

IMPORTANT: PLEASE RETAIN THIS INSTRUCTION SHEET FOR YOUR RECORDS

EMPLOYEE SIGNATURE

You can either:

Accept the health insurance coverage provided through your employer by signing on the space provided on the bottom of 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 insurance 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 secure the Declination of Coverage form from your employer.

TEMPORARY ID CARD

This cover sheet will serve as your temporary identification. It is valid for 30 days from the effective date of coverage. Please keep it with you and present it each time you require services. You will be personally responsible for the cost of services if you are not eligible or the services are not covered. If you do not receive your permanent ID card within 30 days after you become eligible, please call us at the appropriate number listed below.

TERMS AND CONDITIONS. PLEASE READ CAREFULLY BEFORE SIGNING.

On behalf of myself and my eligible dependents, I hereby apply for medical coverage that I have indicated above in PacifiCare of California's ("PacifiCare") Group Health Plan or PacifiCare Life and Health Insurance Company ("PacifiCare Life") 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 Master Group Policy ("Policy") if I have chosen the PPO or Indemnity plan.
2. My employer may deduct from my earnings the employee contribution required to cover my share of the premium, if any.
3. Any differences between myself and/or my dependents and PacifiCare relating to PacifiCare of California or its performance are subject to binding arbitration. Differences between myself and/or my dependents and any health care providers, including claims of medical malpractice are not governed by the Agreement or Policy.
4. PacifiCare or PacifiCare Life or a designee shall have access to and use of 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 purposes reasonably related to the performance of the Agreement or Policy.
5. 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 membership or grounds for rescission of the insurance policy with PacifiCare or PacifiCare Life.
6. Coverage shall not begin until acceptance of this enrollment by PacifiCare or PacifiCare Life. Upon acceptance of this application, PacifiCare or PacifiCare Life shall be bound by the terms of the Agreement or Policy, and any Amendments thereto.
7. I have received, read and understand the PacifiCare Disclosure Form, Directory of Participating Medical Groups and a copy of this Enrollment Form.
8. You and your dependents must live in our service area if enrolling in PacifiCare's HMO or POS plans.

PacifiCare®

PacifiCare®
Life and Health Insurance Company

5701 Katella Avenue
P.O. Box 6006
Cypress, California 90630
www.pacificare.com

P.O. Box 6098
Cypress, CA 90630
866-316-9776 (PPO)
866-816-2018 (TDHI)

800-624-8822 (HMO)
800-913-9133 (POS)
800-442-8833 (TDHI)

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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 1-866-316-9776

PacifiCare®

PacifiCare®
Life and Health Insurance Company

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.

ENROLLMENT IDENTIFICATION CARD

Name _____
Employer Name _____
Group Code _____
Doctor _____ Phone _____
 HMO POS PPO/Indemnity
1-800-624-8822 1-800-913-9133 1-866-316-9776

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P.O. Box 6006, MS CY24-515
Cypress, CA 90630
Fax Numbers (HMO/POS):
Incoming: (714) 226-5947
Imaging: (714) 226-5622

P.O. Box 6098
Cypress, CA 90630
Fax Number (PPO/Ind):
Incoming: (714) 226-5002

IMPORTANT: PLEASE COMPLETE ALL SECTIONS This form cannot be processed if information is incomplete.

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	Employer Verification
Annual Salary	Occupation and Title	Life Class		Group Life/AD&D Amount		

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* Indemnity Plan* Life* *Underwritten by PacifiCare Life and Health Insurance Co.

LIST YOURSELF AND FAMILY MEMBERS TO BE COVERED (Select a Doctor if electing HMO or POS)

- 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)**, **1-800-913-9133 (POS)** or **1-866-316-9776 (PPO/IND)**.

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

Over age dependents require proof of full-time student status or permanent disability status within 31 days of enrollment.

PERSONAL INFORMATION

Employee ID Number	Division/Location (If Applicable)	Are you currently on COBRA? If yes, qualifying event and date: - - -
Residence Mailing Address (Number, Street, Apartment)	City	State Zip
Home Telephone () ()	Work Telephone () ()	Have you or any of your dependents ever been a PacifiCare member? <input type="checkbox"/> Yes <input type="checkbox"/> No Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed

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 _____

3. Is anyone listed permanently disabled? Yes No Name _____ Date disability began _____ - _____ - _____

If you have answered "Yes" to questions 1-3 above, please explain. Diagnosis _____ Current Condition _____

4. Is anyone listed eligible for Medicare? Yes No Name _____

5. 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

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	

Signature required on Arbitration Disclosure.

ARBITRATION DISCLOSURE

I agree and understand that any and all disputes, 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 claims subject to ERISA, between myself and PacifiCare of California, PacifiCare Dental or PacifiCare Life and Health Insurance Company, 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 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 I have read, understand and agree to the terms and conditions on all pages of this form. A reproduction of this authorization shall be valid as the original.

X _____
Signature (Required) Date