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PORTABILITY PLAN ELECTION FORM

An enrolled Member whose coverage under a Preferred Health Plan, Inc. Group Health Benefit Plan terminates is eligible to obtain a Preferred Health Plan Portability Health Benefit Plan. Eligible individual means an individual who has been continuously covered for 180 days or more under one or more Oregon group health benefit plans; who has applied for portability coverage not later than the 63rd day after termination of the prior contract; and who is an Oregon resident. Eligible individuals may enroll in a Portability Plan before, during or at the end of Federal or state continuation coverage.

An individual Member is not eligible to enroll in a Portability Plan if:

1. The Member is not an Oregon resident;
2. The Member is eligible for Medicare;
3. The Member remains eligible under a Preferred Health Plan, Inc. Policy; or
4. The Member is eligible for coverage or is covered under another Health Benefit Plan.

I elect coverage under: Prevailing Benefit Design (PRT-300) Low Cost Benefit Design (LC-1000)

Applicant's Social Security Number			Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married		Home Telephone Number	
Applicant's Last Name		First Name	MI	Sex M/F <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate MM/DD/YY	Resident County
Street Address (no P.O. Box numbers)			City	State	ZIP+4	
Mailing Address			City	State	ZIP+4	

LIST ALL FAMILY MEMBERS TO BE COVERED

* If a Member elects not to enroll an Eligible Dependent when coverage commences, that Dependent is not eligible for enrollment in the Plan at a later date.

	Last Name of Family Member	First Name	Middle Initial	Sex	Date of Birth	SSN#
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		

I wish to terminate my Group COBRA Coverage effective: _____

My first premium, in the amount of \$ _____, is enclosed.

My signature is a request for the Preferred Health Plan, Inc., Portability Plan. I have enclosed the applicable first monthly premium and hereby certify that I am not eligible under any other Health Benefit Plan.

 (Signature) _____
 (Date)

PREFERRED HEALTH PLAN, INC. USE ONLY

EFF. DATE: _____	POLICY NUMBER: _____
PREM. AMOUNT: _____	PLAN ID NUMBER: _____
PH ACTIVE COVERAGE: <input type="checkbox"/> Yes <input type="checkbox"/> No	DATE POLICY MAILED/DELIVERED: _____