

CALIFORNIA SMALL GROUP ENROLLMENT FORM AND DECLINATION OF COVERAGE

Effective July 1, 2005



■ 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 Domestic Partner coverage eligibility with 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 (Dental HMO) plan.

Section 4: Benefit Coordination/Other Insurance Carrier Information

Please complete information requested.

Section 5: Group Life Insurance

- Complete the information requested only if your Employer is offering this benefit.
- Evidence of Insurability may be required.

Section 6: Group Long Term Disability (LTD) Insurance

Complete the information requested only if your Employer is offering this benefit.

Section 7: 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/Domestic Partner 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.

■ 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 HMO or POS plan or the PacifiCare Life and Health Group Policy ("Policy") if I have chosen the PPO, SDHP or Out-of-State 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 shall have access to and use of my medical records and the medical records of my 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, rating or

purposes of diagnosis and treatment of 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 of the insurance policy with PacifiCare.
5. Coverage shall not begin until acceptance of this enrollment by PacifiCare. Upon acceptance of this enrollment form, 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 live or work in PacifiCare's service area if enrolling in the PacifiCare SignatureValue or PacifiCare SignaturePOS plan.
8. If my Dependent(s) 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.

I represent that the information supplied is true and I hereby authorize payroll deductions from my earnings for any contributions or fees required to maintain my eligibility.

Detach here

PacifiCare SignatureValue (HMO)

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)

**PacifiCare Dental and Vision
Administrators**

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

The Hartford (Life and Disability)

1-888-726-3449
<http://groupbenefits.thehartford.com>

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					
Company Name		Occupation/Title		Date of Hire	Date of Rehire
Last Name		First Name		MI	Suffix <input type="checkbox"/> Male <input type="checkbox"/> Female
Residence Mailing Address			City	State	ZIP
#of hours you work in a normal week:	Have you or any of your dependents ever been a PacifiCare Member? <input type="checkbox"/> Yes <input type="checkbox"/> No		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 If yes, qualifying event and original start date:					
E-Mail		Annual Salary		Would you like to receive information via E-mail? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Employer Required to Complete This Section	
Group #/Plan Code	
Dental/Vision Group #	
Source of Enrollment: <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire	<input type="checkbox"/> QMCSO <input type="checkbox"/> Transfer <input type="checkbox"/> Rehire
Requested Effective Date	
Life Class	Group Life/AD&D Amount

2. Selected Coverage (Select only the plans offered by your Employer)		
Medical Plan Options: PacifiCare SignatureValue (HMO) <input type="checkbox"/> 10-30/100 <input type="checkbox"/> 15-30/250a <input type="checkbox"/> 10/500d <input type="checkbox"/> 20-40/500d <input type="checkbox"/> 35/600d PacifiCare SignaturePOS <input type="checkbox"/> 15/80-60 PacifiCare SignatureOptions (PPO) <input type="checkbox"/> 15/90-50/250 <input type="checkbox"/> 20/80-60/250 <input type="checkbox"/> 30/70-50/250 <input type="checkbox"/> 35/80-60/500 <input type="checkbox"/> 35/70-50/1000 <input type="checkbox"/> 35/50-50/1000 <input type="checkbox"/> 70-50/2000 <input type="checkbox"/> 70-50/3500 PacifiCare SignatureOptions (HSA-Compatible) <input type="checkbox"/> 100-50/5000 <input type="checkbox"/> 80-50/2700 <input type="checkbox"/> 70-50/3500 PacifiCare SignatureIndependence (Indemnity) <input type="checkbox"/> 80/1000 PacifiCare SignatureFreedom (SDHP) <input type="checkbox"/> 80-50/2000 <input type="checkbox"/> 80-50/2000 with Dental <input type="checkbox"/> 70-50/2000 <input type="checkbox"/> 70-50/2000 with Dental <input type="checkbox"/> 50-50/3000 <input type="checkbox"/> 50-50/3000 with Dental Please complete the Declination of Coverage form if declining coverage for Self and/or Eligible Dependent(s)	Dental Plan Options: <input type="checkbox"/> PacifiCare SignatureValue (Dental HMO) <input type="checkbox"/> PacifiCare SignatureOptions (Dental PPO) <input type="checkbox"/> PacifiCare SignatureIndependence (Dental Indemnity) Vision Plan Options: <input type="checkbox"/> PacifiCare SignatureOptions (Vision PPO – Full Service) <input type="checkbox"/> PacifiCare SignatureOptions (Vision PPO – Eyewear Only) Discount Dental & Vision <input type="checkbox"/> PacifiCare SignatureSavings Discount Dental & Vision Program Please complete the Declination of Coverage form if declining coverage for Self and/or Eligible Dependent(s)	Life/Disability <input type="checkbox"/> Life/AD&D <input type="checkbox"/> Long Term Disability Individual(s) to be covered: <input type="checkbox"/> Self Only <input type="checkbox"/> Self and Eligible Dependent(s)

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
Dentist Name & City				Dental Provider Group #	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
Dentist Name & City				Dental Provider Group #	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
Dentist Name & City				Dental Provider Group #	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
Dentist Name & City				Dental Provider Group #	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
Dentist Name & City				Dental Provider Group #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

Check box if additional enrollment page is attached for dependents.
Overage (19-24 years) dependents require proof of full-time student status or permanent disability status within 31 days of enrollment.

Detach here

4. Benefit Coordination/Other Insurance Carrier Information

■ Do you or any of your Dependents have any other health insurance? Yes No If yes, complete boxes a–j:
 If yes, will this coverage remain in effect if this application is accepted? Yes No

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 permanently disabled? Yes No If yes, complete boxes k + l and submit a completed Individual Health Statement for each person:

k. Name	l. Date Disability Began
---------	--------------------------

■ Is anyone listed eligible for Medicare? Yes No If yes, complete boxes m + n:

m. Name	n. Medicare ID#
---------	-----------------

■ Does anyone listed have other dental insurance? Yes No If yes, complete boxes o–r:

o. Name	p. Insurance Company Name	q. Policy #	r. Effective Date
---------	---------------------------	-------------	-------------------

5. *Group Life Insurance (Complete only if your Employer is offering this benefit)

I elect coverage <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Job Title	Employee's Benefits – Life: \$	AD&D: \$	Supp. Life**: \$
# of hours worked per week	Salary/Wages <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Annual \$	Spouse/Domestic Partner – Amount: \$	Children – Per Child Amount: \$	

As a covered employee, you have the right to select and/or change your beneficiary(ies) in accordance with the provisions of your policy.

Life Insurance Primary Beneficiary (full name)	Percentage	Telephone ()	Relationship***
Contingent Beneficiary (full name)	Percentage	Telephone ()	Relationship

** Evidence of Insurability may be required.

*** Your spouse MUST sign this form if you designate someone other than your spouse as beneficiary.

Spouse Signature X	Date
-----------------------	------

6. *Group Long Term Disability (LTD) (Complete only if your Employer is offering this benefit)

Job Duties

I understand that a medical examination, at my own expense, may be required if I want to participate at a later date.

Employee Signature X	Date
LTD Insurance Beneficiary (full name)	Relationship

* Life/AD&D and LTD underwritten by The Hartford. The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Accident Insurance Company and CNA Group Life Assurance Company. Any and all disputes related to coverage provided by The Hartford are not subject to arbitration.

7. Signature Required for Terms and Conditions and 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 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 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)
---------------------------	-----------------

Detach here

Employee Name _____ Social Security # _____

Company Name _____

Source Code	Tracking #
-------------	------------

DECLINATION OF COVERAGE FORM

Complete this section if any coverage is to be declined by you or your eligible dependents

Unless one of the these circumstances set forth below applies to you, failure to enroll during the initial enrollment period will permit the plan to treat you as a Late Enrollee and to impose a twelve-month waiting period at the time you decide to enroll.

I certify that the reason I am declining enrollment in PacifiCare’s Group Health Plan Dental Plan Vision Plan is: (check, as applicable)

- I am covered under another group health plan dental plan vision plan offered to my spouse/Domestic Partner.
- I am covered under another group health plan dental plan vision plan offered by my EMPLOYER.
- I am covered under an Individual health plan.
- I am declining because _____
- I am declining the health plan dental plan vision plan for my spouse/Domestic Partner, name _____, because _____
- I am declining for my child/children:
 - health plan dental plan vision plan, name _____, because _____
 - health plan dental plan vision plan, name _____, because _____
 - health plan dental plan vision plan, name _____, because _____

If I or one of my dependents have declined coverage as listed above:

I understand that in the event I and/or my eligible dependents choose to enroll in a PacifiCare plan at a later date, we may be considered “Late Enrollees” and may have to wait for coverage for a period of twelve (12) months after the date we enroll, or the next open enrollment period.

I have been informed that under the three following circumstances, I and my eligible dependents will not be considered Late Enrollees, and thus will not have to wait for a period of twelve (12) months after we enroll in PacifiCare:

1. OTHER EMPLOYER health plan COVERAGE. You and your dependents (collectively “You”) shall not be considered Late Enrollees if:
 - a. You are currently covered under another employer health plan (“Plan”) although You are also eligible to enroll in a PacifiCare plan;
 - b. You certify in writing on this Declination of Coverage that You are declining PacifiCare coverage because You are already covered under another group Plan;
 - c. You learn at a later date that You have lost or will lose coverage under the other Plan because of:
 - (1) the termination of your employment or the employment of the person through whom You are covered as a dependent;
 - (2) a change in your employment status or the employment status of the person through whom You are covered as a dependent;
 - (3) the termination of coverage under the other Plan;
 - (4) the termination of an employer’s monetary contribution toward your coverage under the other Plan;
 - (5) the death of the person through whom You are covered as a dependent;

- (6) the legal separation or divorce; or
- (7) loss of no share-of-cost Medi-Cal coverage from the person through whom You are covered as a dependent; and
- (8) your declination of coverage when enrollment was previously offered and you subsequently acquired a dependent;
- (9) the termination of coverage under the other Plan for your dependent(s); and

d. You request enrollment no later than thirty (30) days after termination of your coverage under the other Plan due to one of the reasons stated here in subsection 1(c).

If You meet each of the requirements listed above, You will not be classified as a Late Enrollee, and will not have to wait twelve (12) months after You enroll.

2. MULTIPLE PLANS. If your employer offers one or more other plans and You enrolled in one of such Plans during an open enrollment period, You will not be classified as a Late Enrollee if You enroll in PacifiCare at a later date.
3. COURT ORDER. You and your spouse and/or minor child will not be classified as Late Enrollees, if a court has ordered that coverage be provided for a spouse or minor child under an employee’s health plan. PacifiCare will enroll a Dependent child with thirty (30) days after receipt of a court order or request from the district attorney, either parent or the person having custody of the child as defined in Section 3751.5 of the Family Code, the employer or the group administrator. In the case of children who are eligible for Medicaid, the State Department of Health Services may also make the request.

My signature on the inside of this form represents that I have read, understand and agree to the terms and conditions listed above.

Signature – I have read, understand and agree to the above Declination of Coverage.

Signature (Required) X	Date (Required)
---------------------------	-----------------

Please open
to complete this form

Please open
to complete this form

