

OREGON STANDARD HEALTH STATEMENT
(Standard Form Per ORS 743.766)

AGENT INFORMATION

Agency Name and Time Number _____

Agent Name and Time Number _____ Phone # _____

Agent Fax Number _____ General Agent is located in the state of _____

TYPE OF ACTIVITY check appropriate box

- New Applicant
- Upgrading Coverage Existing Policy # _____
- Change to an existing policy. Policy # _____
 - Adding Dependent
 - Reinstatement of Coverage
 - Other _____

APPLICANT INFORMATION

Name: _____

1. Resident Address

Street _____ City _____ State _____ Zip _____

2. Home Phone Number _____ Area Code _____ Number _____ Best time to call _____

POLICY & DISCOUNT PROGRAM INFORMATION
If signed proposal is provided, this section does not need to be completed.

Premium Amount

Plan Name: _____

Plan Type:

MaxPlan OneDeductible Traditional RightStart Traditional SaveRight HSA Traditional

CoreMed OneDeductible PPO RightStart PPO SaveRight HSA PPO

If PPO, Network Selected _____ Other _____

Plan Deductible: _____ Rate of Payment: _____

Lifetime Maximum: _____ Prescription Drug Card Deductible: _____

HSA Type: HSA Fundamentals HSA Tools Other None

Optional Coverage:

Doctor's Office Copayment Dental Benefit - Basic Dental Benefit - Plus

First Dollar Preventive Services Benefit Cancer Outpatient Maximum Benefit

Accident Medical Expense: First Dollar Amount \$ _____

Other _____

Primary Insured \$ _____

Spouse/Domestic Partner \$ _____

Children \$ _____

Rx Drug Card \$ _____

D.O.C. \$ _____

First Dollar Preventive Services \$ _____

Dental Benefit \$ _____

Cancer Outpatient Maximum Benefit \$ _____

AME \$ _____

Lifetime Maximum Buy-Up Option \$ _____

RightStart Prescription Drug Buy-Up Option \$ _____

Other \$ _____

TOTAL PREMIUM \$ _____

PROCESSING FEE \$ _____

DENTAL-VISION DISCOUNT PLAN \$ _____

Indicate any plan or coverage changes from original proposal/quote, sign and initial. Not all optional coverages are available with all plan types. For additional information contact your agent.

Discount Programs: Dental-Vision Discount Plan Other _____

The Dental-Vision Discount Plan is a discount program and not an insurance product.

BILLING

3. Monthly Check-O-Matic Quarterly Semi-Annual Annual List Bill (monthly only)

Credit Card: First Payment Only* Quarterly Semi-Annual Annual

*With this option, you must select a secondary billing mode for subsequent payments. Please make selection above and provide all necessary information.

If billing address is different than resident address, please complete:

Payor Name _____ Address _____ City _____ State _____ ZIP _____

OTHER COVERAGE IN FORCE OR APPLIED FOR

4. Are any of the proposed insureds covered by, or has application been made for any type of medical insurance?
 Yes (Complete section below) No

Proposed Insured's Name	Company Name	Company Phone Number	Group/ Individual	Type of Coverage	Effective Date	Term Date

5. Were all proposed insureds covered under the prior plan listed above? Yes No

(If no, list those not covered) _____

6. Will this proposed coverage replace or change any existing health insurance? Yes No

7. Do you or any family member work for an employer who offers health benefits to employees? Yes No

Are you or any family members enrolled? Yes No

If no, why? _____

PART B: OREGON STANDARD HEALTH STATEMENT

NOTICE TO APPLICANT: You are not required to disclose any information on any part of this application about genetic testing or genetic information relating to you or to any blood relative. You are not required to disclose any decision by an insurance company that is based on a genetic test or on genetic information.

Has any insurance company declined, postponed, rated up, refused, or restricted life or health insurance coverage for you or any of your family members to be covered within the last five years? Yes No

If yes, name of person affected and name of insurance company: _____

List all family members to be covered.

	Last name of family member	First name, initial	Height	Weight	Sex	Age	Date of Birth	Social Security Number
Subscriber								
Spouse/ Domestic Partner								
Child								
Child								
Child								

Explain relationship to the subscriber for any person listed above whose last name is different from the subscriber:

Please mark "Yes" or "No" for each item (for you and any family members requesting coverage). Provide details on Page 5 to any questions answered "Yes." (For the purpose of these questions, chronic means persistent, continuous, or periodic, or a combination of any of these terms.)

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 health care professional or had any illness, ailment, injury, health problem, symptoms, physical impairment, surgery or hospital confinement related to any of the following conditions:

- 1. AIDS, ARC, HIV positive Yes No
- 2. Alcohol/chemical/drug abuse/habit Yes No
- 3. Anemia/chronic fatigue Yes No
- 4. Appendicitis/chronic abdominal pain Yes No
- 5. Back/neck/spine Yes No
- 6. Birth defect/congenital deformities Yes No
- 7. Bladder/urinary tract Yes No
- 8. Blood/circulatory Yes No
- 9. Bone/orthopedic Yes No
- 10. Brain disease or injury/concussion Yes No
- 11. Breast (lumps or masses) Yes No
- 12. Cancer Yes No
- 13. Chemotherapy/radiation treatment Yes No
- 14. a. Colon/rectum/intestine/bowel Yes No
- b. Blood in stool Yes No
- 15. Convulsion/seizures/epilepsy Yes No
- 16. Diabetes/sugar in urine Yes No
- 17. Chronic ear/nose/throat/tonsil Yes No
 condition/disease/disorder
- 18. Eating disorders such as, Yes No
 but not limited to, anorexia or bulimia
- 19. Emphysema/asthma Yes No
 chronic lung disease (COPD)
- 20. Endocrine/gland/hormone system Yes No
- 21. Disease or injury of eye/ Yes No
 cataract/glaucoma
- 22. Gallbladder/pancreatic disease Yes No
- 23. Chronic headaches/migraines Yes No
- 24. Heart/chest pain/angina Yes No
- 25. Hernia Yes No
- 26. High cholesterol Yes No
 (if "Yes," record last reading on page 5)
- 27. High blood pressure Yes No
 (if "Yes," record last reading on page 5)
- 28. Kidney/kidney stones Yes No
- 29. Knee/shoulder/hip/other joints Yes No
- 30. Liver condition/hepatitis Yes No
- 31. Lupus, chronic muscle pain, Yes No
 muscle injury or disease,
 or fibromyalgia
- 32. a. Mental/emotional Yes No
 condition/depression
- b. Therapy/counseling within Yes No
 last 5 years (if "Yes," record date
 of last session on page 5)
- 33. Neurological condition/disease/injury Yes No
- 34. Phlebitis/blood clot Yes No
- 35. Osteoarthritis/osteoporosis/osteopenia Yes No
- 36. Prostate/elevated PSA/prostatitis Yes No
- 37. Reproductive system disorder/infertility Yes No
- 38. Chronic respiratory/lung condition Yes No
- 39. Rheumatoid arthritis Yes No
- 40. Sexually transmitted disease(s) Yes No
- 41. Skin condition, abnormal or cancerous Yes No
 moles or eczema/cysts/cancer
- 42. Sleep apnea/chronic sleep disorder Yes No
- 43. Stomach disorders/ulcer/acid reflux Yes No
- 44. Stroke/paralysis/seizures Yes No
- 45. Tumors Yes No
- 46. TMJ/jaw joint Yes No
- 47. Weight fluctuation (+/-20 lbs.) Yes No
- 48. Cosmetic surgery/implants, Yes No
 use of prosthetic devices/limbs

49. Has any person on this application used tobacco products in any form within the last 5 years? Yes No

If yes,:

Name: _____ type of product _____

Name: _____ type of product _____

Name: _____ type of product _____

50. Please provide the following information for each female on this application:

Family member	Name:	Name:	Name:	Name:
a) Initial menstrual cycle begun?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Date of last menstrual period?				
c. If (b) is more than 35 days ago, please explain:				
d) Excessive or absent menstrual bleeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) If (d) is yes, please explain				
Date of last DEPO Provera shot?				
Abnormal Pap smears?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prior Cesarean section or miscarriage?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

51. Is any person on this application now pregnant? Yes No
 If yes, name _____ due date ____/____/____.
52. Is any person on this application, including male applicants and dependent males or females, Yes No
 responsible for a current pregnancy?
 If yes, name _____ due date ____/____/____.
53. Please provide the following information for each person on this application.
 Within the last five years, has any person on this application:
- a. Had any medical advice, diagnosis, care, or treatment, including prescribed medications, recommended or received from a licensed health care professional, or had any illness, ailment, injury, health problem, symptoms, physical impairment, surgery or hospital confinement not listed above? Yes No
 - b. Had chronic cough, fatigue, diarrhea, or enlarged glands? Yes No
 - c. Been advised to have or contemplated having an operation or medical procedure not yet performed? Yes No
 - d. Been scheduled to see a health care provider? Yes No
 - e. Taken any prescription medication on a regular basis? Yes No
54. List all medications currently being taken by any person on this application:

Name	Medications	Prescribed by (name/address/phone)	Date prescribed

Attach additional pages if necessary. I have attached _____ page(s).

EMPLOYER SPONSORED BUSINESS (ESB) STATEMENT

You understand and agree that you are applying for individual health insurance for you (and your family). You further understand that this application for health insurance will be fully medically underwritten and that coverage is not guaranteed. You are personally paying the entire premium for this health insurance coverage. Your employer is not contributing in any way to the payment of premium, either directly or indirectly.

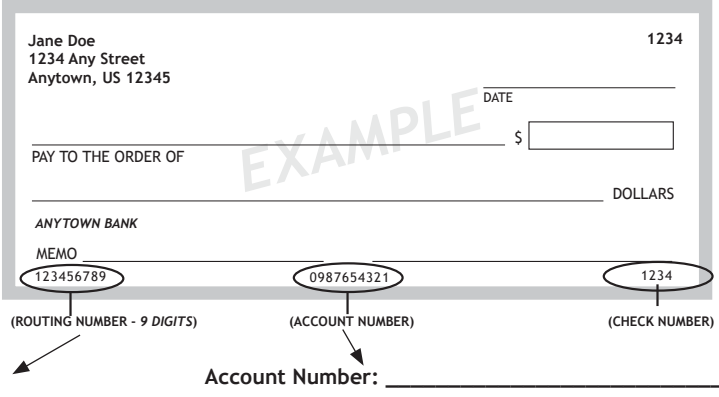
Do you agree with this statement? Yes No

Time Insurance Company Authorization for Check-O-Matic and Credit Card Billing

AUTHORIZATION FOR CHECK-O-MATIC BILLING ONLY - Choose the following option that applies:

To begin Check-O-Matic withdrawals:
 Select a desired withdrawal day (1-28): _____
 Bank Name: _____
 City: _____ State: _____

To add this policy to an existing Check-O-Matic:
 Existing COM Number: _____
 Associated Policy Number: _____



Routing Number: _____

Account Number: _____

Check-O-Matic (Complete authorization below)

I (we) hereby authorize Time Insurance Company, hereinafter called COMPANY, to initiate debit entries to the account and depository, hereinafter called DEPOSITORY, indicated on the other side, to debit the same to such account. This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

 Signature of Payor

 Date Signed

AUTHORIZATION FOR CREDIT CARD PAYMENTS

When selecting MasterCard/VISA Card: I authorize Assurant Health to charge my account for the Individual Medical policy listed above. I understand there will be no refund of premium after the 10-day free look period in the contract.

Visa Card Number: _____

MasterCard Number: _____

Exp. Date: ____ / ____

Name as it appears on card: _____

Signature of Payor: _____ Date: .

AUTHORIZATION

I agree that:

Except as otherwise provided in the Conditional Receipt, the insurance, if approved by Time Insurance Company, will be in force only when issued by Time Insurance Company. The first full premium must be paid. Coverage will become effective on the later of: A) The date we receive the enrollment form; B) the requested Effective Date. A change in the health of the proposed insured(s) after the completion of the enrollment form and before the delivery of the contract may affect my eligibility for insurance with the company. The contract may only be effective prior to the contract delivery subject to the terms of the Conditional Receipt.

I agree that a photographic copy of this authorization shall be valid for two years from the date signed.

I acknowledge receiving the notification regarding the Medical Information Bureau, the Abbreviated Notice of Insurance Information Practices and the Outline of Coverage for Health Insurance, if required.

We, the undersigned Proposed Insured(s) and agent, acknowledge that the Proposed Insured(s) has read the completed enrollment form. We understand and acknowledge that any fraudulent statement or material misrepresentation or omission on the enrollment form and/or any amendments may result in claim denial or contract rescission, subject to the time limit on certain defenses or incontestability provisions of the contract.

I hereby authorize any health care provider or medically related facility, pharmacy or pharmacy related facility, the Medical Information Bureau, Inc., consumer reporting agency, insurance or reinsurance company or employer having information about me or my minor children to provide all such information as may be requested to Time Insurance Company, its legal representative or any medical records retrieval service Time Insurance Company may engage, including, but not limited to, EMSI and its agents.

This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, prescription history, lab data and EKGs. This information may also be disclosed to the Medical Information Bureau, Inc. and any medical records company engaged by Time Insurance Company, including but not limited to EMSI and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Time Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. A copy of this authorization will be valid as an original.

I understand that this authorization is required in order to enable Time Insurance Company to make eligibility or enrollment determinations relating to me and/or my minor children or for Time Insurance Company's underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, Time Insurance Company may refuse to consider my application for enrollment.

I understand that I may revoke this authorization at any time by notifying Time Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Time Insurance Company, P.O. Box 3050, 501 West Michigan, Milwaukee, WI 53201-3050. Such revocation will not be valid if Time Insurance Company has taken action in reliance on the authorization.

Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: 30 days after denial of my application, or declination of enrollment, or, if insured, 30 days after when I am no longer an insured of Time Insurance Company. But in no event will this authorization be in effect for longer than 24 months from the date signed.

You have the right to revoke your authorization at any time by notifying Time Insurance Company.

CERTIFICATION OF COMPLETION AND CORRECTNESS

I Affirm that the answers given in this "Oregon Standard Health Statement" are complete and correct. I am providing these answers as part of the application procedure required by this insurance carrier to enroll in their insurance coverage. I understand that if this application contains any material misstatements or omissions, the insurance carrier may, within the first two years of coverage, deny coverage, modify or cancel the contract, and/or take any other legal action available to it by law. I will promptly inform the insurance carrier in writing if anything happens before my coverage takes effect that makes this incomplete or incorrect. I understand and agree that no coverage shall be in force until approved by the insurance carrier. If approved, coverage will be in force as of the effective date determined by the carrier. The carrier may phone me to clarify answers on this application. As the applicant, I understand I have the right to inspect the information in my file.

Only medical questions on this application that have been answered "yes" may be inquired about.

Signature of Primary Proposed Insured

Signature of Spouse or Other Insured
(If proposed to be insured)

Signature(s) of Other Dependents 18 or Over
(If proposed to be insured)

Guardian's Signature
(If minor, custodial parents signature is
required)

A.M.
 P.M.

Date Signed Time Signed City/State

Requested Effective Date _____

Amount Collected \$ _____

One-time Processing Fee sent \$ _____

Conditional Receipt Given? Yes No

ATTENTION: (Agent)

I have reviewed this application to ensure that all required items have been completed.

To the best of my knowledge

there is,

is not

a replacement of Medical Insurance involved in this transaction.

Licensed Resident Agent's Signature

Print Agent Name & Agent Number or Business Number

Initial here if you witnessed
the signing of this form by the Proposed
Insured(s).

ADDITIONAL NOTICES

NOTIFICATION REGARDING ("MIB") formerly known as the MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. Time Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as 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 in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866 692-6901 (TTY 866 346-3642). If you question the accuracy of 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, Suite 400, Braintree, Massachusetts 02184-8734.

Time 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.

ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

To issue an insurance policy or certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will be received from you, and some will be generated from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, Underwriting Department, 501 West Michigan, Milwaukee, Wisconsin, 53203.

FRAUD NOTICE

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Division of Insurance within the Department of Regulatory Agencies.

PRIVACY

We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law. We collect non-public information about you from the following sources: (1) information we receive from you on enrollment forms or other information related thereto or as part of policy administration, and (2) information about your transactions with our affiliates, others or us. We restrict access to non-public personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your non-public personal information. We may disclose non-public personal information about you to nonaffiliated third parties as permitted by law.

CONDITIONAL RECEIPT

This Conditional Receipt is received from _____, this _____ day of _____ (month) _____ (year).

If full premium is paid and Time Insurance Company accepts this application as applied for within (30) days of the date the application is signed, the effective date will be as specified above, but I agree that I have no insurance coverage under this application until Time Insurance Company notifies me in writing that my application is approved. No agent or broker of the Company is authorized to alter or waive the conditions of this conditional receipt.

For coverage to become effective, each individual to be covered must be a risk acceptable to Time Insurance Company as applied for and at a standard or preferred rate with no Special Exception Riders on the later of: the Requested Effective Date or the Date on which Time Insurance Company receives the application at its home office.

I understand that Time Insurance Company has the right to deny my application and if it does so I will be notified in writing and the premium I submitted will be returned.

If I do not select an effective date, Time Insurance Company will assign an effective date that is later than the date the application is approved.

I must advise Time Insurance Company of any change in information included in the application for me or any person to be insured that occurs after the date I sign the application until the later of the effective date of coverage or the date Time Insurance Company receives the application at its home office. Failure to update Time Insurance Company regarding these changes may result in coverage being voided.