

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"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <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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