

New Enrollee Coverage Change

PART I (Complete using dark ink)

EMPLOYEE NAME (Please Print) LAST		FIRST		MI	PHONE NUMBER ()
RESIDENCE ADDRESS		STREET		CITY	STATE ZIP CODE
SOCIAL SECURITY NUMBER	BIRTHDATE Mo Da Yr		SEX M F	PLACE OF BIRTH	ANNUAL SALARY \$
NAME OF EMPLOYER PROVIDING INSURANCE Corvallis School District – WBT 000085			OCCUPATION		DATE OF EMPLOYMENT
<p>Administrative, Confidential, Certified and Classified Employees working between 20 and 39 hours per week.</p> <p>CONTRIBUTORY LIFE/AD&D, DEPENDENT LIFE AND LONG TERM DISABILITY INSURANCE</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <ul style="list-style-type: none"> Do not complete Part II of this form (medical questions) if you are applying WITHIN your initial 31 day eligibility period. Complete Part II of this form if you are applying at any time AFTER your initial 31 day eligibility period including during any annual enrollment period. 					

I request to be insured and authorize payroll deductions to cover the cost of coverage. Information in this application is given to obtain insurance, and the statements and answers are represented, to the best of my (our) knowledge and belief, to be true and complete. I (we) understand that (a) the insurance applied for shall not take effect until the application is approved and I will be notified of the insurance effective date; and (b) all insurance is subject to the eligibility provisions of the policy; and (c) I must be actively at work (as defined in the group policy) to be insured. If I am not actively at work on the date my (our) coverage would become effective, my (our) coverage will not begin until the day I return to work.

Authorization to Release Information: I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, MIB or other organization, institution or person that has any records or knowledge of me or my health to give the Regence Life and Health Insurance Company or its reinsurers any such information (including information about drug or alcohol use or abuse, mental illness, HIV (AIDS virus) or other sexually transmitted diseases). This authorization is valid for 24 months from the date it is signed. I agree that a photocopy of this authorization shall be as valid as the original. I acknowledge that I have received a copy of the Notice of Information Practices.

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.

If your answers on this application are incorrect or untrue, Regence Life and Health Insurance Company has the right to deny benefits or rescind your coverage for up to two years from the date coverage becomes effective.

_____ _____
 Employee Signature Date

PART II

Complete all spaces/answer Yes or No to all questions. Circle all conditions which apply and provide details below.

Employee Height _____ Weight _____			
	EMPLOYEE		
1. Have you used cigarettes or other tobacco products in the last 2 years?	<input type="checkbox"/> Y	<input type="checkbox"/> N	
2. Are you pregnant? If "YES", give expected delivery date and describe any complications.	<input type="checkbox"/> Y	<input type="checkbox"/> N	
3. Within the past 5 years, have you been medically counseled or treated for, or been told by a medical practitioner that you had: high blood pressure; any disease or defect of the heart or blood vessels; diabetes; albumin, blood or sugar in the urine; any kidney disorder; tumor; cancer; asthma; lung or respiratory disorder; any disorder of the stomach, liver or intestines; back, spine or bone disease or disorder; epilepsy; any mental or nervous system disorder; any immunodeficiency?	<input type="checkbox"/> Y	<input type="checkbox"/> N	
4. Within the past 5 years have you been treated for or diagnosed as having or advised to take a diagnostic test for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/> Y	<input type="checkbox"/> N	
5. Within the past 5 years have you consulted or been attended by a doctor, psychiatrist, psychologist or medical practitioner for any health reason or condition not disclosed in the preceding questions?	<input type="checkbox"/> Y	<input type="checkbox"/> N	
6. Are you presently receiving any treatment by a medical practitioner or taking any medication?	<input type="checkbox"/> Y	<input type="checkbox"/> N	
7. Have you ever had or been told by a medical practitioner that you had (or still have) a problem with substance abuse?	<input type="checkbox"/> Y	<input type="checkbox"/> N	
8. Have you ever been rated, declined, postponed or limited in any way for life, health, accident, or sickness insurance?	<input type="checkbox"/> Y	<input type="checkbox"/> N	

9. Name and address of **your** personal physician:

Date last seen and reason:

IMPORTANT:

Provide details of all 'YES' answers given to questions stated above.
If additional space is required, attach a separate signed and dated sheet.

Question Number	Illness/Reason for Checkup or Physician's Treatment/Consultation	Dates From To	Full Name & Complete Address of Attending Physician or Other Practitioner

INFORMATION PRACTICES NOTICE

(Retain with your insurance records)

Thank you for enrolling for Group Insurance with Regence Life and Health Insurance Company. As a part of the normal procedure of processing the group policy, information concerning proposed insureds may be obtained relative to each person's insurability.

Information regarding your insurability will be treated as confidential. Regence Life and Health Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as the Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 1-866-692-6901 (TTY 1-866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Regence Life and Health Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.