CaliforniaChoice®
Your Health. Your Choice.®
www.calchoice.com

Medical / Dental / Life / Vision Enrollment Application

Application must be COMPLETED in FULL, SIGNED and DATED for processing.
IF YOU ARE WAIVING COVERAGE, YOU MUST COMPLETE, SIGN AND DATE WAIVER ON PAGE 5 OF THIS APPLICATION.

Please select one: ❑ New Hire Enrollment ❑ New Renewal Enrollment ❑ New COBRA Enrollment

A. PERSONAL INFORMATION

Name of Company	Employer Phone #	Employee Job Title	**Full-time Employment Date**

Sex ❑ M ❑ F **Status** ❑ Married ❑ Single ❑ Domestic Partner *(Note: If you or any of your dependents are not enrolling, you must also complete and sign the waiver section on page 5.)*

Employee Last Name **Employee Social Security Number**

Employee First Name **Date of Birth** MO DAY YEAR **Group Number**

Residence Address Apt #

City State Zip Code

Home Telephone ( ) Email Address

Mailing Address *(if different from above)*

B. ENROLLMENT INFORMATION

Complete this section ONLY if you are electing medical, dental and/or vision for yourself and dependents

	Employee	Spouse	Child	Child	Child
Last Name	❑ Life only				
First Name					
Relationship to Employee		❑ Spouse ❑ Domestic Partner			
Social Security No.		Social Security # required!	Social Security # required!	Social Security # required!	Social Security # required!
Gender		❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female
Date of Birth		/ /	/ /	/ /	/ /
Primary Care Physician*					
Physician ID# & City					
Current Patient of PCP?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Disabled?			❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Enrolling For?	❑ Med ❑ Dent ❑ Vision	❑ Med ❑ Dent† ❑ Vision	❑ Med ❑ Dent† ❑ Vision	❑ Med ❑ Dent† ❑ Vision	❑ Med ❑ Dent† ❑ Vision

❑ Check here if you would like your Healthcare Service Plan to assign you a Primary Care Physician.

➡ For additional dependent enrollment, complete sections A & B on a separate application.

* *Please be sure to verify that your PCP is contracted with your selected carrier prior to enrolling, otherwise a PCP will automatically be assigned to you. New Hire applications added to existing groups will automatically be assigned a PCP if one is not chosen or PCP is not contracted with the selected health plan. For Kaiser Permanente enrollees, no PCP selection is required.*

† *Dependents enrolled for dental must match dependents enrolled for medical (except voluntary dental or children under Age 3).*

COBRA Applicants:
Please check COBRA type:
❑ **COBRA** ❑ **Cal-COBRA**

Indicate Qualifying Event:
❑ Termination of employment ❑ Reduction of hours ❑ Child no longer eligible ❑ Divorce/legal separation ❑ Medicare entitlement ❑ Death of employee

Date of Qualifying Event

PLEASE SIGN AND DATE APPLICABLE SECTIONS INSIDE APPLICATION

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C. MEDICAL BENEFIT (select one plan only)

HMO

Anthem Blue Cross/ Anthem Blue Cross Select	Health Net/ Health Net Silver	Kaiser Permanente	Sharp Health Plan	Western Health Advantage
❑ CalChoice® HMO 15	❑ CalChoice HMO 15	❑ CalChoice HMO 15	❑ CalChoice HMO 15	❑ CalChoice HMO 15
❑ CalChoice HMO 25	❑ CalChoice HMO 25	❑ CalChoice HMO 25	❑ CalChoice HMO 25	❑ CalChoice HMO 25
❑ CalChoice HMO 25 Value	❑ CalChoice HMO 25 Value	❑ CalChoice HMO 30	❑ CalChoice HMO 30	❑ CalChoice HMO 30
❑ CalChoice HMO 30	❑ CalChoice HMO 30	❑ CalChoice HMO 40	❑ CalChoice HMO 40	❑ CalChoice HMO 40
❑ CalChoice HMO 40	❑ CalChoice HMO 30 Value			❑ CalChoice HMO 40 Value
❑ CalChoice HMO 40 Value	❑ CalChoice HMO 40			
	❑ CalChoice HMO 40 Value			
	❑ Elect Open Access			
	❑ Elect Open Access 25 Plus			
	❑ Elect Open Access 40 Plus			

PPO

❑ PPO 750 ❑ PPO 1000 ❑ PPO 3000 ❑ HSA 1800* ❑ PPO 1500

❑ PPO 750 GenRx ❑ PPO 1000 GenRx ❑ PPO 4000 ❑ HSA 2500* ❑ PPO 1750 GenRx

** HSA-Qualified High Deductible Health Plan*

PPO PLAN AVAILABILITY WILL BE BASED ON GROUP ELIGIBILITY AND MAY BE SUBJECT TO CHANGE

D. OPTIONAL BENEFITS — Ask your health plan administrator if any of the optional benefits below are being offered by your employer

Sections A, B & E must be completed for life coverage

Life Insurance

Full Name of Beneficiary	Date of Birth for Beneficiary
Relationship of Beneficiary	Life Amount

Dental Coverage

❑ FDH 100 ❑ Prepaid 3000† ❑ EPO 3000 ❑ PPO 4000

❑ Prepaid 1000† ❑ Voluntary Prepaid 3000 ❑ EPO 3500 ❑ PPO 5000

❑ Check if dentist chosen is current provider

❑ Check if you would like a dentist assigned

† If you choose prepaid plans 1000 or 3000, you must select a dentist:

Dentist: **ID#:**

Vision Coverage

❑ Vision (discount plan)

❑ Voluntary Vision (additional charge)

Premium Only Plan (P.O.P.)

❑ I want my portion of eligible insurance premiums paid on a pre-tax basis

Employee Name _____ Group Number _____

E. YOUR LEGAL ACKNOWLEDGEMENT (Read, sign and date where indicated on next page)

By submitting this signed application, I agree and understand that the health plan I have chosen through the California*Choice*® program shall automatically have a lien on any payment of monies from any source, for services rendered in conjunction with an injury caused by the acts or omissions of a third party.

I agree for myself and my dependents to be bound by the benefits, copays, deductibles, exclusions, limitations and other terms of the health plan's small group contract.

I authorize my physician, healthcare provider, hospital, clinic or other medically related facility to furnish my, and my dependent's, protected health information, including medical records, to the health plan I have chosen through the California*Choice* program or its authorized agents for the purpose of review, investigation, or evaluation of an application or claim, and for quality assurance and utilization review. I authorize California*Choice* and the health plan I have chosen, and their agents, designees or representatives, to disclose to a hospital, health plan, insurer or healthcare provider any protected health information if such disclosure is necessary to allow the performance of any of those activities. This authorization shall become effective immediately and shall remain in effect for up to 30 months from the date the authorization was signed. I understand that I, or a person authorized to act on my behalf, is entitled to receive a copy of this authorization form.

I have read and understand the information provided to me pertaining to the Premium Only Plans and the tax consequences.

I declare under the penalty of perjury under the laws of the state of California that the following statements are true, correct and pertain to the employer named on this application, myself and my dependents named on this application.

- I am either actively, permanently working for the employer and considered eligible by my employer because I work either 20+ or 30+ hours per week, or I am an eligible COBRA/Cal-COBRA participant.
- I am not a temporary, seasonal, per diem or a 1099 employee or insured by or eligible to be insured by the employer's union policy.
- My children's dates of birth are accurate. My children are born to me or my spouse/domestic partner, or legally adopted and/or a non-temporary legal ward of me or my spouse/domestic partners.

I understand that the preceding statements are subject to audit at any time and **agree** to provide California*Choice* with any and all information necessary to prove the above statements.

I understand that false statements and/or failure **to provide the information upon request will cause the termination of all** California*Choice* benefits 15 days following the date of the notice of termination and I will be held responsible for all services and charges incurred through California*Choice* program providers thereafter.

I understand that any persons, business or health plan that suffers a loss because of false-declarations contained in this statement may take legal action against me to recover their losses.

- The representations made are the basis upon which coverage may be issued.
- If any Material fact was omitted or misrepresented, the coverage may be cancelled or the employer's contract rescinded.
- I have READ, UNDERSTAND and ATTEST that I myself and my dependents have met all of the eligibility requirements listed on page 6 of this application.

California law prohibits an HIV test from being required or used by health care service plans as a condition of obtaining coverage.

(continued on next page)

E. YOUR LEGAL ACKNOWLEDGEMENT *(continued)*

ANTHEM BLUE CROSS ENROLLEES:

I understand that if my coverage is provided pursuant to an employer-sponsored benefit plan that is exempt from Employee Retirement Income Security Act of 1974 (ERISA) or if I have a dispute that is not governed by ERISA that I will be subject to the following binding arbitration provision.

The following provision does not apply to class actions:

IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. *It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, 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 arbitration.* THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.

HEALTH NET ENROLLEES:

BINDING ARBITRATION AGREEMENT:

Subject to the terms of the Plan Contract or Insurance Policy (which may prohibit mandatory arbitration of certain disputes if the Plan Contract or Insurance Policy is subject to ERISA, 29 U.S.C. section 1001, et seq.), I, the Employee, understand and agree that any and all disputes or disagreements between me (including any of my enrolled family members or heirs or personal representatives) and the Health Net Entities regarding the construction, interpretation, performance or breach of the Plan Contract or Insurance Policy, or regarding other matters relating to or arising out of my Health Net Entities membership, whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or employees, are also involved, must be submitted to final and binding arbitration in lieu of a jury or court trial. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties, including the Health Net Entities, are giving up their constitutional right to have their dispute decided in a court of law before a jury. I also understand that disputes that I may have with the Health Net Entities involving claims for medical malpractice are also subject to final and binding arbitration. A more detailed arbitration provision is included in the Plan Contract or Insurance Policy. My signature below indicates that I agree to submit any dispute to binding arbitration.

KAISER FOUNDATION HEALTH PLAN ENROLLEES:

Arbitration Agreement: I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in a group that is subject to ERISA, certain benefit-related disputes) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage.*

SHARP ENROLLEES:

It is understood that any dispute or controversy between the Member and the Plan arising out of or in connection with this Group Agreement, excluding a claim of medical malpractice, will be determined by submission to final and binding arbitration in accordance with the provisions of Article XIII of this Group Agreement, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this Group Agreement, by entering into it, are giving up their constitutional right to have any such dispute or controversy decided in a court of law before a jury, and instead are accepting the use of arbitration.

WESTERN HEALTH ADVANTAGE ENROLLEES:

Arbitration Agreement:

I agree and understand that any and all disputes between myself (including any heirs or assigns) and Western Health Advantage, including 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 Small Claims Court cases and claims subject to ERISA, 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 California law provides for judicial review of arbitration proceedings. The parties, including any heirs or assigns, to this arbitration 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.

Employee **SIGN HERE FOR MEDICAL, DENTAL, LIFE OR VISION COVERAGE:** Print Name Date:

My signature acknowledges that I have read Section E, the applicable arbitration disclosure of the HMO I selected in Section C and my decision to enroll in the medical, dental, life or vision coverage that I selected in Sections C and D.

Employer/California*Choice* Use Only

❑ New Group-employee ❑ New Hire ❑ Renewal Effective Date:

MEDICAL / DENTAL WAIVER

IMPORTANT!

Complete this page only if you DO NOT WANT MEDICAL OR DENTAL COVERAGE for yourself and/or your eligible dependents. If offered by your employer, the life coverage benefit cannot be waived and you are required to complete an Enrollment Application. Chiropractic coverage cannot be waived when enrolling for medical coverage.

A. Personal Information

Name of Company	Employer Phone Number

Employee Last Name

Employee First Name

Employee Social Security Number

Group Number

B. Type of Waiver

I have been offered coverage by my employer, but at this time I wish to DECLINE coverage as follows:

1) **Medical for:** ❑ Myself and dependents ❑ Spouse/Domestic Partner ❑ Child(ren)

2) **Dental for:** ❑ Myself and dependents ❑ Spouse/Domestic Partner ❑ Child(ren)

C. Reason

Required only if employee waiving coverage—not required if waiving coverage for dependents only

1) **Reason waiving Medical:**
- ❑ Other group coverage Carrier Name: _____Group # _____
- ❑ Medicare
- ❑ Medi-cal
- ❑ Individual Policy
- ❑ Other Reason: _____ (explanation required)

2) **Reason waiving Dental:**
- ❑ Other group coverage Carrier Name: _____Group # _____
- ❑ Medicare
- ❑ Medi-cal
- ❑ Individual Policy
- ❑ Other Reason: _____ (explanation required)

D. Signature

☒ **I understand that by failing to elect coverage now, *CHOICE* Administrators® Insurance Services, Inc. can impose up to a 12 month period of exclusion as well as a 6 month pre-existing condition exclusion, both of which would begin at the time of my later decision to elect coverage.**

☒ I also understand that if my employer is offering life coverage, I CANNOT WAIVE LIFE COVERAGE.

This waiver provision will not apply if: 1) Court orders coverage of a spouse or child and the request for enrollment occurs within 30 days of the court order; or 2) Employee meets ALL of the following: A) Was covered under another employer-sponsored health plan at the time of initial eligibility; B) Lost coverage as a result of termination of employment, change in employment status, involuntary termination of other plan's coverage, cessation of employer's contribution, or death or divorce of spouse; C) Requests enrollment within 30 days of loss of coverage.

Employee **SIGN HERE TO WAIVE COVERAGE:** ➡	Date

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Family Coverage Eligibility Requirements

Who can be covered?	Effective dates	Requirements that MUST be met:
New Spouse/ New Stepchild	If marriage occurred before the 16th of the month, coverage begins on the first day of the month of the date of marriage. If marriage occurred on the 16th of the month or after, coverage begins on the first of month following date of marriage.	■ New spouse must be legally married to the employee ■ New stepchild must also meet the dependent children requirements listed below
New Baby, Adopted Child, Non-Temporary Legal Ward, and Dependent Children	If birth/date of placement occurred before the 16th of the month, coverage begins on the first day of the month of the date of birth/placement. If birth/date of placement occurred on the 16th or after, child is automatically covered at no cost under Subscriber between date of birth/placement and the first of the following month. Coverage for the dependent begins on the first of the month following the birth/date of placement.	MEDICAL, CHIRO, VISION and **SMILESAVER** DENTAL Dependent eligibility: ■ Born to, a stepchild or legal ward of, or adopted by eligible employee, employee spouse or domestic partner ■ Under age 26 (unless disabled, disability diagnosed prior to age 26) **AMERITAS** DENTAL Dependent eligibility: ■ Born to, a stepchild or legal ward of, or adopted by eligible employee, employee spouse or domestic partner ■ Financially dependent upon the employee per IRS guidelines ■ Unmarried or not involved in a domestic partnership ■ Under age 26 (unless disabled, disability diagnosed prior to age 26) **Disabled Dependents:** Dependents who are incapable of self-support because of continuous mental or physical disability that existed before the age limit are eligible for coverage until the incapacity ends. Documentation of disability will be requested. Once the child reaches the age limit for coverage, verification of eligibility will occur annually at the child's birthday. **Dependents must meet all requirements listed in order to be eligible for enrollment**
Domestic Partner/ Child of Domestic Partner	During Initial Enrollment or Group's Annual Renewal: Coverage begins on group's effective date. Involuntary Loss of Other Coverage: Domestic Partner can be added outside of Renewal only if he/she loses other coverage involuntarily. Coverage is effective the first of following month. Mid-Year Addition: Mid-year additions of a domestic partner will require a state-stamped copy of the Certificate of Registration of Domestic Partnership from a state or local government agency authorized to perform such registrations within 30 days of issue or a signed affidavit for opposite sex and under age 62 domestic partnerships. If domestic partnership established before the 16th of the month, coverage begins on the first day of the month of the date of event. If domestic partnership established on the 16th of the month or after, coverage begins on the first of month following date of event.	For a Domestic Partner to qualify, Employee and Domestic Partner must: ■ Share a common residence ■ Neither is married under either statutory, common law or part of another domestic partnership ■ Both be 18 years of age or older ■ Share an intimate and committed relationship ■ Agree to be jointly responsible for each other's basic living expenses incurred during the domestic relationship ■ Both be mentally competent ■ Not related by blood to a degree of closeness that would prohibit marriage in this state ■ Agree to notify California*Choice*® immediately upon termination of domestic partnership Children of Domestic Partner must also meet the dependent children requirements listed above Members who are in a same sex partnership or are over the age of 62 are required to submit a state-stamped Certificate of Registration of Domestic Partnership from a state or local government agency authorized to perform such registrations within 30 days of issue; all others must submit a signed Affidavit of Domestic Partnership. **Employee and Domestic Partner must meet all requirements listed in order to be eligible for enrollment**

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