CALIFORNIA

PacifiCare®

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 ☐ Open Enrollment ☐ Transfer ☐ New Hire ☐ 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 SignatureValue – Advantage (HMO) ☐ PacifiCare SignaturePOS (POS)
☐ PacifiCare SignatureOptions (PPO)* ☐ PacifiCare SignatureIndependence (Indemnity)* ☐ PacifiCare SignatureFreedom (SDHP)*
☐ Life** – Self only ☐ 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).**

		Last Name	Social Security Number	Primary Care Physician Name	PCP # – OR – Group #	Primary Care Physician (PCP) Number	Existing Patient?
1	**Self**	Sex M or F — First Name M.I.	Date of Birth (Month - Day - Year)	Medical Group Name		Medical Group Number	☐ Yes ☐ 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	☐ Yes ☐ 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	☐ Yes ☐ 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	☐ Yes ☐ 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	☐ Yes ☐ 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? ☐ Yes ☐ No	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Please answer the following questions regarding family members listed on this Enrollment Form.

1. Is anyone listed permanently disabled? ☐ Yes ☐ No Name _____ Date disability began _____
   If "Yes", please explain: Diagnosis _____ Current Condition _____
2. Is anyone listed eligible for Medicare? ☐ Yes ☐ No Name _____
3. 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

If Other Medical Coverage Has Been Entered It Will Appear on the Following Page(s)

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

PacifiCare SignatureOptions℠ (PPO)*, PacifiCare SignatureIndependence℠ (Indemnity)* and PacifiCare SignatureFreedom℠ (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**

Employee Name: _____ SSN: _____

6	Relationship	Last Name	Social Security Number	Primary Care Physician Name	Primary Care Physician (PCP) Number	Existing Patient?
	Sex	First Name MI	Date of Birth	Medical Group Name	Medical Group Number	☐ Yes
	M F					☐ No
7	Relationship	Last Name	Social Security Number	Primary Care Physician Name	Primary Care Physician (PCP) Number	Existing Patient?
	Sex	First Name MI	Date of Birth	Medical Group Name	Medical Group Number	☐ Yes
	M F					☐ No
8	Relationship	Last Name	Social Security Number	Primary Care Physician Name	Primary Care Physician (PCP) Number	Existing Patient?
	Sex	First Name MI	Date of Birth	Medical Group Name	Medical Group Number	☐ Yes
	M F					☐ No
9	Relationship	Last Name	Social Security Number	Primary Care Physician Name	Primary Care Physician (PCP) Number	Existing Patient?
	Sex	First Name MI	Date of Birth	Medical Group Name	Medical Group Number	☐ Yes
	M F					☐ No
10	Relationship	Last Name	Social Security Number	Primary Care Physician Name	Primary Care Physician (PCP) Number	Existing Patient?
	Sex	First Name MI	Date of Birth	Medical Group Name	Medical Group Number	☐ Yes
	M F					☐ No
11	Relationship	Last Name	Social Security Number	Primary Care Physician Name	Primary Care Physician (PCP) Number	Existing Patient?
	Sex	First Name MI	Date of Birth	Medical Group Name	Medical Group Number	☐ Yes
	M F					☐ No
12	Relationship	Last Name	Social Security Number	Primary Care Physician Name	Primary Care Physician (PCP) Number	Existing Patient?
	Sex	First Name MI	Date of Birth	Medical Group Name	Medical Group Number	☐ Yes
	M F					☐ No
13	Relationship	Last Name	Social Security Number	Primary Care Physician Name	Primary Care Physician (PCP) Number	Existing Patient?
	Sex	First Name MI	Date of Birth	Medical Group Name	Medical Group Number	☐ Yes
	M F					☐ No

Employee Name: _____ SSN: _____

14	Relationship	Last Name	Social Security Number	Primary Care Physician Name	Primary Care Physician (PCP) Number	Existing Patient?
	Sex	First Name MI	Date of Birth	Medical Group Name	Medical Group Number	☐ Yes
	M F					☐ No
15	Relationship	Last Name	Social Security Number	Primary Care Physician Name	Primary Care Physician (PCP) Number	Existing Patient?
	Sex	First Name MI	Date of Birth	Medical Group Name	Medical Group Number	☐ Yes
	M F					☐ No
16	Relationship	Last Name	Social Security Number	Primary Care Physician Name	Primary Care Physician (PCP) Number	Existing Patient?
	Sex	First Name MI	Date of Birth	Medical Group Name	Medical Group Number	☐ Yes
	M F					☐ No
17	Relationship	Last Name	Social Security Number	Primary Care Physician Name	Primary Care Physician (PCP) Number	Existing Patient?
	Sex	First Name MI	Date of Birth	Medical Group Name	Medical Group Number	☐ Yes
	M F					☐ No
18	Relationship	Last Name	Social Security Number	Primary Care Physician Name	Primary Care Physician (PCP) Number	Existing Patient?
	Sex	First Name MI	Date of Birth	Medical Group Name	Medical Group Number	☐ Yes
	M F					☐ No
19	Relationship	Last Name	Social Security Number	Primary Care Physician Name	Primary Care Physician (PCP) Number	Existing Patient?
	Sex	First Name MI	Date of Birth	Medical Group Name	Medical Group Number	☐ Yes
	M F					☐ No
20	Relationship	Last Name	Social Security Number	Primary Care Physician Name	Primary Care Physician (PCP) Number	Existing Patient?
	Sex	First Name MI	Date of Birth	Medical Group Name	Medical Group Number	☐ Yes
	M F					☐ No
21	Relationship	Last Name	Social Security Number	Primary Care Physician Name	Primary Care Physician (PCP) Number	Existing Patient?
	Sex	First Name MI	Date of Birth	Medical Group Name	Medical Group Number	☐ Yes
	M F					☐ No