



PacifiCare Small Business Employee Enrollment and Declination of Coverage Form

.....

Welcome to PacifiCare.

.....

Note: All eligible employees must complete, sign and forward this form to PacifiCare, whether accepting or declining coverage.

If you have questions, or need assistance with this form, call your employer or one of our toll-free helplines at

1-800-624-8822 (HMO)

1-800-913-9133 (POS)

1-800-531-4294 (PPO/Indemnity)

PacifiCare[®]
of California

PacifiCare[®]
Life and Health Insurance Company



P.O. Box 6006, MS CY24-515
Cypress, CA 90630

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 <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire	<input type="checkbox"/> Transfer <input type="checkbox"/> Rehire	Date of Hire	Effective Date
Annual Salary	Occupation and Title	Life Class		Group Life/AD&D Amount	

YOU COMPLETE THIS SECTION – GROUP MEDICAL AND LIFE (Note: Must be completed even if declining coverage)

SELECTING YOUR PLAN (Check one)

Please note that you and your eligible dependents must enroll in the same health plan.

- HMO Plan POS Plan PPO Plan* Out-of-State Indemnity Plan*

* Underwritten by PacifiCare Life and Health Insurance Co.

SELECT A DOCTOR FOR YOU AND YOUR FAMILY (HMO and POS Plans only)

- Please select a doctor from the Provider Directory for you and each of your family members by writing the 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), or 1-800-913-9133 (POS).**

	Self	Last Name	Social Security Number	Primary Care Physician Name	PCP # - OR - Group #	Primary Care Physician (PCP) Number	Existing Patient?
1	Sex M or F	First Name	M.I. Date of Birth (Month - Day - Year)	Medical Group Name		Medical Group Number	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	Spouse	Last Name	Social Security Number	Primary Care Physician Name	PCP # - OR - Group #	Primary Care Physician (PCP) Number	Existing Patient?
	Sex M or F	First Name	M.I. Date of Birth (Month - Day - Year)	Medical Group Name		Medical Group Number	<input type="checkbox"/> Yes <input type="checkbox"/> No
3	Relationship	Last Name	Social Security Number	Primary Care Physician Name	PCP # - OR - Group #	Primary Care Physician (PCP) Number	Existing Patient?
	Sex M or F	First Name	M.I. Date of Birth (Month - Day - Year)	Medical Group Name		Medical Group Number	<input type="checkbox"/> Yes <input type="checkbox"/> No
4	Relationship	Last Name	Social Security Number	Primary Care Physician Name	PCP # - OR - Group #	Primary Care Physician (PCP) Number	Existing Patient?
	Sex M or F	First Name	M.I. Date of Birth (Month - Day - Year)	Medical Group Name		Medical Group Number	<input type="checkbox"/> Yes <input type="checkbox"/> No
5	Relationship	Last Name	Social Security Number	Primary Care Physician Name	PCP # - OR - Group #	Primary Care Physician (PCP) Number	Existing Patient?
	Sex M or F	First Name	M.I. Date of Birth (Month - Day - Year)	Medical Group Name		Medical Group Number	<input type="checkbox"/> Yes <input type="checkbox"/> No
6	Relationship	Last Name	Social Security Number	Primary Care Physician Name	PCP # - OR - Group #	Primary Care Physician (PCP) Number	Existing Patient?
	Sex M or F	First Name	M.I. Date of Birth (Month - Day - Year)	Medical Group Name		Medical Group Number	<input type="checkbox"/> Yes <input type="checkbox"/> No

Overage (19-25 years) dependents require proof of full-time student status or permanent disability status within 31 days of enrollment.

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, list qualifying event date:	
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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you or any of your dependents waived PacifiCare coverage in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Marital Status <input type="checkbox"/> Single with Domestic Partner <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed

GROUP LIFE INSURANCE (Only complete if your employer is offering group life through PacifiCare)

Last Name	First	M.I.	Date of Birth (Month - Day - Year)	Social Security Number
I wish coverage <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, I apply for coverage for <input type="checkbox"/> Self Only <input type="checkbox"/> Self and eligible dependents (Domestic partners are not eligible for Group Life Insurance)				
Life Insurance Beneficiary (Full name)			Relationship	

ARBITRATION DISCLOSURE

PacifiCare and PacifiCare Life and Health Insurance Company use binding arbitration to resolve disputes with Members, including, but not limited to, allegations against PacifiCare of medical malpractice. On behalf of myself and/or my Dependents, I understand and expressly agree that I am voluntarily giving up my constitutional right to have all such disputes decided in a court of law before a jury, and instead am accepting the use of binding arbitration for resolving disputes with PacifiCare and/or PacifiCare Life and Health Insurance Company. Differences between myself (and/or my Dependents) and any health care providers, including claims of medical malpractice, are not governed by the Subscriber Agreement or Policy.

SIGNATURE I have read, understand and agree to the terms and conditions on all the pages of this form. A reproduction of this authorization shall be as valid as the original.

X _____

Signature

Date

Employee
Social Security # _____

Source Code	Tracking #
-------------	------------

HEALTH CARE COORDINATION

To help us coordinate ongoing care, please answer the following questions regarding family members listed on this Enrollment Form.

1. Is anyone currently receiving ongoing medical care for a serious illness or condition? Yes No Name _____
2. Does anyone require medical care for a chronic illness or condition? Yes No Name _____

BENEFIT COORDINATION

1. Is anyone listed permanently disabled? Yes No Name _____ Date disability began ____ - ____ - ____
M - D - Y
2. Is anyone listed eligible for Medicare? Yes No Name _____
3. Does anyone listed have other health insurance? Yes No If yes, complete section below.

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

FOR EMPLOYER GROUPS WITH 2-15 ENROLLING EMPLOYEES, PLEASE COMPLETE INDIVIDUAL HEALTH STATEMENT APPLICATIONS

Please obtain a Health Statement Application from your employer and submit your completed Health Statement Application with your enrollment form.

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 PacifiCare Life and Health 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 enrollment in PacifiCare or PacifiCare Life and Health.
5. Coverage shall not begin until acceptance of this enrollment form by PacifiCare or PacifiCare Life and Health. Upon acceptance of this enrollment form, PacifiCare or PacifiCare Life and Health 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).

If I have applied for Group Life Insurance coverage as listed on the inside of this form:

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.

Complete the temporary Enrollment Identification Cards at right, and keep until you receive your permanent ID card.

ENROLLMENT IDENTIFICATION CARD

Name _____
Employer Name _____
Group Code _____
Doctor _____ Phone _____
 HMO POS PPO/Indemnity
1-800-624-8822 1-800-913-9133 1-800-531-4294

PacifiCare®
Life and Health Insurance Company

PacifiCare®
of California

ENROLLMENT IDENTIFICATION CARD

Name _____
Employer Name _____
Group Code _____
Doctor _____ Phone _____
 HMO POS PPO/Indemnity
1-800-624-8822 1-800-913-9133 1-800-531-4294

PacifiCare®
Life and Health Insurance Company

PacifiCare®
of California

Employee
Social Security # _____

Source Code	Tracking #
-------------	------------

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.

Contacting us:

PacifiCare of California	800-624-8822 (HMO)
5701 Katella Avenue	800-913-9133 (POS)
Cypress, California 90630-5028	800-531-4294 (PPO)
www.pacificare.com	800-442-8833 (TDHI)
	M-F, 8 a.m. to 8 p.m.

©2000 by PacifiCare Health Systems, Inc.
CM-1299-14729.25
PC7300-002 Rev. 3/00

ENROLLMENT IDENTIFICATION CARD

Additional People Covered

Name _____

Doctor _____ Phone _____

Name _____

Doctor _____ Phone _____

Name _____

Doctor _____ Phone _____

ENROLLMENT IDENTIFICATION CARD

Additional People Covered

Name _____

Doctor _____ Phone _____

Name _____

Doctor _____ Phone _____

Name _____

Doctor _____ Phone _____

Complete the temporary Enrollment Identification Cards at left, and keep until you receive your permanent ID card.