



ENROLLMENT FORM

■ Instructions

Section 1: Signature Required on Arbitration Disclosure

Please read this section carefully and provide your signature(s) as required.

Section 2: Personal Information

Please complete information requested.

Section 3: Selected Coverage

- Select only the plans offered by your Employer.
- For each plan your Employer offers, select the individual to be covered.

Section 4: Employee & Dependent Information

- List yourself and family members to be covered. You may attach additional sheets if necessary.
- Select a Primary Care Physician (PCP) from the *Provider Directory* for you and each of your family members by writing the PCP name and Provider number in the area provided. You may choose a different PCP for each member in your family.

PCP selection is only required if a PacifiCare SignatureValueSM (HMO) or PacifiCare SignaturePOSSM plan is selected. If you do not select a PCP when selecting one of these plans, a PCP will be automatically assigned to you.

- Verify that domestic partner coverage is available through your Employer.
- Over age Dependents require proof of full-time student status or permanent disability status within 31 days of enrollment.

Section 5: Benefit Coordination/Other Insurance Carrier Information

Please complete information requested, if applicable.

■ Employee Signature

You can either:

Accept the health care services coverage provided through your Employer by signing the space provided

on the enrollment form. Your signature indicates that you have read, understand and agree to the terms and conditions below. Affixing your signature also indicates your acceptance of payroll deductions (if necessary) to pay your share of the cost.

OR

You can waive the health care services coverage provided through your Employer for yourself, your spouse or your Dependents by signing the DECLINATION OF COVERAGE FORM. We strongly recommend that you read through the entire form carefully before signing your name in ink and dating it. Please request the Declination of Coverage Form from your Employer.

■ Terms and Conditions – Please read carefully before signing

On behalf of myself and my eligible Dependents, I hereby apply for health care services coverage indicated in PacifiCare's Group Health Plan 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 PacifiCare SignatureValueSM (HMO), PacifiCare SignatureValueSM Direct (Open Access), PacifiCare SignaturePOSSM (POS), PacifiCare SignatureOptionsSM (PPO), PacifiCare SignatureOptionsSM (HDHP), PacifiCare SignatureFreedomSM (SDHP) or PacifiCare SignatureIndependenceSM (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 may access and/or use my medical records and the medical records of my enrolled 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 or other purposes reasonably related to the performance of treatment, payment, or health care operations 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 Dependents' membership in the insurance policy with PacifiCare.
- 5. Coverage shall not begin until acceptance of this enrollment by PacifiCare. Upon acceptance of this application, 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 Disclosure Form, Directory of Participating Medical

Groups and a copy of this Enrollment Form.

- 7. My Dependents and I must reside in Arizona and live or work in PacifiCare's service area if enrolling in the PacifiCare SignatureValue or PacifiCare SignaturePOS plan.
- 8. If my Dependents or I elect PacifiCare SignatureValue or PacifiCare SignaturePOS, we will select a Primary Care Physician within a 30-mile radius of our Primary Residence or Primary Workplace.

EMPLOYEE ENROLLMENT FORM (Please Print)

ARIZONA

1. Binding Arbitration

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.

UNDER THE TERMS OF YOUR COVERAGE AND ARIZONA LAW, YOU HAVE THE RIGHT TO APPEAL DECISIONS OF YOUR HEALTH CARE PLAN. YOUR APPEAL RIGHTS ARE SET FORTH IN YOUR ENROLLMENT PACKET UNDER THE TITLE HEALTH CARE INSURER APPEALS PROCESS INFORMATION PACKET. YOU ALWAYS HAVE THE RIGHT TO PURSUE AN APPEAL. NOTHING IN THE BINDING ARBITRATION PROVISION INTERFERES WITH THOSE RIGHTS. THE BINDING ARBITRATION PROVISION ONLY APPLIES AFTER YOU AND PACIFICARE HAVE EXHAUSTED ALL THE ADMINISTRATIVE PROCESSES AVAILABLE TO YOU THROUGH THE APPEALS PROCESS AND THE ISSUE HAS NOT BEEN RESOLVED TO YOUR SATISFACTION. THE BINDING ARBITRATION PROVISION ALSO APPLIES TO ISSUES THAT ARE NOT SUBJECT TO THE APPEALS PROCESS. THE TYPES OF MATTERS THAT ARE SUBJECT TO THE APPEALS PROCESS ARE OUTLINED FOR YOU IN THE HEALTH CARE INSURER APPEALS PROCESS INFORMATION PACKET.

BINDING ARBITRATION APPLIES TO ANY AND ALL DISPUTES OF ANY KIND WHATSOEVER WHERE:

- 1. THE ISSUE IS NOT OF A TYPE SUBJECT TO THE ARIZONA APPEALS PROCESS AS OUTLINED IN THE HEALTH CARE INSURER APPEALS PROCESS INFORMATION PACKET; AND
- 2. ISSUES THAT HAVE GONE THROUGH THE APPEALS PROCESS BUT WITH WHICH YOU CONTINUE TO BE DISSATISFIED WITH THE FINAL DETERMINATION AFTER EXHAUSTION OF ALL APPEAL RIGHTS INCLUDING SUBMISSION TO THE OFFICE OF ADMINISTRATIVE HEARINGS (OAH) AND FOR WHICH YOU WOULD OTHERWISE FILE A LAWSUIT AFTER RECEIVING THE DETERMINATION OF THE OAH.

THIS INCLUDES CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE HEALTH 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, NEGLIGENT, OR INCOMPETENTLY RENDERED), EXCEPT FOR DISPUTES OVER BENEFIT DENIALS SUBJECT TO ERISA, BETWEEN MEMBER (INCLUDING ANY HEIRS, SUCCESSORS OR ASSIGNS OF MEMBER) AND PACIFICARE OF ARIZONA, INC. OR ANY OF ITS PARENTS, SUBSIDIARIES OR AFFILIATES (COLLECTIVELY, "PACIFICARE ENTITIES"). MEMBER UNDERSTANDS AND AGREES THAT THESE ISSUES AND DISPUTES SHALL BE SUBMITTED 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 ARE GIVING UP THEIR CONSTITUTIONAL RIGHTS 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)	
Name (please print)	Group #	Social Security #	

2. Personal Information (Please print on all sections of form)					
Company Name			Date of Hire		
Last Name		First Name		MI	Suffix
Residence Mailing Address				City	
State	ZIP	Home Telephone () ()		Work Telephone () ()	
Date of Birth (mm-dd-yy)		Social Security #		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Widow <input type="checkbox"/> Married <input type="checkbox"/> Divorced	
Are you currently on COBRA? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, qualifying event:				COBRA Qualifying Event Effective Date	
Preferred Language (optional): <input type="checkbox"/> English <input type="checkbox"/> Spanish					
Ethnicity (optional): <input type="checkbox"/> Caucasian <input type="checkbox"/> Black or African-American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Asian, Native Hawaiian, other Pacific Islander <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Not provided by member					

Employer Required to Complete This Section	
Group #/Plan Code	
Source of Enrollment:	<input type="checkbox"/> QMCSO <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Employee Status Change <input type="checkbox"/> New Hire <input type="checkbox"/> Rehire
Requested Effective Date	
Employer Verification/Signature	
Employee Class	

3. Selected Coverage (Select only the plans offered by your Employer)	
Medical Plan Options:	<input type="checkbox"/> PacifiCare SignatureValue (HMO) <input type="checkbox"/> High <input type="checkbox"/> Low <input type="checkbox"/> PacifiCare SignatureOptions (HDHP) (HSA-Compatible) <input type="checkbox"/> PacifiCare SignatureValue Direct (Open Access) <input type="checkbox"/> PacifiCare SignatureFreedom (SDHP) <input type="checkbox"/> PacifiCare SignaturePOS <input type="checkbox"/> PacifiCare SignatureIndependence (Indemnity) <input type="checkbox"/> PacifiCare SignatureOptions (PPO) <input type="checkbox"/> High <input type="checkbox"/> Low
Individual(s) to be covered:	<input type="checkbox"/> Self <input type="checkbox"/> Self + Spouse <input type="checkbox"/> Self + Dependent(s) <input type="checkbox"/> Self + Family <input type="checkbox"/> Waive Medical (Complete Waiver Form)

4. Employee & Dependent Information (List yourself and family members to be covered – attach additional sheets if necessary)					
Self		Primary Care Physician (PCP) Name		Provider #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse/ Domestic Partner		<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name	First Name	M.I.
Date of Birth (mm-dd-yy)		Social Security #		Address, if different than Employee's	
Primary Care Physician (PCP) Name			Provider #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent 1		<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name	First Name	M.I. Date of Birth (mm-dd-yy)
Relationship		Social Security #		Address, if different than Employee's	
Primary Care Physician (PCP) Name			Provider #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent 2		<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name	First Name	M.I. Date of Birth (mm-dd-yy)
Relationship		Social Security #		Address, if different than Employee's	
Primary Care Physician (PCP) Name			Provider #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent 3		<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name	First Name	M.I. Date of Birth (mm-dd-yy)
Relationship		Social Security #		Address, if different than Employee's	
Primary Care Physician (PCP) Name			Provider #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent 4		<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name	First Name	M.I. Date of Birth (mm-dd-yy)
Relationship		Social Security #		Address, if different than Employee's	
Primary Care Physician (PCP) Name			Provider #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

5. Benefit Coordination/Other Insurance Carrier Information				
■ Does anyone listed have other health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete boxes a–e:				
a. Name	b. Insurance Company Name	c. Policy #	d. Effective Date	e. Other Employer Name and Address
■ Is anyone listed eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete boxes f + g:				
f. Name		g. Medicare ID#		

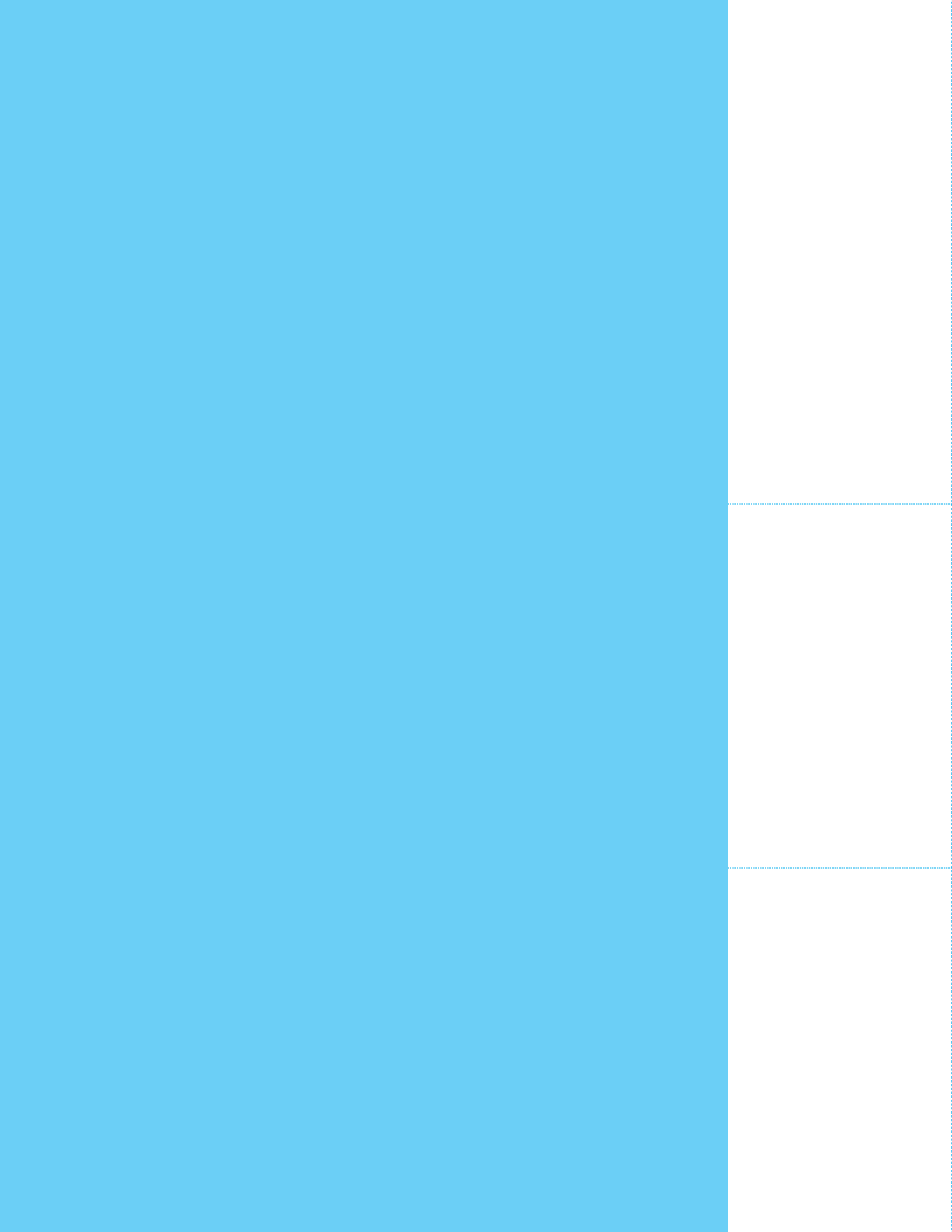
PacifiCare® Enrollment Identification Card

Name	
Employer Name	Group Code
Doctor	Phone
<input type="checkbox"/> PacifiCare Signature/Value (HMO)/ PacifiCare Signature/Value Direct (HMO) 1-800-347-8600	<input type="checkbox"/> PacifiCare SignatureOptions (PPO)*/ PacifiCare SignatureOptions (HDHP)/ PacifiCare SignatureIndependence (Indemnity)* 1-866-316-9776
<input type="checkbox"/> PacifiCare SignaturePOS (POS) 1-800-347-8600	<input type="checkbox"/> PacifiCare SignatureFreedom (SDHP)* 1-866-867-0700
Coverage shall not begin until acceptance of your enrollment by PacifiCare of Arizona, Inc. or PacifiCare Life Assurance Co. Upon acceptance of your enrollment, PacifiCare of Arizona, Inc. or PacifiCare Life Assurance Co. shall be bound by the terms of the Agreement or Policy and any Amendments thereto.	
* Underwritten by PacifiCare Life Assurance Company	

PacifiCare® Enrollment Identification Card

Name	
Employer Name	Group Code
Doctor	Phone
<input type="checkbox"/> PacifiCare Signature/Value (HMO)/ PacifiCare Signature/Value Direct (HMO) 1-800-347-8600	<input type="checkbox"/> PacifiCare SignatureOptions (PPO)*/ PacifiCare SignatureOptions (HDHP)/ PacifiCare SignatureIndependence (Indemnity)* 1-866-316-9776
<input type="checkbox"/> PacifiCare SignaturePOS (POS) 1-800-347-8600	<input type="checkbox"/> PacifiCare SignatureFreedom (SDHP)* 1-866-867-0700
Coverage shall not begin until acceptance of your enrollment by PacifiCare of Arizona, Inc. or PacifiCare Life Assurance Co. Upon acceptance of your enrollment, PacifiCare of Arizona, Inc. or PacifiCare Life Assurance Co. shall be bound by the terms of the Agreement or Policy and any Amendments thereto.	
* Underwritten by PacifiCare Life Assurance Company	

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



**PacifiCare SignatureValue (HMO)
and PacifiCare SignatureValue Direct (HMO Open Access)**

4601 E. Hilton Ave.
Phoenix, AZ 85034
1-800-347-8600
1-800-360-1797 (TTY)

PacifiCare SignaturePOS

4601 E. Hilton Ave.
Phoenix, AZ 85034
1-800-347-8600
1-800-360-1797 (TTY)

**PacifiCare SignatureOptions (PPO), PacifiCare
SignatureOptions (HDHP) and PacifiCare
SignatureIndependence (Indemnity)**

P.O. Box 6098
Cypress, CA 90630
1-866-316-9776
1-866-816-2018 (TDHI)
(714) 226-5622 (Fax)

PacifiCare SignatureFreedom (SDHP)

PacifiCare Health Plan Administrators
P.O. Box 63912
Harrisburg, PA 17106
1-866-867-0700
1-866-867-0701 (TDHI)
(714) 226-5622 (Fax)

Visit our Web site @ www.pacificare.com

PacifiCare products and services are offered by one or more of the following PacifiCare family of companies: Health plan products and services are offered by PacifiCare of Arizona, Inc. Indemnity insurance products offered in Arizona are underwritten by PacifiCare Life Assurance Company. Other products and services are offered by PacifiCare Health Plan Administrators, Inc., RxSolutions, Inc., and PacifiCare Behavioral Health, Inc. PacifiCare® is a federally registered trademark of PacifiCare Life and Health Insurance Company.