

# Enrollment Form

## Instructions

### Section 1: Personal Information

Please complete information requested.

### Section 2: Selected Coverage

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

### Section 3: 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 SignatureValue® (HMO) or PacifiCare SignaturePOS® 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 spousal and 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.
- Dentist and Dental Provider Group Number selection is also required if you choose a PacifiCare SignatureValue (HMO) plan.

### Section 4: Benefit Coordination/Other Insurance Carrier Information

Please complete information requested, if applicable.

### Section 5: Signature Required on Arbitration Disclosure

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

### 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 SignatureValue® (HMO), PacifiCare SignaturePOS® (POS), PacifiCare SignatureElite<sup>SM</sup> (PPO), PacifiCare SignatureFreedom® (SDHP) or PacifiCare SignatureIndependence® (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, billing, payment or health care operations of the Agreement or Policy.
4. Any intentional, incomplete or incorrect 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 California 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.

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**PacifiCare SignatureValue (HMO) and PacifiCare SignatureValue Advantage (HMO Value Network)**

P.O. Box 30981  
Salt Lake City, UT 84130  
1-800-624-8822  
1-800-442-8833 (TDHI)  
1-866-372-1316 (Fax)

**PacifiCare SignaturePOS**

P.O. Box 30981  
Salt Lake City, UT 84130  
1-800-913-9133  
1-800-442-8833 (TDHI)  
1-866-372-1316 (Fax)

**PacifiCare SignatureElite (PPO), and PacifiCare SignatureIndependence (Indemnity)**

P.O. Box 30981  
Salt Lake City, UT 84130  
1-866-316-9776  
1-866-816-2018 (TDHI)  
1-866-372-1316 (Fax)

**PacifiCare SignatureFreedom (SDHP)**

PacifiCare Health Plan Administrators, Inc.  
P.O. Box 30981  
Salt Lake City, UT 84130  
1-866-867-0700  
1-866-867-0701 (TDHI)  
1-866-372-1316 (Fax)

**PacifiCare Dental and Vision Administrators**

P.O. Box 25187  
Santa Ana, CA 92799  
1-800-228-3384

Visit our Web site @  
[www.pacificare.com](http://www.pacificare.com)

Insurance coverage provided by or through United HealthCare Insurance Company, underwritten by PacifiCare Life and Health Insurance Company or their affiliates. Health plan products and services are offered by PacifiCare of California; PacifiCare Behavioral Health of California, Inc. Administrative services provided by United HealthCare Insurance Company, United HealthCare Services, Inc., PacifiCare Health Plan Administrators, Inc. or their affiliates. PacifiCare® is a federally registered trademark of PacifiCare Life and Health Insurance Company.

# Employee Enrollment Form (Please Print)

California

1. Personal Information					
Company Name			Date of Hire		
Last Name	First Name	M.I.	Suffix	<input type="checkbox"/> Male	<input type="checkbox"/> Female
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 <input type="checkbox"/> Domestic Partner			
Are you currently on COBRA? <input type="checkbox"/> Yes <input type="checkbox"/> No		COBRA Qualifying Event			
If yes, qualifying event:		Effective Date			
Preferred Language (optional) <input type="checkbox"/> English <input type="checkbox"/> Spanish					
Ethnicity (optional) <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Caucasian <input type="checkbox"/> Asian, Native Hawaiian, other Pacific Islander <input type="checkbox"/> Not provided by member <input type="checkbox"/> American Indian or Alaskan Native					

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

2. Selected Coverage (Select only the plans offered by your Employer)		
<p><b>Medical Plan Options:</b></p> <input type="checkbox"/> PacifiCare SignatureValue (HMO) <input type="checkbox"/> High <input type="checkbox"/> Low <input type="checkbox"/> PacifiCare SignatureValue Advantage (HMO) <input type="checkbox"/> PacifiCare SignatureValue Advantage PlanBien <sup>SM</sup> <input type="checkbox"/> PacifiCare SignatureElite (PPO) <input type="checkbox"/> High <input type="checkbox"/> Low <input type="checkbox"/> PacifiCare SignatureElite (PPO) (HSA- Compatible) <input type="checkbox"/> PacifiCare SignaturePOS <input type="checkbox"/> PacifiCare SignatureIndependence (Indemnity) <input type="checkbox"/> PacifiCare SignatureFreedom (SDHP) <input type="checkbox"/> PacifiCare SignatureValue Access (EPO) <p><b>Individual(s) to be covered:</b></p> <input type="checkbox"/> Self <input type="checkbox"/> Self + Spouse/Domestic Partner <input type="checkbox"/> Self + Dependent(s) <input type="checkbox"/> Self + Family <input type="checkbox"/> Waive Medical (Complete Waiver Form)	<p><b>Dental Plan Options:</b></p> <input type="checkbox"/> PacifiCare SignatureValue (Dental HMO) <input type="checkbox"/> PacifiCare SignatureOptions (Dental PPO) <input type="checkbox"/> PacifiCare SignatureIndependence (Dental Indemnity) <p><b>Individual(s) to be covered:</b></p> <input type="checkbox"/> Self <input type="checkbox"/> Self + Spouse/Domestic Partner <input type="checkbox"/> Self + Dependent(s) <input type="checkbox"/> Self + Family <input type="checkbox"/> Waive Dental (Complete Waiver Form)	<p><b>Vision Plan Options:</b></p> <input type="checkbox"/> PacifiCare SignatureOptions (Vision PPO – Full Service) <input type="checkbox"/> PacifiCare SignatureOptions (Vision PPO – Eyewear Only) <p><b>Individual(s) to be covered:</b></p> <input type="checkbox"/> Self <input type="checkbox"/> Self + Spouse <input type="checkbox"/> Self + Dependent(s) <input type="checkbox"/> Self + Family <input type="checkbox"/> Waive Vision (Complete Waiver Form)

3. Employee and Dependent Information (List yourself and family members to be covered – attach additional sheets if necessary)					
<b>Self</b>	Primary Care Physician (PCP) Name			Provider #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dentist Name & City				Dental Provider Group #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Spouse/ Domestic Partner*</b>	<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 from Employee's		
Primary Care Physician (PCP) Name				Provider #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dentist Name & City				Dental Provider Group #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Dependent 1</b>	<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 from Employee's		
Primary Care Physician (PCP) Name				Provider #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dentist Name & City				Dental Provider Group #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

Detach here

**3. Employee and Dependent Information** (List yourself and family members to be covered – attach additional sheets if necessary)

<b>Dependent 2</b>	<input type="checkbox"/> Male	Last Name	First Name	M.I.	Date of Birth (mm-dd-yy)
	<input type="checkbox"/> Female				
Relationship		Social Security #	Address, if different from Employee's		
Primary Care Physician (PCP) Name				Provider #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dentist Name & City				Dental Provider Group #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Dependent 3</b>	<input type="checkbox"/> Male	Last Name	First Name	M.I.	Date of Birth (mm-dd-yy)
	<input type="checkbox"/> Female				
Relationship		Social Security #	Address, if different from Employee's		
Primary Care Physician (PCP) Name				Provider #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dentist Name & City				Dental Provider Group #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

**4. Benefit Coordination/Other Insurance Carrier Information**

Does anyone listed have other health insurance?  Yes  No If yes, complete section boxes a–j:

a. Name	b. Insurance Company Name	c. Policy #	d. Effective Date	e. Other Employer Name and Address
f. Name	g. Insurance Company Name	h. Policy #	i. Effective Date	j. Other Employer Name and Address

Is anyone listed eligible for Medicare?  Yes  No If yes, complete section boxes k+l

k. Name	l. Medicare ID#
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Does anyone listed have other dental insurance?  Yes  No If yes, complete section boxes m–p

m. Name	n. Insurance Company Name	o. Policy #	p. Effective Date
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**5. Signature Required on Arbitration Disclosure – Read Carefully**

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. I DESIRE TO PARTICIPATE IN THE COVERAGES SELECTED ABOVE AND HEREBY AUTHORIZE MY EMPLOYER TO MAKE THE NECESSARY DEDUCTION(S) FROM MY WAGE/SALARY TO PAY MY PORTION OF THE PREMIUM.**

Signature (Required)	Date (Required)
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**II. ARBITRATION DISCLOSURE: 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)
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# Enrollment Identification Card



PacifiCare

Name \_\_\_\_\_

Employer Name \_\_\_\_\_ Group Code \_\_\_\_\_

Doctor \_\_\_\_\_ Phone \_\_\_\_\_

- PacifiCare SignatureValue (HMO) /  PacifiCare SignatureElite (PPO)\* / PacifiCare SignatureIndependence (Indemnity)\* 1-866-316-9776 (HMO) 1-800-624-8822
- PacifiCare SignaturePOS (POS) 1-800-913-9133

Coverage shall not begin until acceptance of your enrollment by PacifiCare or PacifiCare Life and Health Insurance Co. Upon acceptance of your enrollment, PacifiCare or PacifiCare Life and Health Insurance Co. shall be bound by the terms of the Agreement or Policy and any Amendments thereto.

\* Underwritten by PacifiCare Life and Health Insurance Company

# Enrollment Identification Card



PacifiCare

Name \_\_\_\_\_

Employer Name \_\_\_\_\_ Group Code \_\_\_\_\_

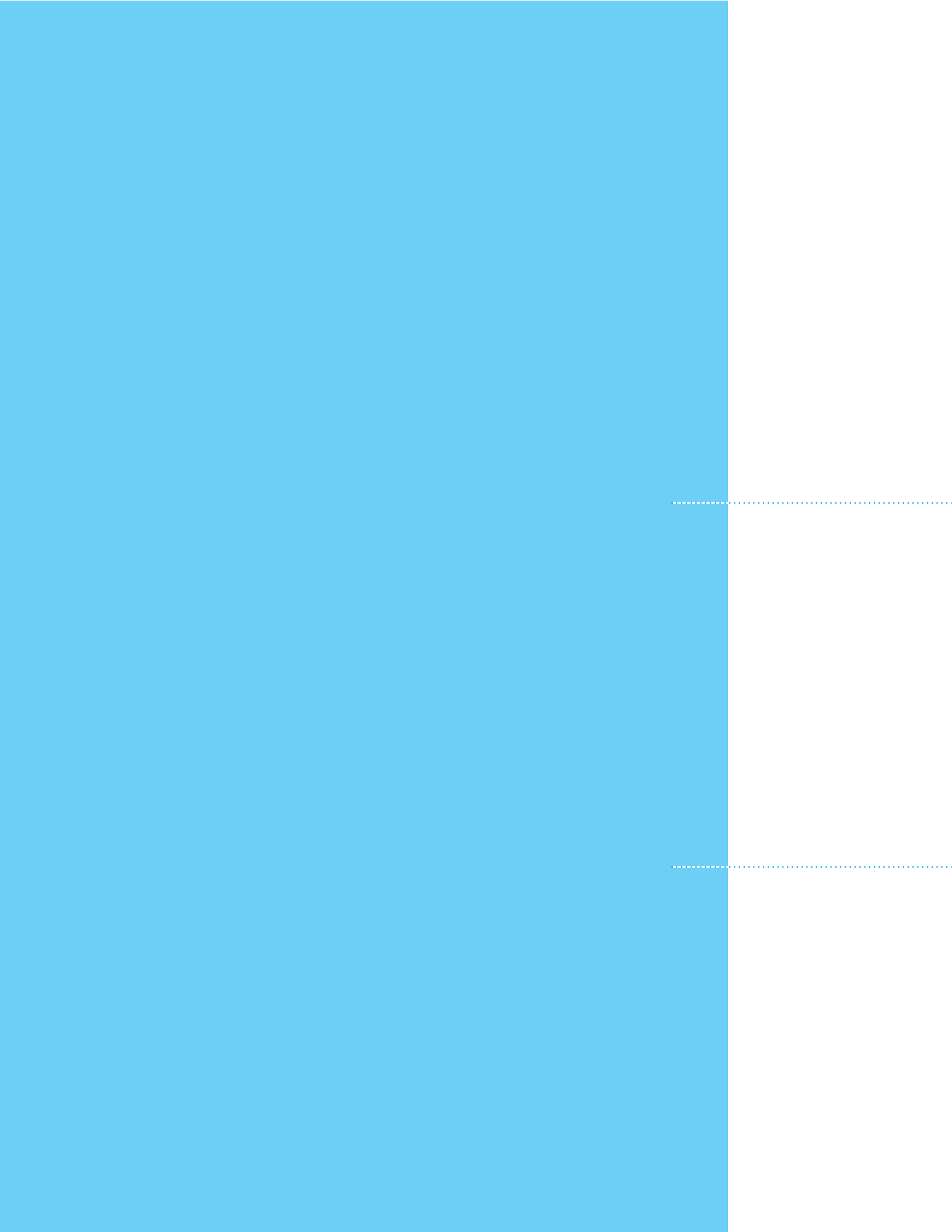
Doctor \_\_\_\_\_ Phone \_\_\_\_\_

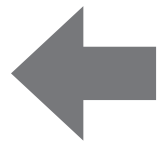
- PacifiCare SignatureValue (HMO) /  PacifiCare SignatureElite (PPO)\* / PacifiCare SignatureIndependence (Indemnity)\* 1-866-316-9776 (HMO) 1-800-624-8822
- PacifiCare SignaturePOS (POS) 1-800-913-9133

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\* Underwritten by PacifiCare Life and Health Insurance Company

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





Please open  
to complete this form

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