DEPENDENT ENROLLMENT APPLICATION

(PacAdvantage Pool Only)

IF YOU SEEK SERVICES PRIOR TO RECEIVING YOUR ID CARD FROM YOUR PLAN, YOU MAY BE REQUIRED TO PAY OUT-OF-POCKET COSTS FOR CARE RECEIVED. THESE OUT-OF-POCKET COSTS MAY BE REIMBURSED BY THE PLAN, IF THEY ARE PART OF YOUR COVERED BENEFITS.

CHECK APPLICABLE BOX: ☐ **NEW DEPENDENT** ☐ **CHANGE**

PLEASE COMPLETE A SEPARATE DEPENDENT ENROLLMENT APPLICATION FOR EACH DEPENDENT ENROLLING.

For my dependent(s) under age 2, please enroll in the following coverage ☐ **DENTAL** ☐ **VISION** ☐ **CHIROPRACTIC/ACUPUNCTURE**

For all dependents age 2 or older, optional benefit enrollment must be the same as the employee/member.

GROUP NUMBER ___ ___ ___ ___ ___ ___ ___

EMPLOYEE'S SOCIAL SECURITY NUMBER ___ ___ ___ – ___ ___ – ___ ___ ___ ___

DATE OF BIRTH ___ ___ / ___ ___ / ___ ___ ___ ___

EMPLOYEE'S FIRST NAME ______________________

EMPLOYEE'S LAST NAME ______________________

M.I. ___

SUFFIX (Jr., Sr., etc.) ___ ___

A. DEPENDENT INFORMATION

DEPENDENT'S FIRST NAME ______________________

DEPENDENT'S LAST NAME ______________________

M.I. ___

SUFFIX (Jr., Sr., etc.) ___ ___

DEPENDENT'S SOCIAL SECURITY NUMBER ___ ___ ___ – ___ ___ – ___ ___ ___ ___

DATE OF BIRTH ___ ___ / ___ ___ / ___ ___ ___ ___

GENDER ☐ MALE ☐ FEMALE

RELATIONSHIP ☐ SPOUSE ☐ DOMESTIC PARTNER ☐ CHILD ☐ OTHER (please specify) ______________

IF ADDING SPOUSE, PLEASE SPECIFY DATE OF MARRIAGE ___ ___ / ___ ___ / ___ ___ ___ ___

DEPENDENT'S RESIDENTIAL ADDRESS, IF DIFFERENT THAN ENROLLING MEMBER'S

ADDRESS ______________________ APT. ___ ___ ___ ___ ___

CITY ______________________ STATE ___ ___ ZIP ___ ___ ___ ___ ___

B. MEDICAL PLAN INFORMATION

CURRENT PATIENT? ☐ YES ☐ NO

PRIMARY CARE PHYSICIAN'S FIRST NAME (HMO & POS PLANS) ______________________ LAST NAME ______________________

PRIOR MEDICAL COVERAGE NAME ______________________

START DATE ___ ___ / ___ ___ / ___ ___ ___ ___

END DATE ___ ___ / ___ ___ / ___ ___ ___ ___

☐ PRIVATE INSURANCE ☐ MEDI-CAL ☐ MEDICARE ☐ NONE (UNINSURED) ☐ OTHER ______________

C. DENTAL PLAN INFORMATION (if applicable)

DENTIST'S FIRST NAME ______________________ DENTIST'S LAST NAME ______________________

PRIOR DENTAL COVERAGE NAME ______________________

START DATE ___ ___ / ___ ___ / ___ ___ ___ ___

END DATE ___ ___ / ___ ___ / ___ ___ ___ ___

DEPENDENT ENROLLMENT APPLICATION

GROUP NUMBER ___ ___ ___ ___ ___ ___ ___

EMPLOYEE'S NAME ___

D. 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 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 this contract may have waiting periods for certain dental services.
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 medicine 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 employer, I understand that my eligibility is based on my employer's participation.

E. ARBITRATION NOTICE

PacAdvantage is a purchasing cooperative offering a variety of health/dental/vision/complementary medicine 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. Such disputes could include medical malpractice and other claims related to the delivery of health services. 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 are waiving any right to a jury or court trial.**

F. SIGNATURE

SIGNATURE OF EMPLOYEE ______________________________

DATE SIGNED ___ ___ / ___ ___ / ___ ___ ___ ___

G. COBRA/CAL-COBRA APPLICANT DECLARATIONS

I, the COBRA/Cal-COBRA applicant, declare as follows:

1) I understand that by signing this application, I am responsible for the Declarations 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) I 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 START DATE ___ ___ / ___ ___ / ___ ___ ___ ___

Indicate Qualifying Events

☐ Termination of employment ☐ Child no longer eligible ☐ Medicare coverage

☐ Reduction of hours ☐ Divorce/legal separation ☐ Death of covered employee

DATE OF QUALIFYING EVENT ___ ___ / ___ ___ / ___ ___ ___ ___

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

SIGNATURE OF COBRA APPLICANT ______________________________

DATE SIGNED ___ ___ / ___ ___ / ___ ___ ___ ___