Section C of this application. (Complete Section C).**
- Within the last six months, I was denied an individual health insurance policy due to health reasons. *(Attach a copy of the carrier denial letter).*
- Within the last six months, I was offered an individual health insurance policy that excluded coverage for a specific medical condition. *(Attach copy of letter from carrier denying specific condition).*
- Within the last six months, I was offered an individual health insurance policy but the carrier limited my choice of plans it was willing to offer me due to a specific medical condition. *(Attach copy of carrier letter only offering a limited policy).*
- I have permanently moved to Oregon and I am transferring from another state's high-risk pool.  
 State \_\_\_\_\_ Name of High Risk Pool \_\_\_\_\_ ID #: \_\_\_\_\_  
*(Attach certificate of creditable coverage from prior high-risk pool.)*

## 2. Portability Eligibility\*\*

- I have exhausted my COBRA benefits or state continuation coverage and no portability options are available from my previous health carrier.\*  
*Attach a COBRA Exhaustion letter which indicates that your COBRA coverage is exhausted and that no portability options are available. Please also provide a certificate of coverage with termination dates to verify that this coverage has been terminated.*
- No COBRA or state continuation coverage or portability coverage was available through my previous group plan.\*  
*Attach a letter from your current carrier or former employer stating that these plans are not available.*
- I am eligible for Oregon portability through my previous plan but I moved from my prior insurance carrier's service area.\*  
*Attach a letter from your current carrier that you have moved from the carrier's service area and no further coverage is available.*
- I was offered portability coverage but my insurance carrier no longer services the area where I live.\*  
*Provide a letter from your insurance carrier which explains you are no longer in a service area.*
- I have moved to Oregon and have been continuously covered by group health insurance for 18 months or more, without a single gap in coverage, greater than 63 days and no COBRA or Oregon portability coverage options are available through my previous health carrier.\*  
*Attach a Certificate of Coverage statement from your previous carrier with start and end dates of coverage to verify that you had 18 months of continuous coverage and that it has been terminated.*

**\*In all cases above you must submit a Certificate of Coverage to verify that you had at least 180 days of continuous group coverage from your Oregon employer(s) or at least 18 months of group coverage in another state and you are applying for OMIP within 63 days of exhausting COBRA. You can obtain Certificates of Coverage (termination letters) from your prior health insurance company. If cancellation of your health insurance depends on obtaining OMIP coverage, submit the OMIP application NOW and submit a copy of the certificate of coverage after coverage ends, or provide other documentation showing creditable coverage. Please call 1-800-848-7280 for more details.**

**\*\*Note: Your coverage will start from the termination of your prior coverage and premium is due from the effective date of the OMIP coverage.**

**3. Federal Health Coverage Tax Credit Eligibility**

- The US Department of Labor has certified me as being affected by competition from foreign trade, and I am eligible to receive a federal Health Coverage Tax Credit (HCTC) under Section 35 of the Internal Revenue Code.

I am eligible for the HCTC because:

- The company I worked for went bankrupt & I receive pension benefits from the Pension Benefit Guarantee Corporation.
- I lost my job and I receive federal Trade Adjustment Assistance Benefits.

If you qualify for OMIP under this eligibility category, OMIP is assuming you are eligible for a HCTC, which pays 65% of the cost of your monthly OMIP premium. However, the federal government will make the final determination about eligibility for the HCTC.

OMIP will provide benefits for pre-existing conditions in the first six months of coverage if you apply for OMIP coverage within 63 days of losing your most recent prior health insurance coverage and you must have had the prior coverage in place for a period of not less than 90 days. *Provide a copy of your HCTC Eligibility Notice and a Certificate of Creditable Coverage from your prior health insurance carrier.*

## **E CREDIT TOWARD PRE-EXISTING LIMITATION PERIOD**

You may be eligible to receive credit toward the pre-existing limitation period if you've had prior health coverage before applying to OMIP and are applying for OMIP coverage no later than 63 days after your prior coverage terminated. If your prior coverage was in force six months or more, you may receive credit toward the pre-existing limitation period. Persons eligible under the federal Health Coverage Tax Credit only require three months of prior insurance to receive this credit. OMIP will base your credit on the number of months you were previously insured.

*\*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 limitation period.*

- I meet the above criteria and am requesting credit toward the six-month pre-existing limitation period. *(Attach a copy of the Certificate of Coverage that indicates the start and end dates of your prior coverage and the summary of benefits.)*

## **F 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.

1. Are you (check one)  an employee  self-employed  not employed  retired

If you are an employee, or self-employed, what is your occupation? \_\_\_\_\_

What is the name and location of your employer? \_\_\_\_\_

Does your employer offer health insurance to its employees?  Yes  No

If yes, are you currently, or have you ever been, covered under your employer's plan?  Yes  No

If yes, on what date did that coverage end and why? End date: \_\_\_\_\_ Reason: \_\_\_\_\_

If your employer offers health insurance to its employees and you are not covered under your employer plan, why didn't you take its insurance?  Missed enrollment  Too expensive  Not available for dependents

Other \_\_\_\_\_

2. Have you ever been enrolled in OMIP?  Yes  No  
 If yes, what date did your coverage begin? \_\_\_\_\_ What date did your coverage end? \_\_\_\_\_

3. Have you ever received \$2 million in OMIP benefits?  Yes  No

4. 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? \_\_\_\_\_

5. Are you (check one)  Married  Single  Divorced  Widowed  Child

6. If you are married, is your spouse employed?  Yes  No

If yes, does your spouse's employer offer health insurance to its employees?  Yes  No

If yes, are you currently enrolled in your spouse's employer's plan?  Yes  No

If no, why not?  Missed enrollment  Too expensive  Not available for dependents  Other \_\_\_\_\_

7. If you are under age 18, is your parent or guardian employed?  Yes  No

If yes, does their employer offer health insurance for its employees?  Yes  No

If yes, are you currently enrolled in your parent or guardian's employer's plan?  Yes  No

If no, why not?  Missed enrollment  Too expensive  Not available for dependents

8. What is your total annual gross household income?

\$0-\$11,076  \$25,001-\$35,000  \$45,001-\$55,000  \$65,001-\$75,000

\$11,077-\$15,000  \$35,001-\$45,000  \$55,001-\$65,000  \$75,001 or more

\$15,001-\$25,000

9. What is your racial/ethnic heritage? (*We are asking for this information for statistical purposes only.*)

Caucasian  African-American  Hispanic/Latino

Native American/Alaskan  Asian or Pacific Islander  Other \_\_\_\_\_

# **G 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 receipt of a completed 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. An existing pregnancy is considered a pre-existing condition.

\_\_\_\_\_/\_\_\_\_\_ **Initial here showing you have read & understand the above paragraph.**

(If there is more than one party on this application, all parties must initial or parent/legal guardian  
\_\_\_\_\_/\_\_\_\_\_ if applicant is under 18 years of age or legally incompetent.)

2. If this application contains material misstatements or omissions, OMIP may do any or all of the following within two years from the date the policy was issued: a) cancel the agreement as though it was never effective and refund premiums, less any claims paid; b) deny benefits under the pre-existing condition exclusion period; or c) take any other action available to it by law. This time limit does not apply to fraudulent misstatements. This application is part of any policy issued by OMIP, in compliance with Oregon insurance regulations.

\_\_\_\_\_/\_\_\_\_\_ **Initial here showing you have read & understand the above paragraph.**

(If there is more than one party on this application, all parties must initial or parent/legal guardian  
\_\_\_\_\_/\_\_\_\_\_ if applicant is under 18 years of age or legally incompetent.)

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.

## **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.

<b>Signature of applicant (or parent/legal guardian if applicant is under 18 years of age or legally incompetent):</b>	<b>Date</b>
<b>Signature of spouse/domestic partner if covered in this application:</b>	<b>Date</b>
If signed by a personal representative of the applicant, please complete the following:	
Personal Representative Name (please print) _____	
Relationship to Individual _____ (attach legal documentation if other than parent)	

## **DOCUMENT CHECKLIST**

**Did you remember to:**

Yes No

- Answer all questions completely?
- Attach Proof of Residency? *(Section D on application)*
- Read the affirmations, understandings and disclosure authorization and then sign and date the application? *(Section G 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 medical eligibility, attach either carrier declination letter or select on of the health conditions applying to you on the health conditions list on page 4 of the application.
- If applying through portability eligibility, attach a certificate of coverage from prior insurance carrier reflecting your beginning and ending dates of coverage and stating your previous coverage has been terminated?

# H 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 — reservation number: \_\_\_\_\_
- CareAssist — program number: \_\_\_\_\_

**AUTHORIZATION AGREEMENT FOR MONTHLY AUTOMATIC BANK PAYMENT**

Name of Applicant or Policy Holder	Social Security Number
------------------------------------	------------------------

I, (or we if a joint account) authorize the Oregon Medical Insurance Pool to charge my (our) checking account for monthly insurance premiums. I (we) authorize the financial institution named below to honor and pay these monthly charges. 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/draft. I (we) understand that in order to cancel these automatic deductions, I (we) must provide written notice to the Oregon Medical Insurance Pool no less than 15 days before the next scheduled automatic deduction.

**YOU MUST ATTACH A VOIDED CHECK WITH THIS AUTHORIZATION AGREEMENT**

**Note:** If this form is not completed and signed, premiums will be billed on a monthly direct bill basis. You must pay the billed premium until your bank processes this authorization or your coverage will be affected.

<b>Account Holder Signature</b>		Date
Check/Draft Account No.	Routing No.	
Financial Institution		

Attach  
Voided  
Check Here

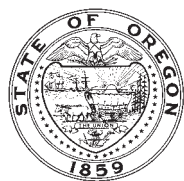
**MAIL YOUR COMPLETED APPLICATION TO:**

Oregon Medical Insurance Pool  
 PO Box 1271  
 Mail Station 5K  
 Portland, OR 97207-1271

## AGENT INFORMATION

I certify by my signature that follows, that I have explained eligibility provisions to the applicant and have reviewed the application to assure that the application is complete and accurate. I have made no statements of benefits, conditions, limitations or exclusions of the agreement except through written material furnished by OMIP. I have informed the applicant that the Oregon Medical Insurance Pool will determine the effective date of coverage upon receipt of the completed application, which includes the required attachments, and verification of eligibility. **Agent signature certifies that the agent has reviewed the application AFTER it was completed and the application is complete and accurate. If the application is not complete and accurate, OMIP may choose to not pay the agent fee.**

Print Agent Name Steve Halberg		Tax I.D. No. 680554368	
Agency Name CDA Insurance LLC		Oregon Lic. No. 609160	
Street Address PO Box 26540		City Eugene	State OR
		Zip 97402	
E-mail steve.halberg@comcast.net	Phone 541.284.2993	Fax 541.284.2994	
Agent signature		Date	



## Oregon Medical Insurance Pool