PacAdvantage

PacAdvantage Pool

Employee Application

Personal Information (Please print)

Company Name	Group #

Last Name	First Name	MI	Suffix	☐ Male ☐ Female

Home Address (no P.O. Box)

City	State	Zip

Home Telephone ( )	Work Telephone ( )	Date of Birth (mm-dd-yyyy)	Social Security #

Mailing Address (if different from home address)

City	State	Zip

Marital Status

☐ Single ☐ Married ☐ Widow ☐ Divorced

☐ Registered Domestic Partner ☐ Non-Registered Domestic Partner

We reserve the right to request documents that verify the validity of a non-registered domestic partnership.

Employer Use Only

Effective Date

Enrollment:

☐ New Hire
☐ Open Enrollment
☐ Change
☐ Add Dependent
☐ COBRA/Cal-COBRA

Date of hire:_____/_____/_______

Hours worked per week

Employer Verification Signature

Employee Classification

☐ Managerial ☐ Non-Managerial
☐ Exempt ☐ Non-Exempt
☐ Union ☐ Non-Union
☐ Full-Time ☐ Part-Time

Medical Benefit (Enter one plan only – refer to Benefits Summary for Plan Numbers)

☐ Check here if you would like your Health Care Service Plan to assign you a Primary Care Physician (PCP) ☐ Waive Medical (Complete Refusal of Coverage Form)

MEDICAL PLAN NAME/DESCRIPTION____________________________________ THREE-DIGIT PLAN NUMBER:____ ____ ____

Co-pay option: ☐ Preferred $10.00 ☐ Plus $20.00 ☐ Standard $30.00

Coverage Choice: ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Children ☐ Employee & Family ☐ Employee & State of CA Registered Domestic Partner ☐ Employee & Non-Registered Domestic Partner

Primary Care Physician (PCP) Last Name	First Name	Provider #	Existing Patient: ☐ Yes ☐ No

Prior Medical Coverage Carrier Name:		Start Date:		End Date:	

Dental Benefits (Complete only if your employer offers this Benefit)

☐ Check here if you wish to waive employer offered Dental coverage

DENTAL PLAN NAME/DESCRIPTION

☐ Prepaid Dental (HMO) Plan # _____________ ☐ PPO Dental Plan # _________________ ☐ Fee-For-Service Dental Plan # ______________

If you choose the Prepaid Dental (HMO) plan, you must select a dentist/office: Dentist/Office Name: ____

ID #:______________________________ ☐ Check if dentist chosen is current Dental Provider ☐ Check if you would like a dentist assigned

Prior Dental Coverage Carrier Name:		Start Date:		End Date:	

Vision Coverage (Complete only if your employers offers this Benefit)

☐ Check here if you wish to waive employer offered Vision coverage

VISION PLAN NAME/DESCRIPTION: ☐ Plus Vision Plan: ___________________________ ☐ Preferred Vision Plan:________________________

Acupuncture / Chiropractic (Complete only if your employer offers this Benefit)

ACUPUNCTURE / CHIROPRACTIC NAME/ DESCRIPTION: ☐ Standard Acupuncture / Chiropractic Plan # ______________________________ ☐ Plus Acupuncture / Chiropractic Plan # ____________________________________

2901 Douglas Boulevard • Suite 305 • Roseville, CA 95661 • 877.735.5742 phone • 916.786.6905 fax
www.pacadvantage.org

Enrollment / Family Information (Complete for Medical, Dental, Vision, and/or Acupuncture/Chiropractic)

Complete this section ONLY if you are enrolling dependents in medical, dental, visions, and/or Acu-Chiro
***IMPORTANT* Spouses, Domestic Partners, and dependents can ONLY be enrolled in services which the Employee is enrolled**

Spouse/ Dom. Partner	☐ Male ☐ Female	Last Name	First Name	M.I.
Date of Birth (mm-dd-yyyy)		Social Security #	Address, if different from Employee's	
Enroll in *(Please check all that apply)*	Medical ☐	Dental ☐	Vision ☐	Acupuncture/Chiropractic ☐
Primary Care Physician (PCP) Last Name		First Name	Provider #	Existing Patient: ☐ Yes ☐ No
Prior Medical Coverage Carrier Name:		Start Date:	End Date:	
Prior Dental Coverage Carrier Name:		Start Date:	End Date	

Dependent 1	☐ Male ☐ Female	Last Name	First Name	M.I.
Date of Birth (mm-dd-yyyy)		Social Security #	Address, if different from Employee's	
Enroll in *(Please check all that apply)*	Medical ☐	Dental ☐	Vision ☐	Acupuncture/Chiropractic ☐
Primary Care Physician (PCP) Last Name		First Name	Provider #	Existing Patient: ☐ Yes ☐ No
Prior Medical Coverage Carrier Name:		Start Date:	End Date:	
Prior Dental Coverage Carrier Name:		Start Date:	End Date	

Dependent 2	☐ Male ☐ Female	Last Name	First Name	M.I.
Date of Birth (mm-dd-yyyy)		Social Security #	Address, if different from Employee's	
Enroll in *(Please check all that apply)*	Medical ☐	Dental ☐	Vision ☐	Acupuncture/Chiropractic ☐
Primary Care Physician (PCP) Last Name		First Name	Provider #	Existing Patient: ☐ Yes ☐ No
Prior Medical Coverage Carrier Name:		Start Date:	End Date:	
Prior Dental Coverage Carrier Name:		Start Date:	End Date	

Read each of the following statements carefully. Any untrue or inaccurate responses may be reason for loss of eligibility, disenrollment by PacAdvantage and other sanctions. By signing this application, you are responsible for each statement: 1) I have reviewed the services, coverage offered, and rates of the participating plans; 2)I understand that I must meet the Program requirements to be an eligible employee; 3) I certify that I work or reside in the service area of the participating insurance plan(s) I have selected; 4) I understand that if I am an eligible employee and do not enroll my dependents at this time, they cannot enroll in the Program until the next Open Enrollment period unless otherwise authorized by Program Governing Rules; 5) I understand that there may be waiting periods for certain dental services; 6) I declare that I will abide by the rules of participation of any participating plan in which I am enrolled; 7) I agree to follow the laws and rules governing the Program; 8) I understand that this contract may require disputes to be resolved through binding arbitration (See disclosure below.); 9) As an employee applying for the Program, I understand my eligibility is based on my employer's continuing qualification to participate; 10) I understand that providing information and returning this form to PacAdvantage does not guarantee enrollment. 11) By signing this application, I certify under penalty of perjury that the information provided on this application is true and correct. I understand that any untrue or inaccurate responses on this application may cause loss of eligibility, disenrollment, and other sanctions.

ARBITRATION NOTICE

PacAdvantage offers a variety of health, dental, vision, and complementary medicine options. Enrollment in many of the plans constitutes an agreement to have certain disputes decided by binding arbitration and waiver of any right to a jury or court trial. Refer to the plan's Evidence of Coverage or Certificate of Insurance to determine whether the plan(s) you have selected require binding arbitration. If you choose a medical, dental, vision, or complimentary medicine plan, which requires resolution of disputes through arbitration, you your dependents, and the plan, may be waiving any right to a jury or court trial.

Employee Signature	Date Signed	Printed Name

COBRA / Cal-COBRA APPLICANT DECLARATIONS (Complete only if section is applicable)

I, the COBRA / Cal-COBRA applicant, declare as follows: 1)I understand that by signing the application, I am responsible for the Declaration set forth above and where the term "employee" is used, the Declarations apply to me as the COBRA / Cal-COBRA applicant; 2) I will abide by the Program premium requirements; 3) must meet the Program requirements and the requirements of federal or state law for continuation of coverage under COBRA or Cal-COBRA; 4) If my former employer terminates its participation in the Program, my coverage under the Program will cease, although I may have continuation coverage through a successor plan with the former employer.

Check COBRA coverage type:	☐ COBRA ☐ Cal-COBRA	COBRA / Cal-COBRA Start Date: ________________	Date of Qualifying Event: ____________
Type of Qualifying Event:	☐ Termination of Employment ☐ Divorce/Legal Separation	☐ Reduction of Hours ☐ Medicare Coverage	☐ Child no longer eligible ☐ Death of covered employee

I, the COBRA/Cal-COBRA applicant, certify that the information provided on this application is true and correct.

____ ____________________

Signature of COBRA applicant Date Signed