

# Short Term Medical Application



**PacificSource**  
HEALTH PLANS

Please type or print neatly in ink

PO Box 7068  
Eugene, Oregon 97401  
(866) 695-8684 • (541) 684-5585  
Fax (541) 684-5401  
www.pacificsource.com  
individual@pacificsource.com

## SECTION 1 — PLAN CHOICE

Policy length:  Daily (30 to 185 days): \_\_\_\_\_  Monthly (1 to 6 months): \_\_\_\_\_

Plan type:  \$500 deductible  \$1,000 deductible  \$2,000 deductible  \$2,500 deductible

Requested effective date: \_\_\_\_\_ (month/day/year)

I request that optional alcoholism treatment be attached to my policy for an additional charge (Oregon only):  No  Yes  
(Call (866) 695-8684 for more information.)

## SECTION 2 — MEDICAL INFORMATION

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

- Does any person named on this application have hospital, medical, Medicare, or Medicaid coverage that will remain in force beyond the requested effective date listed on this application?  No  Yes
- Are you, your spouse, or any dependent now pregnant or responsible for a current pregnancy?  No  Yes
- Is any person listed on this application currently admitted to any hospital or healthcare facility for any reason?  No  Yes
- Within the last 5 years, has anyone listed on this application had any diagnosis, treatment, or advice relating to any of the following: heart, chest pain or angina, stroke, paralysis, diabetes, sugar in urine, cancer, alcohol, chemical or drug abuse or habit, liver, hepatitis or kidney disorder, or AIDS or ARC?  No  Yes

## 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		<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 spouse, attach copy of marriage certificate. 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 (+ \$20 application fee) enclosed: \$ \_\_\_\_\_

### Monthly plan type.

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

Total premium (+ \$20 application fee) enclosed: \$ \_\_\_\_\_

Automatic bank withdrawal. Please submit first month's premium (+\$20 application fee) by check, and include a separate voided check or savings deposit slip. Subsequent withdrawals will occur on the 1st of the month and draw one 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.

\_\_\_\_\_  
Policyholder's Name (please print)

\_\_\_\_\_  
Signature of Bank Account Holder

\_\_\_\_\_  
Date

### IMPORTANT INFORMATION

- 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.
- This policy does not exceed six months, including renewals.
- If this application for coverage is not accepted, any premium paid will be promptly refunded.
- This is not a continuation of any previous medical plan, including any prior short-term medical plan.
- 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 prescription drug has been received, or for which symptoms have been shown, during the five years immediately preceding the effective date of this coverage.
- Under no circumstances will the applicant or dependents make changes once the policy goes into force, except as outlined in the policy.

### 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\*

\_\_\_\_\_  
*\*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)

### 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 Number: \_\_\_\_\_

Producer's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Daily Premium:** \_\_\_\_\_ X \_\_\_\_\_ = \_\_\_\_\_  
(rate) (days) (premium)

**Premium + \$20 application fee = Total Due**

**Monthly Premium:** \_\_\_\_\_ X \_\_\_\_\_ = \_\_\_\_\_  
(rate) (months) (premium)

**Premium + \$20 application fee = Total Due**