

# oregon application and standard health statement



## individual & family plan

[www.providence.org/healthplans](http://www.providence.org/healthplans)

Thank you for choosing Providence Health Plan (PHP) for your individual health plan coverage. You also can apply for coverage online via our Web site at [www.providence.org/healthplans](http://www.providence.org/healthplans). Please consult the Providence Individual and Family Plans brochure or our Web site for additional information about your health plan choices and premium information.

## instructions and information

- This enrollment application is intended for those applying for Oregon Individual and Family coverage only. If you are seeking Employer Group, Portability or Medicare coverage, please do not use this application.
- Please PRINT clearly, use ink, and complete all sections of this application. Incomplete applications will be returned, which will delay processing and may affect your requested effective date for coverage.
- Only one medical plan may be selected per application.
- If you are requesting coverage for your dependent(s) only (age 0-17), please complete a separate application for each dependent.
- If you are making any changes to your existing coverage, other than adding a newborn or an adopted child within 60 days of birth or adoption, you will need to complete and submit all sections of this application, unless otherwise noted.

Please mail your completed application and any necessary documentation, to:

**Providence Health Plan, P.O. Box 4649, Portland, OR 97208-4649**

*Please do **not** include payment with this application*

- ◆ You will be notified by mail regarding the status of your application within 7 to 10 business days of receipt. If you need assistance, please contact your agent, or you may call the Providence Health Plan Sales Team at: 503-574-5000 (in Portland) or toll free at 1-800-988-0088. TTY (For the Hearing Impaired) 503-574-8702 or 1-888-244-6642.

## for agent use only (all fields are required)

I, (the agent) certify I have explained the eligibility provisions to the applicant. I have not made any statements about benefits, conditions or limitations of the contract except through written material furnished by Providence Health Plan. I have informed the applicant that the effective date of coverage is assigned only by Providence Health Plan and provided the Oregon Disclosure Information required. I certify that the information supplied to me by the applicant has been truly and accurately recorded here.

Agent Name <b>Christopher Gardner</b>		Agency Name <b>The Insurance Store, Inc.</b>		Date
PHP Agent Number <b>60848</b>	Agent E-mail <b>cgardner@insurancestoreonline.com</b>	Phone Number <b>(503) 693-1186</b>	FAX Number <b>(503) 650-2414</b>	
Street Address <b>6331 White Tail Dr. #61</b>		City, State, Zip Code <b>West Linn, OR 97068</b>		
Agent Signature <b>X</b> _____				

### For Office Use Only:

**W/I or S/M (circle):** rcvd: \_\_/\_\_/\_\_; time: \_\_\_\_; rcvd by: \_\_\_\_; complete?: y n; item: \_\_\_\_; call'd clnt /agt: 1x \_\_/\_\_/\_\_, h w ; 2x: \_\_/\_\_/\_\_, h w; retrnd: \_\_/\_\_/\_\_, reas: \_\_\_\_\_; snt UW: \_\_/\_\_/\_\_;

**UW:** rcvd: \_\_/\_\_/\_\_; time: \_\_\_\_; lx entrd: \_\_/\_\_/\_\_; recds req?: y n; date req: \_\_/\_\_/\_\_; date rcvd: \_\_/\_\_/\_\_; decis: \_\_\_\_\_, rendered: \_\_/\_\_/\_\_;

## **step 1. apply for new coverage or change your current coverage**

### **a. I'm applying for new coverage:**

**for myself only**

*You must be at least age 18. Once enrolled you, the applicant, will become the policyholder.*

**for myself and my family**

*Family includes you, your spouse and dependent children ages 0-22. Once enrolled you will become the policyholder.*

**for my dependent only** (age 0-17)

*To apply as the policyholder for Dependent-Only coverage, you must be at least age 18 and a parent or legal guardian of the dependent. Please complete a separate application for each dependent.*

### **b. I'm changing my current php individual/family plan coverage:**

**\*add my newborn: date of birth: \_\_\_/\_\_\_/\_\_\_**

*I'm adding my newborn to my existing policy within 60 days of birth.*

**\*add my adopted child: date of placement: \_\_\_/\_\_\_/\_\_\_**

*I'm adding my adopted child to my existing policy within 60 days of adoption.*

**\*Complete all sections of the application, except for the Oregon Standard Health Statement section.**

**add my spouse**

**add my dependent** (age 0-22)

**add an adult to a dependent-only policy**

*Complete all sections of the application, including the Oregon Standard Health Statement section.*

**please enter the current policyholder's member i.d. number: # \_\_\_\_\_**

## **step 2. choose your effective date of coverage**

Your coverage effective date cannot exceed 70 days from the date you sign and submit this application. The date you choose must be either the first or the fifteenth of the month. If for any reason there is a delay in the application process, Providence Health Plan will move your requested effective date forward to the next available date.

**request your effective date of coverage: \_\_\_/\_\_\_/\_\_\_**

### step 3. select a plan

This section pertains only to new applicants and current members wishing to change plans.

Please select one Providence Individual and Family plan for which you are applying.

(For detailed plan information, including rate sheet, view the Providence Individual and Family Plans brochure, or go to our Web site at [www.providence.org/healthplans](http://www.providence.org/healthplans).)

Providence Health Plan Individual Plans	In-Plan Copayment	Out-of-Plan Copayment	Deductible Individual / Family	Out-of-Pocket Maximum Individual / Family
<input type="checkbox"/> Optimum 500*	\$20/20%	40%	\$500 / \$1,500	\$2,500 / \$7,500
<input type="checkbox"/> Optimum 1000*	\$20/20%	40%	\$1,000 / \$3,000	\$2,500 / \$7,500
<input type="checkbox"/> Optimum 2500	\$20/20%	40%	\$2,500 / \$7,500	\$2,500 / \$7,500
<input type="checkbox"/> Optimum 5000	\$20/20%	40%	\$5,000 / \$15,000	\$2,500 / \$7,500
<input type="checkbox"/> Optimum 10,000	\$20/20%	40%	\$10,000 / \$30,000	\$2,500 / \$7,500
<input type="checkbox"/> Value 500*	\$20/30%	50%	\$500 / \$1,500	\$4,000 / \$12,000
<input type="checkbox"/> Value 1000	\$20/30%	50%	\$1,000 / \$3,000	\$4,500 / \$13,500
<input type="checkbox"/> Value 2500	\$20/30%	50%	\$2,500 / \$7,500	\$5,500 / \$16,500
<input type="checkbox"/> Value 5000	\$20/30%	50%	\$5,000 / \$15,000	\$8,500 / \$25,500
<input type="checkbox"/> Value 7500	\$20/30%	50%	\$7,500 / \$22,500	\$11,000 / \$33,000
<input type="checkbox"/> HSA 1200	\$20/20%	40%	\$1,200 / \$2,400	\$5,250 / \$10,500
<input type="checkbox"/> HSA 2500	\$20/20%	40%	\$2,500 / \$5,000	\$5,000 / \$10,000

\*FHIAP eligible plans. FHIAP helps uninsured individuals and families pay for health insurance by providing subsidies of up to 95% of the monthly premium. To find out if you qualify for FHIAP and for information on how to apply, call FHIAP at 1-888-564-9669, or visit [www.fhiap.oregon.gov](http://www.fhiap.oregon.gov)

#### how did you hear about Providence Health Plan?

- Friend  
  Family Member  
  Direct Mail  
  Internet  
  TV  
  Radio  
  Newspaper  
  Agent  
 Other \_\_\_\_\_

### step 4. enroll for coverage

List the individual or family member(s) applying for coverage (PRINT CLEARLY)

FULL LEGAL LAST NAME	FULL LEGAL FIRST NAME AND MIDDLE INITIAL	SEX	AGE	HEIGHT	WEIGHT	DATE OF BIRTH (MO-DAY-YR)	LAST 4 DIGITS OF SOCIAL SECURITY NUMBER	RESIDENCE ZIP CODE
1. Myself						/ /		
2. My Spouse						/ /		
3. Dependent						/ /		
4. Dependent						/ /		
5. Dependent						/ /		
6. Dependent						/ /		

Please explain your relationship to any person listed above whose last name is different than yours:

◆ If you have additional family members to be enrolled, please include them on a separate sheet with this application.

**APPLICANT OR DEPENDENT ADDRESS (Must reside in the PHP Individual and Family Plan Oregon Service Area)**

Residence Street Address 1		Address 2	
City	State	Zip Code	County
Home Phone Number	Work Phone/Other Phone Number	E-mail Address	
Mailing Address 1 (if different from street address)		Address 2	
City	State	Zip Code	

◆ *The Policyholder is the person who will hold the Individual contract and is required for a Dependent Only application.*

**POLICYHOLDER INFORMATION FOR DEPENDENT ONLY COVERAGE**

Name		Relationship to Dependent	
Mailing Address 1		Address 2	
City	State	Zip Code	County
Home Phone Number	Work Phone/Other Phone Number	E-mail Address	

**BILLING ADDRESS (Complete only if billing information should be sent to an address or person other than listed above)**

Name		Relationship to Applicant or Dependent	
Mailing Address			
City	State	Zip Code	

**other insurance information / creditable coverage**

1. Are you or any family members listed on this application currently enrolled in a health plan offered by Providence Health Plan?  Yes  No

1a. If Yes, please provide your Member I.D. number(s): \_\_\_\_\_  
 \_\_\_\_\_

2. Were you or any family members listed on this application previously enrolled in a health plan offered by Providence Health Plan?  Yes  No

2a. If Yes, please provide your Member I.D. number(s): \_\_\_\_\_  
 \_\_\_\_\_

3. Do you or any family members listed on this application have other current health or medical coverage, such as an Employer Group plan (other than Providence Health Plan), Medicare, Social Security Disability, CHAMPUS / Tricare or other?  Yes  No

4. Do you or any family members listed on this application have a certificate of creditable coverage?  Yes  No

◆ If you answered "Yes" to questions #3 and/or #4 above, please complete the **Other Insurance Coverage Information** section below.

◆ If you answered "Yes" to questions #3 and/or #4 above, please enclose a copy of your **Certificate of Coverage** with this application or forward when available. A **Certificate of Coverage** is verification of your current health coverage, and is available through your health insurance carrier.

OTHER INSURANCE COVERAGE INFORMATION		
Insurance Company (Full Name)		Insurance Company Phone Number
Address of Insurance Company		
Type of Insurance coverage: <input type="checkbox"/> Employer Group <input type="checkbox"/> Individual <input type="checkbox"/> Medicare <input type="checkbox"/> S.S. Disability <input type="checkbox"/> Portability <input type="checkbox"/> Other: (Please list): _____		
Policy and /or Member I.D. number(s)		
#1 _____	#2 _____	#3 _____
Name of Insured Family Member(s)	Date coverage started	Date coverage ends
#1 _____	_____	_____
#2 _____	_____	_____
#3 _____	_____	_____

◆ If you have additional "Other Insurance Coverage Information," please include on a separate sheet with this application.

Within the last five years, has **anyone** listed on this application been refused health insurance coverage for health reasons?  Yes  No

If yes, name of person affected: \_\_\_\_\_

Reason for denial: \_\_\_\_\_

Name of insurance company: \_\_\_\_\_

# Oregon Standard Health Statement

(Standard Form per ORS 743.766)

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

## Oregon Standard Health Statement, (cont)

(Standard Form per ORS 743.766)

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, responsible for a current pregnancy?  Yes  No

If yes, name \_\_\_\_\_ due date \_\_\_\_/\_\_\_\_/\_\_\_\_.

## Oregon Standard Health Statement, (cont)

(Standard Form per ORS 743.766)

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/telephone)	Date prescribed

## Oregon Standard Health Statement, (cont)

(Standard Form per ORS 743.766)

Please provide specific details below to each question answered "yes" on the previous pages. Include insured/applicant's name; the number of the question to which you answered "yes"; the condition, treatment and date; the result of treatment, including any medications; and the name, address and telephone number of the attending physician, other health care provider, or clinic/hospital.

### Health History Details

Please provide details below to any questions answered "YES" on the previous page.

NAME	QUESTION NUMBER	START TO END DATES	CONDITION	TREATMENT INCLUDING MEDICATIONS	FINAL RESULT ONGOING OR RESOLVED (PLEASE CIRCLE)	ATTENDING PHYSICIAN/ HEALTH CARE PROVIDER OR HOSPITAL NAME/ADDRESS/TELEPHONE
					O/R	
					O/R	
					O/R	
					O/R	
					O/R	
					O/R	
					O/R	
					O/R	
					O/R	
					O/R	
					O/R	
					O/R	
					O/R	
					O/R	
					O/R	

Attach additional pages, if necessary.  I have attached \_\_ page(s).

Name, address, and telephone number of medical provider with current medical records/history:

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**IMPORTANT:** Please make sure the answers you have provided are complete and accurate. Failure to do so could jeopardize your application and/or future benefits.

## Certification and Authorization

### Certification Of Completion And Correctness

I affirm that the answers given in this Application for Coverage and Oregon Standard Health Statement are complete and correct. I am providing these answers as part of the application procedure required by Providence Health Plan (PHP) to enroll for insurance coverage. I understand that if this application contains any material misstatements or omissions, PHP 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 PHP in writing if anything happens before my coverage takes effect that makes this application incomplete or incorrect.** I understand and agree that no coverage shall be in force until the effective date determined by PHP and that PHP may contact me to clarify answers on this application. As the applicant, I understand I have the right to inspect the information in my file.

### Authorization for the Release and Use and Disclosure of Personal Health Information

I authorize any physician, healthcare provider, hospital, insurance or reinsurance company, or other insurance information exchange service to disclose to Providence Health Plan (PHP) or its representatives personal health information relating to me and/or any family members included in this Application for Coverage. Furthermore, I agree to sign any additional forms related to release of personal health information, as needed by PHP to obtain this information. I acknowledge and understand that the health information released to PHP:

- Will only be used for the purpose of determining enrollment in health plan coverage or eligibility for benefits;
- May include claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, medication records, dental records, or hospital records (including nursing records and progress notes); and
- May address all medical and mental health conditions and services, including HIV treatment, but shall exclude psychotherapy notes and genetic information.

I understand that I may cancel this authorization at any time by sending a written request to PHP. My cancellation of this authorization will not affect any action PHP took before it received my request. If I do not revoke this authorization, it will automatically expire upon termination of my coverage with PHP. I understand that if I choose not to sign this authorization that PHP will be unable to process my Application for Coverage.

In addition, if I and/or any of my family members are accepted and enroll in PHP's Individual and Family plan coverage, I understand that PHP may request and disclose personal health information, other than psychotherapy notes, for the purpose of: (a) performing the health plan business operations of PHP; (b) facilitating health care treatment; (c) issuing or facilitating payment for health care services; or (d) as required by law. The disclosure of psychotherapy notes by PHP is restricted to circumstances in which the patient has provided a signed authorization.

For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Notice of Privacy Practices. A copy is available at our Internet site at [www.providence.org/healthplans](http://www.providence.org/healthplans) or by calling Customer Service.

## Acceptance Of Enrollment Procedure

1. I understand that Providence Health Plan will:
  - a) notify me in writing as to the status of my application.
  - b) send me a legal contract upon enrollment.
2. I am the parent or legal guardian of any dependent listed on this application.
3. I verify that my employer will not be paying the premium on this policy.
4. By signing, I agree to the above conditions.

Signature of Applicant (or the Parent/Legal Guardian signature for a Dependent-Only application) <b>X</b> _____	Relationship to dependent applicant under 18:	Date
Signature of Spouse * <b>X</b> _____ <input type="checkbox"/> Signed by applicant for spouse*		Date

\* The applicant may sign for a spouse. Please check the appropriate box above.