



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 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 4: 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 SignaturePOSSM (POS), PacifiCare SignatureOptionsSM (PPO), 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 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.

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

P.O. Box 6006
Cypress, CA 90630
1-800-624-8822
1-800-442-8833 (TDHI)
(714) 226-5622 (Fax)

PacifiCare SignaturePOS

P.O. Box 6019
Cypress, CA 90630
1-800-913-9133
1-800-442-8833 (TDHI)
(714) 226-5622 (Fax)

**PacifiCare SignatureOptions (PPO) 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 California; PacifiCare Behavioral Health of California, Inc.; and PacifiCare Dental (in California). Indemnity insurance products (including PPO products) offered in California are underwritten by PacifiCare Life and Health Insurance 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.

Employee Enrollment Form (Please Print)

CALIFORNIA

1. Personal Information (Please print on all sections of form)

Company Name		Date of Hire			
Last Name	First Name	MI	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"/> Widowed <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 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 employee					

Employer Required to Complete This Section

Group #/Plan Code	
Source of Enrollment: <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire	<input type="checkbox"/> QMCSO <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)

Medical Plan Options: PacifiCare SignatureValue (HMO) High Low PacifiCare SignatureValue Access (EPO) PacifiCare SignatureValue Advantage
 PacifiCare SignatureOptions (PPO) (HSA-Compatible) PacifiCare SignatureOptions (PPO) High Low
 PacifiCare SignatureIndependence (Indemnity) PacifiCare SignatureFreedom (SDHP) PacifiCare SignaturePOS

Individual(s) to be covered: Self Self + Spouse/Domestic Partner Self + Dependent(s) Self + Family Waive Medical (Complete Waiver Form)

3. 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	

4. Benefit Coordination/Other Insurance Carrier Information

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

a. Name	b. Insurance Company Name	c. Policy #	d. Effective Date	e. Other Employer Name and Address
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■ Is anyone listed eligible for Medicare? Yes No If yes, complete boxes f + g:

f. Name	g. Medicare ID#
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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.

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) X	Date (Required)
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PacifiCare® Enrollment Identification Card

Name	Employer Name	Group Code
Doctor	Phone	
<input type="checkbox"/> PacifiCare SignatureValue (HMO)/ PacifiCare SignatureValue - Advantage (HMO) 1-800-624-8822	<input type="checkbox"/> PacifiCare SignatureOptions (PPO)*/ PacifiCare SignatureIndependence (Indemnity)* 1-866-316-9776	
<input type="checkbox"/> PacifiCare SignaturePOS (POS) 1-800-913-9133	<input type="checkbox"/> PacifiCare SignatureFreedom (SDHP)* 1-866-867-0700	

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

PacifiCare® Enrollment Identification Card

Name	Employer Name	Group Code
Doctor	Phone	
<input type="checkbox"/> PacifiCare SignatureValue (HMO)/ PacifiCare SignatureValue - Advantage (HMO) 1-800-624-8822	<input type="checkbox"/> PacifiCare SignatureOptions (PPO)*/ PacifiCare SignatureIndependence (Indemnity)* 1-866-316-9776	
<input type="checkbox"/> PacifiCare SignaturePOS (POS) 1-800-913-9133	<input type="checkbox"/> PacifiCare SignatureFreedom (SDHP)* 1-866-867-0700	

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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.



