COBRA / Cal-COBRA ENROLLMENT APPLICATION

Use black or blue ink. For optimum accuracy, please print in capital letters. Please write dates as Month / Day / Year.

PacAdvantage
Choice • Simplicity • Affordability

FORMER EMPLOYER NAME _____

FORMER EMPLOYER GROUP # __ __ __ __ __ __ __

EMPLOYER INFORMATION

Select your coverage option
☐ Employee only ☐ Employee and spouse/domestic partner ☐ Employee and child(ren)
☐ Family ☐ Spouse/domestic partner only ☐ Child(ren) only
☐ Spouse/domestic partner and child(ren) only

Salutation
☐ Mr. ☐ Mrs. ☐ Ms.

Employee first name | M.I. | Employee last name | SUFFIX (Jr., Sr., etc.)

Date of birth | Social security number | Gender
__ __ / __ __ / __ __ __ __ | __ __ __ – __ __ – __ __ __ __ | ☐ Male ☐ Female

Home address | Apt.

City | State | Zip

Mode of correspondence ☐ Mail ☐ Fax ☐ E-mail

Home telephone
__ __ __ / __ __ __ / __ __ __ __

Fax number
__ __ __ / __ __ __ / __ __ __ __

E-mail address

Mailing/billing address (if different from home address)

Suite | City

State | Zip
__ __ | __ __ __ __ __ – __ __ __ __

WHY ARE YOU ELECTING COBRA/CAL-COBRA?

Date effective

☐ The termination of employee's employment (for reasons other than misconduct) on: __ __ / __ __ / __ __ __ __ — __ __ / __ __ / __ __ __ __
☐ The reduction of the employee's work hours on: __ __ / __ __ / __ __ __ __
☐ Death of employee on: __ __ / __ __ / __ __ __ __
☐ The legal annulment, dissolution of marriage or divorce between the employee and spouse as of: __ __ / __ __ / __ __ __ __
☐ Dependent no longer meets eligibility requirements as of: __ __ / __ __ / __ __ __ __
☐ Employee is eligible for MediCare as of: __ __ / __ __ / __ __ __ __

COVERAGE INFORMATION

What type of coverage are you electing ☐ Medical ☐ Vision ☐ Dental ☐ Chiropractic / Acupuncture

Coverage is only available if you were enrolled prior to COBRA enrollment.

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Mode of payment ☐ **CHECK** ☐ **EFT** ☐ **CREDIT CARD**

ELECTRONIC FUNDS TRANSFER ELECTION FORM (EFT)

If you would like to take advantage of the convenience of having your premium automatically deducted from your bank account each month, please complete and return with the Employer Application. If submitting separately:

Mail to 3013 Douglas Blvd., Suite 200, Roseville, CA 95661 or Fax to 916-786-6905

I authorize PacAdvantage to initiate debit transactions to the bank account indicated below for the payment of my monthly insurance premiums. I understand that:

- **My account will be debited on the last business day before the due date.**
- **Bank account changes must be reported at least 15 days prior to the withdrawal date.**
- **I will continue to receive an itemized invoice each month for my records.**

Group Number ___ ___ ___ ___ ___ ___ ___ ☐ Start EFT ☐ Change

Name on bank account

___ ___

Bank name

___ ___

Account type ☐ Checking ☐ Savings

Bank Routing (ACH) number

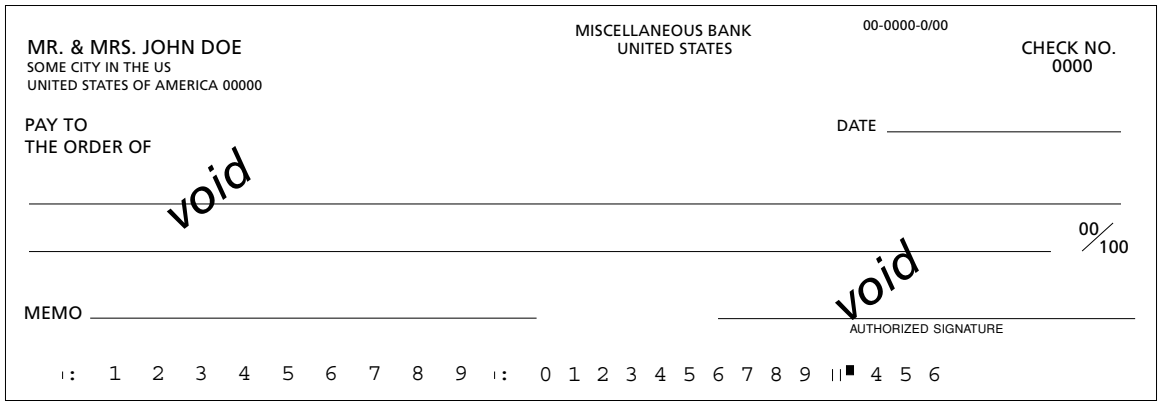
___ ___ ___ ___ ___ ___ ___ ___ ___

Bank account number

___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Signature: _____

PLEASE INCLUDE A COPY OF A VOIDED CHECK



ROUTING NO. (ABA) ⬆
Always 9 digits and to the left of the account number

ACCOUNT NO. ⬆
Number of digits varies

⬆ **CHECK NO.**
Sometimes to the left of the account number

CREDIT CARD INFORMATION

First name M.I. Last name (Suffix Jr., Sr., etc.)

___ ___

Credit card type ☐ American Express ☐ Visa ☐ Mastercard

Card number _____ Expiration date ___ ___ / ___ ___ / ___ ___ ___ ___

Signature: _____

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DECLARATIONS

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 participant.
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 eligible 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 COBRA/Cal-COBRA enrollee applying for the Program, I understand my eligibility is based on my former employer's continuing qualification to participate.
10) 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 on this application may be reason for loss of eligibility, disenrollment, and other sanctions.

AUTHORIZATION FOR DISCLOSURE OF PERSONAL INFORMATION

I hereby authorize health care providers to release medical, dental, vision, and complementary care information, including medical information regarding substance abuse or mental/emotional conditions, pertaining to me or my dependents to the health plan(s) which I have selected and to PacAdvantage. 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

PacAdvantage is a purchasing pool offering a variety of health/dental/vision/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 complementary medicine plan which requires resolution of disputes through binding arbitration, you, your dependents, and the plan may be waiving any right to a jury or court trial.**

It is understood that, after exhaustion of administrative remedies, any dispute with PacAdvantage will be determined by submission to arbitration before a single, neutral arbitrator, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. You, your dependents, and PacAdvantage are giving up their consitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

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

Signature of applicant (required) _____ Date signed __ __ / __ __ / __ __ __ __

Signature of applicant's spouse (required if listed on application) _____ Date signed __ __ / __ __ / __ __ __ __

Signature of applicant's dependent (required if over age 18) _____ Date signed __ __ / __ __ / __ __ __ __