

## APPLICATION FOR SMALL GROUP COVERAGE

APPLICATION is hereby made to PACIFICARE of ARIZONA and/or PACIFICARE LIFE ASSURANCE COMPANY (Herein called "the Company") for group coverage based upon the following statements and representations:

**1. Coverage Requested**

- PacifiCare SignatureValue<sup>SM</sup> (HMO)     PacifiCare SignatureOptions<sup>SM</sup> (PPO)     PacifiCare SignatureIndependence<sup>SM</sup> (Indemnity)  
 PacifiCare SignatureValue<sup>SM</sup>-Direct (Open Access HMO)     Employee Basic Life/AD&D     Supplemental Life  
 Plan Code: \_\_\_\_\_

**2. Supplemental Application For:**

- Dental/Vision     Employee Choice (Voluntary)     Group Retiree     PacifiCare SignatureFreedom<sup>SM</sup> (SDHP)  
 Other: \_\_\_\_\_

**3. Employer Information**

Employer's Legal Name		Tax ID Number	
<input type="checkbox"/> Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Other			
Employer's address		City	State    ZIP
Executive contact		Title	
E-mail address	Fax (    )	Phone (    )	
Administrative contact	Billing contact (if different)		Title
E-mail address	Fax (    )	Phone (    )	
Name and address of any affiliated or subsidiary firms whose Employees are to be covered			
Industry/Nature of Business (be specific)			SIC Code
Proposed Effective Date	Proposed Renewal Date	Open Enrollment From	To
Employer Contribution – Medical    Employee _____ %    Dependent _____ %			
Total # of employees _____			
Eligible Employees _____			
Total # of employees not eligible _____			
Total # of eligible employees waiving _____			
Total # of eligible employees electing PPO _____			
Total # of eligible employees electing HMO _____			
Total # of eligible employees located outside of Arizona _____			
Is this business currently in Chapter 11 or has the business filed for bankruptcy of any kind within the last 12 months?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this plan intended to replace any existing coverage?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of existing carrier(s)		Date(s) of termination	
Workers' Compensation carrier		Are all Employees covered? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, state reason:			

**4. Eligibility**

Eligible Employees are those who usually work a minimum of \_\_\_\_\_ hours per week.

Employees become eligible on     1st day of employment (if no waiting period)     1st day of month following \_\_\_\_\_ days of employment     The day following \_\_\_\_\_ days of employment

Employees terminate on     Last day of month following date of termination     Date of termination

## 5. Risk Evaluation

In order to evaluate an application properly, PacifiCare requires the employer to answer the questions below. Please answer each question to the best of your knowledge with respect to all eligible employees and dependents that you intend to have covered under the plan, including those that will be on continuation of benefits under COBRA or other state continuation program.

To the best of your knowledge, are you aware of any employee or dependent having been diagnosed or treated for any of the following conditions in the past 3 years?		
a. Cardiac disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	g. Aids/Immune System Deficiency (excluding HIV)
b. Cancer (any form)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	h. Psychological disorders
d. Kidney disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Respiratory disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	i. Neuromuscular disorder
f. Liver disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		j. Transplant candidate
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		k. Alcohol/Drug abuse
		<input type="checkbox"/> Yes <input type="checkbox"/> No
1. To the best of your knowledge, are any of the employees or their dependents currently pregnant? (Indicate complications below)		
		<input type="checkbox"/> Yes <input type="checkbox"/> No
2. To the best of your knowledge, are any of the employees or their dependents disabled or have a mental/physical disorder?		
		<input type="checkbox"/> Yes <input type="checkbox"/> No
3. To the best of your knowledge, have any of the employees or their dependents been diagnosed with a significant condition such as, but not limited to cancer, heart/cardiovascular disease, liver disorder, diabetes, kidney disorder, neurological disorder, respiratory disorder, digestive disorder, musculoskeletal disorder, acute or chronic infections, or any immune system disorder?		
		<input type="checkbox"/> Yes <input type="checkbox"/> No
4. To the best of your knowledge, does the group have any claim(s) in excess of \$5,000 in the past 24 months, for conditions other than those listed in question #3?		
		<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered "Yes" to any of the above questions, please provide the employee(s) with PacifiCare's Statement of Health.

In accordance with Title X of COBRA, please complete the following for each person for whom COBRA or other state continuation of coverage is provided. Attach additional sheet, if needed. This information is required in addition to an Employee Enrollment Form.

<b>1</b>	COBRA Beneficiary Name	Date of Birth	Qualifying Event
	Date Continuation Began (Mo/Yr)	Date Continuation Expires (Mo/Yr)	Is COBRA Beneficiary Disabled or Hospital Confined?
<b>2</b>	COBRA Beneficiary Name	Date of Birth	Qualifying Event
	Date Continuation Began (Mo/Yr)	Date Continuation Expires (Mo/Yr)	Is COBRA Beneficiary Disabled or Hospital Confined?
<b>3</b>	COBRA Beneficiary Name	Date of Birth	Qualifying Event
	Date Continuation Began (Mo/Yr)	Date Continuation Expires (Mo/Yr)	Is COBRA Beneficiary Disabled or Hospital Confined?
Total number of all COBRA/State Continuation of Coverage beneficiaries. ➔			

## 6. HMO Benefits Applied For

The following benefit descriptions are not complete. Please refer to the Evidence of Coverage and the GSA for more details.

<b>Check one medical plan</b> <input type="checkbox"/> PacifiCare SignatureValue Plan 1 (\$10/100%) <input type="checkbox"/> PacifiCare SignatureValue Plan 2 (\$15/100%) <input type="checkbox"/> PacifiCare SignatureValue Plan 3 (\$10/\$25/\$150) <input type="checkbox"/> PacifiCare SignatureValue Plan 4 (\$15/\$30/\$250) <input type="checkbox"/> PacifiCare SignatureValue Plan 5 (\$15/\$30/\$350) <input type="checkbox"/> PacifiCare SignatureValue Plan 6 (\$20/\$40/\$500)	<b>Optional Riders – Check all applicable Riders</b>	
	<b>Dental</b> <input type="checkbox"/> High <input type="checkbox"/> Standard <b>Optical</b> <input type="checkbox"/> 50 <input type="checkbox"/> 10 <b>RX</b> <input type="checkbox"/> 10/20 <input type="checkbox"/> 10/25/50 <input type="checkbox"/> Preventive Solutions <input type="checkbox"/> Especially For Women	<input type="checkbox"/> EZ Pay <input type="checkbox"/> 3 year persistency discount <b>Tier Structure</b> <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4

## 7. Open Access Benefits Applied For

<input type="checkbox"/> PacifiCare SignatureValue–Direct Plan 1 (\$10/\$25/\$100) <input type="checkbox"/> PacifiCare SignatureValue–Direct Plan 2 (\$15/\$30/\$200) <input type="checkbox"/> PacifiCare SignatureValue–Direct Plan 3 (\$20/\$40/\$300) <input type="checkbox"/> PacifiCare SignatureValue–Direct Plan 4 (\$10/\$30/90%)	<input type="checkbox"/> PacifiCare SignatureValue–Direct Plan 5 (\$15/\$35/90%) <input type="checkbox"/> PacifiCare SignatureValue–Direct Plan 6 (\$15/\$35/80%) <input type="checkbox"/> PacifiCare SignatureValue–Direct Plan 7 (\$20/\$45/80%)
--	--

## 8. PPO Benefits Applied For

The following benefit descriptions are not complete. Please refer to the Evidence of Coverage and the GSA for more details.

<b>Check one medical plan</b>			
<input type="checkbox"/> AS1 (90/70/\$250)	<input type="checkbox"/> AS3 (80/60/\$500)	<input type="checkbox"/> AS5 (Indemnity)	<input type="checkbox"/> AS7 (70/50/\$1,500)
<input type="checkbox"/> AS2 (80/60/\$250)	<input type="checkbox"/> AS4 (70/50/\$1,000)	<input type="checkbox"/> AS6 (80/60/\$1,000)	

## 9. Self-Directed Health Plan Benefits Applied For

<input type="checkbox"/> PacifiCare SignatureFreedom Plan 1 (70-50/\$3,000)	<input type="checkbox"/> PacifiCare SignatureFreedom Plan 2 (80-60/\$2,500)
---	---

## 10. Group Term Life Insurance

<input type="checkbox"/> Basic \$ _____ OR Salary _____% OR <input type="checkbox"/> Scheduled Plan: \$ _____ Title _____ on all employees of annual earnings \$ _____ Title _____ \$ _____ Title _____									
<input type="checkbox"/> Accidental Death & Dismemberment (AD&D) (Amount same as life insurance) <input type="checkbox"/> Dependent Life Insurance: Spouse: <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$1,000 Child: <input type="checkbox"/> \$1,000 <input type="checkbox"/> Other: _____									
<input type="checkbox"/> Supplemental Life Coverage: Attach description of plan design sold									
<table border="0" style="width: 100%;"> <tr> <td><b>Life Rate</b></td> <td><input type="checkbox"/> Employee \$ _____ /per 1,000</td> <td>Employee % _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Dependent \$ _____ /per unit</td> <td>Dependent % _____</td> </tr> <tr> <td><b>AD&amp;D</b></td> <td><input type="checkbox"/> Employee \$ _____ /per 1,000</td> <td>Employee % _____</td> </tr> </table>	<b>Life Rate</b>	<input type="checkbox"/> Employee \$ _____ /per 1,000	Employee % _____		<input type="checkbox"/> Dependent \$ _____ /per unit	Dependent % _____	<b>AD&amp;D</b>	<input type="checkbox"/> Employee \$ _____ /per 1,000	Employee % _____
<b>Life Rate</b>	<input type="checkbox"/> Employee \$ _____ /per 1,000	Employee % _____							
	<input type="checkbox"/> Dependent \$ _____ /per unit	Dependent % _____							
<b>AD&amp;D</b>	<input type="checkbox"/> Employee \$ _____ /per 1,000	Employee % _____							
<b>Supplemental Life Rate</b> Attach Rate Sheet The Life Insurance Policy is written on an Actively at Work basis. Those Employees disabled on the Effective Date of the plan are not eligible for coverage until they return to Actively at Work status.									

## 11. Employer Statement

1. The Employer hereby applies for the coverage indicated and agrees to all of the following:
  - a. The Employer warrants that all the information on this application is true and complete, and that PacifiCare may rely on this application in deciding whether to provide coverage. If the application is not complete, or if the information provided on the application is inconsistent with any request for proposal for coverage submitted to PacifiCare, PacifiCare reserves the right to re-rate the premium associated with such coverage, or reject the application. If this application is accepted, it becomes part of our Subscriber Agreement/Policy with PacifiCare.
  - b. Any material misstatement or omission of information on this application, any request for proposal for coverage, or on any enrollment form will be considered a misrepresentation and may be the basis of later termination or rescission of coverage issued on the basis of the submitted information.
  - c. Employer understands and agrees that no coverage will be effective before the date determined by PacifiCare (the "Effective Date") and only if Employer has paid the first month's premium and this application has been received and accepted by PacifiCare.
  - d. Premium rates quoted and benefits proposed may be adjusted based on actual enrollment.
  - e. Covered persons are not insured prior to the Effective Date. If proof of insurability is required, insurance is not effective until PacifiCare has approved this proof (for life insurance only).
  - f. Employer agrees that PacifiCare may, for the limited purpose of underwriting this application, contact its employees.
  - g. No statement, representation or promise shall have any effect unless contained in a document signed by an officer or Underwriting Manager of the Company; either contained in, or attached to the application.
2. IT IS UNDERSTOOD AND AGREED THAT NO AGENT OF EMPLOYER HAS THE AUTHORITY TO:
  - a. modify this form;
  - b. waive the answer to any question;
  - c. bind PacifiCare in any way by giving or receiving any data which is not written on this form; or
  - d. bind PacifiCare by making any promise or representation.

## 12. Employer Group Statement

On behalf of our group, I hereby make application to PacifiCare and/or its subsidiaries for group coverage. I understand there is no coverage in effect until PacifiCare accepts this application, premium is deposited, and an effective date of coverage is established. If this application is not accepted, the premium deposit will be refunded. THE EMPLOYER UNDERSTANDS AND AGREES THAT THE EMPLOYER SHOULD KEEP PRIOR COVERAGE IN FORCE UNTIL NOTIFIED OF ACCEPTANCE IN WRITING BY PACIFICARE AND THAT NO AGENT OR BROKER HAS THE RIGHT TO ACCEPT THIS APPLICATION OR BIND COVERAGE.

Estimated first month's premium of \$ \_\_\_\_\_ accompanies this application.

**Arbitration Agreement:** Under this coverage, Employer and PacifiCare are voluntarily giving up their constitutional right to have any dispute decided in a court of law before a jury and instead are accepting the use of binding arbitration for resolving disputes between Employer and PacifiCare of Arizona.

### Employer

\_\_\_\_\_  
Officer's Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Officer's Signature

\_\_\_\_\_  
Date

### PacifiCare Representative

\_\_\_\_\_  
PacifiCare Representative's Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
PacifiCare Representative's Signature

\_\_\_\_\_  
Date

## 13. Broker Statement

To the best of my knowledge, the information submitted on the Group Application is accurate. The in-force carrier has not notified me of any adverse claims experience not already detailed in this application nor am I aware of any information not disclosed in this application by the client which may have bearing on this risk. I hereby certify that I have advised the client not to terminate any existing coverage until receiving written notification from PacifiCare that the coverage being applied for by this application is accepted.

\_\_\_\_\_  
Broker Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
E-mail address

\_\_\_\_\_  
Fax #

## 14. To Be Completed By PacifiCare Underwriting Department

Underwriter Name	Date Reviewed / /	Application Disposition <input type="checkbox"/> Approved <input type="checkbox"/> Declined <input type="checkbox"/> Re-Rated
------------------	----------------------	--