INDIVIDUAL ASSOCIATION MEMBER APPLICATION

Pacific Health Advantage
Choice • Simplicity • Affordability

Please complete this form and return to your association/agent. Use black or blue ink. For optimum accuracy, please print in capital letters and avoid contact with the edge of the box. When you see a choice of one or more boxes, please put an X in the one that most accurately applies. Please write dates as Month/Day/Year.

CHECK APPLICABLE BOX:

☐ **NEW ENROLLMENT** ☐ **CHANGE**

ASSOCIATION INFORMATION

NAME OF ASSOCIATION

ASSOCIATION MEMBER NUMBER

ASSOCIATION MEMBER SINCE / /

MEMBERSHIP TYPE

☐ INDIVIDUAL MEMBER ☐ EMPLOYEE OF MEMBER

DATE OF EMPLOYMENT (IF APPLICABLE) / /

NAME OF EMPLOYER (IF APPLICABLE)

INDVIDUAL INFORMATION

SALUTATION

☐ MR. ☐ MRS. ☐ MS.

GENDER

☐ MALE ☐ FEMALE

MARITAL STATUS

☐ SINGLE ☐ MARRIED

MEMBER FIRST NAME M. I. MEMBER LAST NAME

SUFFIX (Jr, Sr, etc.) BIRTH DATE / /

SOCIAL SECURITY NUMBER - -

HOME ADDRESS

APARTMENT CITY

STATE ZIP CODE -

MAILING ADDRESS

SUITE / APARTMENT CITY

STATE ZIP CODE -

BEST TIME TO RECEIVE A WELCOME CALL

☐ MORNING ☐ AFTERNOON ☐ EVENING

HOME PHONE NUMBER ( ) -

FAX NUMBER ( ) -

61094

Revised 03/23/00

GROUP NUMBER

SOCIAL SECURITY NUMBER

HEALTH PLAN SELECTION

PLAN NUMBER

INDICATE YOUR SELECTED PARTICIPATING HEALTH PLAN NAME

INDICATE COVERAGE CHOICE

- ☐ MEMBER ONLY
- ☐ MEMBER AND CHILD(REN)
- ☐ MEMBER AND SPOUSE
- ☐ FAMILY

INDICATE YOUR HEALTH PLAN OPTION (HMO ONLY)

- ☐ PREFERRED
- ☐ PLUS
- ☐ STANDARD

PRIMARY CARE PHYSICIAN / MEDICAL GROUP ID NUMBER

ARE YOU AN EXISTING PATIENT?

- ☐ YES
- ☐ NO

PRIMARY CARE PHYSICIAN'S LAST NAME

PRIMARY CARE PHYSICIAN'S FIRST NAME

PRIOR HEALTH PLAN INFORMATION

PRIOR COVERAGE TYPE

- ☐ PRIVATE INSURANCE
- ☐ MEDI-CAL
- ☐ MEDICARE
- ☐ NONE / UNINSURED
- ☐ OTHER

PRIOR HEALTH COVERAGE NAME

START DATE OF PRIOR INSURANCE

END DATE OF PRIOR INSURANCE

ARE YOU KEEPING OTHER HEALTH INSURANCE COVERAGE ALONG WITH THE PROGRAM?

- ☐ YES
- ☐ NO

OTHER HEALTH INSURANCE COVERAGE YOU ARE KEEPING ALONG WITH THE PROGRAM

GROUP NUMBER

SOCIAL SECURITY NUMBER

DENTAL PLAN SELECTION (IF APPLICABLE)

PLAN NUMBER

INDICATE YOUR SELECTED PARTICIPATING DENTAL PLAN NAME

INDICATE COVERAGE CHOICE

☐ MEMBER ONLY ☐ MEMBER AND CHILD(REN)

☐ MEMBER AND SPOUSE ☐ FAMILY

DENTIST / DENTAL GROUP ID NUMBER

ARE YOU AN EXISTING PATIENT?

☐ YES ☐ NO

DENTIST'S LAST NAME

DENTIST'S FIRST NAME

PRIOR DENTAL PLAN INFORMATION (IF APPLICABLE)

PRIOR COVERAGE TYPE

☐ PRIVATE INSURANCE ☐ MEDI-CAL ☐ MEDICARE ☐ NONE / UNINSURED ☐ OTHER

NAME OF CURRENT OR MOST RECENT PRIOR DENTAL COVERAGE

START DATE OF PRIOR INSURANCE

END DATE OF PRIOR INSURANCE

VISION PLAN SELECTION (IF APPLICABLE)

PLAN NUMBER

INDICATE YOUR SELECTED PARTICIPATING VISION PLAN NAME

INDICATE YOUR VISION OPTION

☐ PREFERRED ☐ PLUS

COMPLEMENTARY MEDICINE SELECTION (IF APPLICABLE)

PLAN NUMBER

COMPLEMENTARY MEDICINE PLAN NAME

GROUP NUMBER

SOCIAL SECURITY NUMBER

BILLING INFORMATION

HOW WOULD YOU PREFER TO BE BILLED?

☐ MONTHLY BILLING

☐ ELECTRONIC FUND TRANSFER

If you select Electronic Fund Transfer, please complete the following information.

BANK NAME

ACTION

☐ SET-UP ☐ CHANGE ☐ CANCEL

BANK ROUTING (ACH) NUMBER

BANK ACCOUNT NUMBER

ACCOUNT TYPE

☐ CHECKING ☐ SAVINGS

DEPOSITOR NAME

GROUP NUMBER

SOCIAL SECURITY NUMBER

AGENT INFORMATION

Agent/Broker must complete the **Agent of Record** and **Writing Agent** sections to receive proper credit. The Agent(s) of Record will receive fees. Agencies or corporations will not be accepted as a Writing Agent. All correspondence, including Open Enrollment materials, will be sent to the Writing Agent. Please fill out any name information as it appears on your California license.

Agent of Record 1

LAST NAME

FIRST NAME

M. I.

AGENT CODE

COMMISSION SPLIT PERCENTAGE %

Agent of Record 2

LAST NAME

FIRST NAME

M. I.

AGENT CODE

COMMISSION SPLIT PERCENTAGE %

Writing Agent

LAST NAME

FIRST NAME

M. I.

LICENSE NUMBER

I, the writing agent, certify that I have met with the association submitting this application and that Ihave fully explained its contents. I have discussed coverage, eligiblity, pre-existing condition limitations, the effect of misrepresentations, and termination provisions.

SIGNATURE OF WRITING AGENT

DATE SIGNED / /

GROUP NUMBER

SOCIAL SECURITY NUMBER

Declarations

Read each of the following statements carefully. Any untrue or inaccurate responses may be reason for loss of enrollment or application of other sanctions. By signing below, you are responsible for each statement.

1) I have reviewed the services, coverages offered, and the rates of the participating plan.
2) I understand that I must meet the Program requirements to be an individual member of the association through which I am applying.
3) I certify that I reside in the service area of the participating insurance plan(s) I have selected.
4) I understand that if I am an eligible individual member 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 this contract may have waiting periods for certain dental conditions.
6) I declare that I will abide by the rules of participation, the utilization review process and the dispute resolution process of any participating health/dental/vision/complementary care(i.e. chiropractic) 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) By signing this application, I certify that the information provided on this application is true and correct. I understand that any untrue or inaccurate responses may be reason for loss of eligibility and enrollment.
10) As an individual member applying for the Program through my association, I understand that my eligiblity is based on my association's participation.

Authorization for Disclosure of Personal Information

I hereby authorize health care providers to release medical/dental/vision/complementary careinformation, including medical information regarding substance abuse or mental/emotional conditions, pertainging to me or my dependents to the health plan(s) which I have selected and to Pacific Health Advantage (also known as The Health Insurance Plan of California). This information may be used for any purpose related to enrollment and plan administration, including but not limited to utilization management, quality improvement, disease or case management programs and premium risk adjustment. I further authorize payment of medical/dental/vision/complementary care benefits to the provider of care. A photocopy of this authorization is as valid as the original. My authorized representative or I am entitled to receive a copy of this authorization.

Arbitration Notice

Pacific Health Advantage is a purchasing cooperative offering a variety of health/dental options. Enrollment in many of the plans constitutes an agreement to have any dispute 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 complementary care plan which requires resolution of disputes through binding arbitration, you, your dependents and the plan are waiving any right to a jury or court trial.

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

SIGNATURE OF MEMBER (REQUIRED)

DATE SIGNED

If on this application, an association is adding a new member who was not included on the original application to the Program, the association authorized representative must sign and date the following:

I certify that the member on this application is an eligible member under the governing rules of the program.

SIGNATURE OF ASSOCIATION AUTHORIZED REPRESENTATIVE (REQUIRED)

DATE SIGNED