

# ENROLLMENT FORM INSTRUCTIONS

**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 PacifiCare SignatureValue<sup>SM</sup> (HMO) or PacifiCare SignaturePOS<sup>SM</sup> (POS) plan, or the PacifiCare Life Master Group Policy (“Policy”) if I have chosen the PacifiCare SignatureOptions<sup>SM</sup> (PPO), PacifiCare Signature Independence<sup>SM</sup> (Indemnity) or PacifiCare SignatureFreedom<sup>SM</sup> (SDHP) 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 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 of

diagnosis and treatment of the patient, billing, claims management, medical data processing and administrative 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 Dependent’s membership in the insurance policy with PacifiCare or PacifiCare Life.
5. 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.
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 plans.
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<sup>SM</sup> (HMO) and PacifiCare SignaturePOS<sup>SM</sup> (POS)**

P.O. Box 6006  
Cypress, CA 90630  
[www.pacificare.com](http://www.pacificare.com)  
800-624-8822 – HMO  
800-913-9133 – POS  
800-442-8833 – TDHI

**PacifiCare SignatureOptions<sup>SM</sup> (PPO), PacifiCare SignatureIndependence<sup>SM</sup> (Indemnity) and PacifiCare SignatureFreedom<sup>SM</sup> (SDHP)**

P.O. Box 6098  
Cypress, CA 90630  
[www.pacificare.com](http://www.pacificare.com)  
866-316-9776 – PPO/Indemnity  
866-816-2018 – TDHI  
866-867-0700 – SDHP  
866-867-0701 – TDHI

©2003 by PacifiCare Health Systems, Inc.  
CM-503-45482.50  
PC3316-004 Rev. 5/03



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

**PacifiCare<sup>®</sup> Enrollment Identification Card**

Name \_\_\_\_\_

Employer Name \_\_\_\_\_

Group Code \_\_\_\_\_

Doctor _____	Phone _____
--------------	-------------

PacifiCare SignatureValue (HMO) 1-800-624-8822

PacifiCare SignatureOptions (PPO)\* 1-866-316-9776

PacifiCare SignaturePOS (POS) 1-800-913-9133

PacifiCare SignatureIndependence (Indemnity)\* 1-866-316-9776

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<sup>®</sup> Enrollment Identification Card**

Name \_\_\_\_\_

Employer Name \_\_\_\_\_

Group Code \_\_\_\_\_

Doctor _____	Phone _____
--------------	-------------

PacifiCare SignatureValue (HMO) 1-800-624-8822

PacifiCare SignatureOptions (PPO)\* 1-866-316-9776

PacifiCare SignaturePOS (POS) 1-800-913-9133

PacifiCare SignatureIndependence (Indemnity)\* 1-866-316-9776

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

# ENROLLMENT FORM

Medical and Hospital Group Subscriber Agreement  
PacifiCare Life and Health Insurance  
Company Master Group Policy

**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	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.

- PacifiCare SignatureValue (HMO)    PacifiCare SignaturePOS (POS)    PacifiCare SignatureOptions (PPO)\*    Life\*\* – Self only  
 PacifiCare SignatureIndependence (Indemnity)\*    PacifiCare SignatureFreedom (SDHP)\*    Life\*\* – Self and eligible Dependents

### List Yourself and Family Members to be Covered – Attach additional sheets if necessary

(Select a Doctor if electing PacifiCare SignatureValue or PacifiCare SignaturePOS)

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), 1-866-316-9776 (PPO/IND) or 1-866-867-0700 (SDHP).**

	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

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.

- Is anyone listed permanently disabled?      Yes      No     Name \_\_\_\_\_ Date disability began \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
If "Yes", please explain: Diagnosis \_\_\_\_\_ Current Condition \_\_\_\_\_
- Is anyone listed eligible for Medicare?      Yes      No     Name \_\_\_\_\_
- Does anyone listed have other health insurance?      Yes      No     If yes, complete section below.

Name	Insurance Company Name	Policy # and Effective Date	Other Employer Name and Address

### Arbitration Disclosure – SIGNATURE REQUIRED

**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** 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

**PacifiCare SignatureValue<sup>SM</sup> (HMO) and PacifiCare SignaturePOS<sup>SM</sup> (POS)**  
P.O. Box 6006, MS CY24-515  
Cypress, CA 90630  
Fax numbers:  
(714) 226-5947 – Incoming  
(714) 226-5622 – Imaging

**PacifiCare SignatureOptions<sup>SM</sup> (PPO)\*, PacifiCare SignatureIndependence<sup>SM</sup> (Indemnity)\* and PacifiCare SignatureFreedom<sup>SM</sup> (SDHP)\***  
P.O. Box 6098  
Cypress, CA 90630  
Fax Number:  
(714) 226-5002 – PPO/Indemnity Incoming

**\* Underwritten by PacifiCare Life and Health Insurance Company**

**\*\* Life coverage is underwritten by Continental Assurance Company or CNA Group Life Assurance Company**