

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	M.I.	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"/> Married <input type="checkbox"/> Widow <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner			
Are you currently on COBRA? <input type="checkbox"/> Yes <input type="checkbox"/> No		COBRA Qualifying Event			
If yes, qualifying event:		Effective Date			
Preferred Language (optional) <input type="checkbox"/> English <input type="checkbox"/> Spanish					
Ethnicity (optional) <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Caucasian <input type="checkbox"/> Asian, Native Hawaiian, other Pacific Islander <input type="checkbox"/> Not provided by member <input type="checkbox"/> American Indian or Alaskan Native					

Employer Required to Complete This Section
Group #/Plan Code
Source of Enrollment: <input type="checkbox"/> Open Enrollment <input type="checkbox"/> OMCSO <input type="checkbox"/> New Hire <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:		
<input type="checkbox"/> PacifiCare SignatureValue (HMO) <input type="checkbox"/> High <input type="checkbox"/> Low	<input type="checkbox"/> PacifiCare SignatureValue Access (EPO)	<input type="checkbox"/> PacifiCare SignatureValue Advantage
<input type="checkbox"/> PacifiCare SignatureElite (HDHP) (HSA-Compatible)	<input type="checkbox"/> PacifiCare SignatureElite (PPO) <input type="checkbox"/> High <input type="checkbox"/> Low	<input type="checkbox"/> PacifiCare SignatureValue Advantage PlanBien SM
<input type="checkbox"/> PacifiCare SignatureIndependence (Indemnity)	<input type="checkbox"/> PacifiCare SignatureFreedom (SDHP)	<input type="checkbox"/> PacifiCare SignaturePOS
Individual(s) to be covered:		
<input type="checkbox"/> Self	<input type="checkbox"/> Self + Spouse	<input type="checkbox"/> Self + Family
	<input type="checkbox"/> Self + Dependent(s)	<input type="checkbox"/> Waive Medical (Complete Waiver Form)

3. Employee and 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
<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 from Employee's		
Primary Care Physician (PCP) Name		Provider #		Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent 1		Last Name		First Name	M.I.
<input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth (mm-dd-yy)		Address, if different from Employee's	
Relationship		Social Security #	Address, if different from Employee's		
Primary Care Physician (PCP) Name		Provider #		Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent 2		Last Name		First Name	M.I.
<input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth (mm-dd-yy)		Address, if different from Employee's	
Relationship		Social Security #	Address, if different from Employee's		
Primary Care Physician (PCP) Name		Provider #		Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent 3		Last Name		First Name	M.I.
<input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth (mm-dd-yy)		Address, if different from Employee's	
Relationship		Social Security #	Address, if different from Employee's		
Primary Care Physician (PCP) Name		Provider #		Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent 4		Last Name		First Name	M.I.
<input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth (mm-dd-yy)		Address, if different from Employee's	
Relationship		Social Security #	Address, if different from Employee's		
Primary Care Physician (PCP) Name		Provider #		Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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4. Benefit Coordination/Other Insurance Carrier Information

Does anyone listed have other health insurance? Yes No If yes, complete section 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 section 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.

Signature (Required) X	Date (Required)
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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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