Small Business Employee Enrollment and Declination of Coverage Form

PacifiCare®

Effective August 1, 2003

PacifiCare SignatureValue℠ and PacifiCare SignaturePOS℠:
P.O. Box 6006, MS CY24-515
Cypress, CA 90630
Fax: (714) 226-5947
(714) 226-5622

PacifiCare SignatureOptions℠, PacifiCare SignatureIndependence℠ and PacifiCare SignatureFreedom℠:
P.O. Box 6098
Cypress, CA 90630
Fax: (714) 226-5002

IMPORTANT: PLEASE COMPLETE ALL SECTIONS
This form cannot be processed if information is incomplete.

Source Code	Tracking #

YOUR EMPLOYER COMPLETES THIS SECTION – GROUP MEDICAL AND LIFE

Company Name	Group Number/Plan Code	Source of Enrollment: ☐ QMCSO ☐ Open Enrollment ☐ Transfer ☐ New Hire ☐ Rehire	Date of Hire	Date of Rehire	Requested Effective Date

Annual Salary	Occupation and Title	Life Class	Group Life/AD&D Amount

YOU COMPLETE THIS SECTION – GROUP MEDICAL AND LIFE (If you are waiving coverage, skip to the Declination of Coverage section.)

SELECTING YOUR PLAN (Check one after confirming the plan(s) being offered by your Employer)

PacifiCare SignatureValue (HMO)	PacifiCare SignatureOptions (PPO)	PacifiCare SignatureIndependence (Indemnity)
☐ 10–30/100	☐ 20/80–60/250	☐ 80/250
☐ 15–30/250a	☐ 30/70–50/250	**PacifiCare SignaturePOS (POS)**
☐ 20–40/500d	☐ 35/80–60/500	☐ 10/80–70
☐ 30–40/70	☐ 35/70–50/1000	**PacifiCare SignatureFreedom (SDHP)**
	☐ 70–50/2000	☐ 70–50/2000

PERSONAL INFORMATION

Residence Mailing Address (Number, Street, Apartment)	City	State	Zip

Home Telephone ( )	Work Telephone ( )	Are you currently on Cal-COBRA or COBRA? If yes, note type of qualifying event and original start date:	Marital Status ☐ Single ☐ Married ☐ Single with Domestic Partner ☐ Divorced ☐ Widowed

Please list the number of hours you work in a normal week: _____ hours	Have you or any of your dependents ever been a PacifiCare Member? ☐ Yes ☐ No	Have you or any of your dependents waived PacifiCare coverage in the past 12 months? ☐ Yes ☐ No

E-mail	Would you like to receive information via e-mail? ☐ Yes ☐ No

LIST ALL ENROLLING FAMILY MEMBERS INCLUDING YOURSELF BELOW

- PCP selection is only required if an HMO/POS plan is selected **(if you do not select a PCP, one will be assigned).**
- Please select a doctor from the Provider Directory for you and each of your family members by writing the PCP name and number below.
- **You may choose a different doctor for each member of your family.**
- For assistance call Customer Service at **1-800-624-8822 (HMO), 1-800-913-9133 (POS) or 1-866-316-9776 (PPO/Indemnity).**

1	**Self**	Last Name	Social Security Number - -	Primary Care Physician Name	PCP # – OR – Group #	Primary Care Physician (PCP) Number	Existing Patient? ☐ Yes ☐ No
	Sex M or F	First Name M.I.	Date of Birth (Month - Day - Year) - -	Medical Group Name		Medical Group Number	
2	**Spouse**	Last Name	Social Security Number - -	Primary Care Physician Name	PCP # – OR – Group #	Primary Care Physician (PCP) Number	Existing Patient? ☐ Yes ☐ No
	Sex M or F	First Name M.I.	Date of Birth (Month - Day - Year) - -	Medical Group Name		Medical Group Number	
3	Relationship	Last Name	Social Security Number - -	Primary Care Physician Name	PCP # – OR – Group #	Primary Care Physician (PCP) Number	Existing Patient? ☐ Yes ☐ No
	Sex M or F	First Name M.I.	Date of Birth (Month - Day - Year) - -	Medical Group Name		Medical Group Number	
4	Relationship	Last Name	Social Security Number - -	Primary Care Physician Name	PCP # – OR – Group #	Primary Care Physician (PCP) Number	Existing Patient? ☐ Yes ☐ No
	Sex M or F	First Name M.I.	Date of Birth (Month - Day - Year) - -	Medical Group Name		Medical Group Number	
5	Relationship	Last Name	Social Security Number - -	Primary Care Physician Name	PCP # – OR – Group #	Primary Care Physician (PCP) Number	Existing Patient? ☐ Yes ☐ No
	Sex M or F	First Name M.I.	Date of Birth (Month - Day - Year) - -	Medical Group Name		Medical Group Number	

Overage (19-24 years) dependents require proof of full-time student status or permanent disability status within 31 days of enrollment.

Source Code	Tracking #

Employee Name _____ Social Security # _____

Company Name _____

BENEFIT COORDINATION/OTHER INSURANCE CARRIER INFORMATION

1. Does anyone listed have other health insurance? ☐ Yes ☐ No If yes, complete section below.

2. Is anyone listed permanently disabled? ☐ Yes ☐ No Name _____ Date disability began _____ M - D - Y

3. Is anyone listed eligible for Medicare? ☐ Yes ☐ No Name _____ Medicare ID# _____

NAME	INSURANCE COMPANY NAME	POLICY NO. & EFFECTIVE DATE	OTHER EMPLOYER NAME & ADDRESS

*GROUP LIFE INSURANCE (Complete only if your Employer is offering this benefit)

I wish coverage	I apply for coverage for:	Employee's Benefits –
☐ Yes ☐ No	☐ Self Only ☐ Self and Eligible Dependents	Life: $ AD&D: $ Supp. Life:** $

Spouse –
Date of Birth (mm-dd-yy) Amount: $

As a covered employee, you have the right to select and/or change your beneficiary(ies) in accordance with the provisions of your policy.

Life Insurance Primary Beneficiary (full name)***	Phone Number	Relationship***
	( )	
Contingent Beneficiary (full name)	Phone Number	Relationship
	( )	

** Evidence of Insurability may be required.
*** Your spouse MUST sign this form if: (a) you are a resident of AZ, CA, ID, LA, NV, NM, TX, WA or WI **and** (b) you designate someone other than your spouse as beneficiary

Spouse Signature	Date

*GROUP LONG TERM DISABILITY (LTD)

(Complete only if your Employer is offering this benefit)

Job Duties

I understand that a medical examination, at my own expense, may be required if I want to participate at a later date.

Employee Signature X	Date
LTD Insurance Beneficiary (full name)	Relationship

* Life coverage is underwritten by Continental Assurance Company or CNA Group Life Assurance Company. Long Term Disability is underwritten by Continental Casualty Company or CNA Group Life Assurance Company. The issuing company is identified on the group policy.

Source Code	Tracking #

Employee Name _____ Social Security # _____

Company Name _____

IF YOU ARE DECLINING COVERAGE, PLEASE COMPLETE THE INFORMATION ON THE LAST PAGE OF THIS FORM.

TERMS AND CONDITIONS

PLEASE READ CAREFULLY BEFORE SIGNING THIS FORM

On behalf of myself and my eligible dependents, I hereby apply for the group health coverage indicated on the inside in PacifiCare Health Plan's ("PacifiCare") Small Group Health Plan or PacifiCare Life and Health Insurance Company ("PacifiCare Life and Health") offered through my employer, and agree to and understand the following:

1. To be bound by the PacifiCare Medical and Hospital Group Subscriber Agreement ("Agreement") if I have chosen the HMO or POS plan or the PacifiCare Life and Health Group Policy ("Policy") if I have chosen the PPO or Out-of-State Indemnity Plan.
2. My employer may deduct from my earnings the employee contribution required to cover my share of the premium, if any.
3. PacifiCare or a designee shall have access to and use of my medical records and the medical records of my dependents, including mental health medical records and medical records from drug and alcohol abuse treatment or prevention, for purposes of Utilization Review, Quality Assurance, surveys, processing of claims, financial audit, rating, insurance or purposes reasonably related to the performance of the Agreement or Policy.
4. Any material omission or misrepresentation in answering the questions on this application may result in the denial of benefits and the termination of my and/or my dependent's membership or grounds for rescission of the insurance policy with PacifiCare.
5. Coverage shall not begin until acceptance of this enrollment form by PacifiCare. Upon acceptance of this enrollment form, PacifiCare shall be bound by the terms of the Agreement or Policy and any Amendments thereto.
6. I have received, read and understand the PacifiCare Combined Evidence of Coverage and Disclosure Form, Schedule of Benefits, Limitations and Exclusions, Directory of Participating Medical Groups, and a copy of this Enrollment Form.
7. I and/or my dependents live in PacifiCare of California's licensed service area (if enrolling in PacifiCare's HMO or POS plans).

I represent that the information supplied is true and I hereby authorize payroll deductions from my earnings for any contributions or fees required to maintain my eligibility.

SIGNATURE REQUIRED ON ARBITRATION DISCLOSURE.

Arbitration Disclosure By signing below, I acknowledge that I have read, understand and agree to the Terms and Conditions and Arbitration Disclosure on all the pages of this form. A reproduction of this authorization shall be as valid as the original.

I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE (THAT IS AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR CLAIMS SUBJECT TO ERISA, BETWEEN MYSELF AND MY DEPENDENTS ENROLLED IN THE PLAN (INCLUDING ANY HEIRS OR ASSIGNS) AND PACIFICARE OF CALIFORNIA OR ANY OF ITS PARENTS, SUBSIDIARIES OR AFFILIATES SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS THE FEDERAL ARBITRATION ACT PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. ALL PARTIES TO THIS AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

Signature (Required)	Date (Required)
X	

Source Code	Tracking #

Employee Name _____ Social Security # _____

Company Name _____

DECLINATION OF COVERAGE

Unless one of the three circumstances set forth below applies to you, failure to enroll during the initial enrollment period will permit the plan to treat you as a Late Enrollee and to impose a twelve-month waiting period at the time you decide to enroll.

I certify that the reason I am declining enrollment is: (check, as applicable)

- □ I am covered under another group health benefit plan offered to my spouse.
- □ I am covered under another group health benefit plan offered by my EMPLOYER.
- □ I am covered under an Individual health plan.
- □ I am declining for my spouse, name: _____,
  because _____
- □ I am declining for my child/children, name(s): _____, _____, _____
  because _____
- □ I am declining because _____

If I or one of my dependents have declined coverage as listed above:

I understand that in the event I and/or my eligible dependents choose to enroll in a PacifiCare plan at a later date, we may be considered "Late Enrollees" and may have to wait for coverage for a period of twelve (12) months after the date we enroll, or the next open enrollment period.

I have been informed that under the three following circumstances, I and my eligible dependents will not be considered Late Enrollees, and thus will not have to wait for a period of twelve (12) months after we enroll in PacifiCare:

1. OTHER EMPLOYER HEALTH BENEFIT PLAN COVERAGE. You and your dependents (collectively "You") shall not be considered Late Enrollees if:
   a. You are currently covered under another employer health benefit plan ("Plan") although You are also eligible to enroll in a PacifiCare plan;
   b. You certify in writing on this Declination of Coverage that You are declining PacifiCare coverage because You are already covered under another group Plan;
   c. You learn at a later date that You have lost or will lose coverage under the other Plan because of:
      (1) the termination of your employment or the employment of the person through whom You are covered as a dependent;
      (2) a change in your employment status or the employment status of the person through whom You are covered as a dependent;
      (3) the termination of coverage under the other Plan;
      (4) the termination of an employer's monetary contribution toward your coverage under the other Plan;
      (5) the death of the person through whom You are covered as a dependent;
      (6) the legal separation or divorce; or
      (7) loss of no share-of-cost Medi-Cal coverage from the person through whom You are covered as a dependent; and
      (8) your declination of coverage when enrollment was previously offered and you subsequently acquired a dependent;
      (9) the termination of coverage under the other Plan for your dependent(s); and
   d. You request enrollment no later than thirty (30) days after termination of your coverage under the other Plan due to one of the reasons stated here in subsection 1(c).

   If You meet each of the requirements listed above, You will not be classified as a Late Enrollee, and will not have to wait twelve (12) months after You enroll.
2. MULTIPLE PLANS. If your employer offers one or more other plans and You enrolled in one of such Plans during an open enrollment period, You will not be classified as a Late Enrollee if You enroll in PacifiCare at a later date.
3. COURT ORDER. If a court has ordered that You obtain health care coverage for your spouse or minor child, and You submit an application for enrollment within thirty (30) days after issuance of the court order, You and your spouse and/or minor child will not be classified as Late Enrollees.

My signature on the inside of this form represents that I have read, understand and agree to the terms and conditions listed above.

SIGNATURE I have read, understand and agree to the above Declination of Coverage.

X_____ _____

Signature (Required) Date

Customer Service:

800-624-8822 PacifiCare SignatureValue℠ (HMO)
800-913-9133 PacifiCare SignaturePOS℠ (POS)
866-316-9776 PacifiCare SignatureOptions℠/ PacifiCare SignatureIndependence℠ (PPO/Indemnity)
866-867-0700 PacifiCare SignatureFreedom℠ (SDHP)
800-442-8833 (TDHI)
866-816-2018 (PPO/Indemnity TDHI)
www.pacificare.com

CM-403-43455
PC7323