



PacAdvantage

Choice • Simplicity • Affordability

DEPENDENT ENROLLMENT APPLICATION

IF YOU SEEK SERVICES PRIOR TO RECEIVING YOUR ID CARD FROM YOUR PLAN, YOU MAY BE REQUIRED TO PAY OUT-OF-POCKET COSTS FOR CARE RECEIVED. THESE OUT-OF-POCKET COSTS MAY BE REIMBURSED BY THE PLAN, IF THEY ARE PART OF YOUR COVERED BENEFITS.

CHECK APPLICABLE BOX: NEW DEPENDENT CHANGE

PLEASE COMPLETE A SEPARATE DEPENDENT ENROLLMENT APPLICATION FOR EACH DEPENDENT ENROLLING.

For my dependent(s) under age 2, please enroll in the following coverage DENTAL VISION CHIROPRACTIC/ACUPUNCTURE

For all dependents age 2 or older, optional benefit enrollment must be the same as the employee/member.

EMPLOYEE'S FIRST NAME _____ EMPLOYEE'S LAST NAME _____ SUFFIX (Jr., Sr., etc.) _____

GROUP NUMBER _____ EMPLOYEE'S SOCIAL SECURITY NUMBER _____ DATE OF BIRTH ____ / ____ / ____

DEPENDENT INFORMATION

DEPENDENT'S FIRST NAME _____ DEPENDENT'S LAST NAME _____ M.I. _____

SUFFIX (Jr., Sr., etc.) _____ DEPENDENT'S SOCIAL SECURITY NUMBER _____ DATE OF BIRTH ____ / ____ / ____

GENDER MALE FEMALE RELATIONSHIP SPOUSE/DOMESTIC PARTNER CHILD OTHER (please specify) _____

IF ADDING SPOUSE, PLEASE SPECIFY DATE OF MARRIAGE ____ / ____ / ____

DEPENDENT'S RESIDENTIAL ADDRESS, IF DIFFERENT THAN ENROLLING MEMBER'S ADDRESS _____ APT. _____

CITY _____ STATE _____ ZIP _____

MEDICAL PLAN INFORMATION

PRIMARY CARE PHYSICIAN/MEDICAL GROUP ID NUMBER (HMO & POS PLANS) _____

CURRENT PATIENT? YES NO

PRIMARY CARE PHYSICIAN'S LAST NAME (HMO & POS PLANS) _____ FIRST NAME _____

PRIOR MEDICAL COVERAGE NAME _____ START DATE ____ / ____ / ____ END DATE ____ / ____ / ____

PRIVATE INSURANCE MEDI-CAL MEDICARE NONE (UNINSURED) OTHER _____

DENTAL PLAN INFORMATION (if applicable)

DENTIST'S LAST NAME _____ DENTIST'S FIRST NAME _____

PRIOR DENTAL COVERAGE NAME _____ START DATE ____ / ____ / ____ END DATE ____ / ____ / ____

DEPENDENT ENROLLMENT APPLICATION

GROUP NUMBER

EMPLOYEE'S NAME

EMPLOYEE'S SOCIAL SECURITY NUMBER

DECLARATIONS

READ EACH OF THE FOLLOWING STATEMENTS CAREFULLY. ANY UNTRUE OR INACCURATE RESPONSES MAY BE REASON FOR LOSS OF ENROLLMENT OR APPLICATION OF OTHER SANCTIONS. BY SIGNING THIS APPLICATION YOU ARE RESPONSIBLE FOR EACH STATEMENT.

- 1) I have reviewed the services, coverage offered, and rates of the participating plans.
- 2) I understand that I must meet the Program requirements to be an eligible employee.
- 3) I certify that I work or reside in the service area of the participating insurance plan(s) I have selected.
- 4) I understand that if I am an eligible employee and do not enroll my dependents at this time, they cannot enroll in the Program until the next Open Enrollment period unless otherwise authorized by Program Governing Rules.
- 5) I understand that this contract may have waiting periods for certain dental services.
- 6) I declare that I will abide by the rules of participation, the utilization review process, and the dispute resolution process of any participating health/dental/vision/complementary medicine plan in which I am enrolled.
- 7) I agree to follow the laws and rules governing the Program.
- 8) I understand that this contract may require disputes to be resolved through binding arbitration. (See disclosure below.)
- 9) By signing this application, I certify that the information provided on this application is true and correct. I understand that any untrue or inaccurate responses may be reason for loss of eligibility and enrollment.
- 10) As an individual member applying for the Program through my employer, I understand that my eligibility is based on my employer's participation.

AUTHORIZATION FOR DISCLOSURE OF PERSONAL INFORMATION

I hereby authorize health care providers to release medical, dental, vision, and complementary medicine information, including medical information regarding substance abuse or mental/emotional conditions, pertaining to me or my dependents to the health plan(s) which I have selected and to Pacific Health Advantage (also known as The Health Insurance Plan of California). This information may be used for any purpose related to enrollment and plan administration, including but not limited to utilization management, quality improvement, disease or case management programs, and premium risk adjustment. I further authorize payment of medical/dental/vision/complementary medicine benefits to the provider of care. A photocopy of this authorization is as valid as the original. My authorized representative or I am entitled to receive a copy of this authorization.

ARBITRATION NOTICE

Pacific Health Advantage is a purchasing cooperative offering a variety of health/dental/vision/complementary medicine options. Enrollment in many of the plans constitutes an agreement to have any dispute decided by binding arbitration and waiver of any right to a jury or court trial. Refer to the plan's Evidence of Coverage or Certificate of Insurance to determine whether the plan(s) you have selected require binding arbitration. **If you choose a medical, dental, vision, or complementary medicine plan which requires resolution of disputes through binding arbitration, you, your dependents, and the plan are waiving any right to a jury or court trial.**

SIGNATURES

SIGNATURE OF EMPLOYEE

DATE SIGNED

_____ / _____ / _____

IF ON THIS APPLICATION AN EMPLOYER IS ADDING A NEW EMPLOYEE WHO WAS NOT INCLUDED ON THE ORIGINAL APPLICATION TO THE PROGRAM, THE EMPLOYER MUST SIGN AND DATE THE FOLLOWING:

I CERTIFY THAT THE EMPLOYEE ON THIS APPLICATION IS AN ELIGIBLE EMPLOYEE UNDER THE GOVERNING RULES OF THE PROGRAM.

SIGNATURE OF EMPLOYER/AUTHORIZED REPRESENTATIVE

DATE SIGNED

_____ / _____ / _____

SIGNATURE OF DEPENDENT AGE 18 OR OLDER

DATE SIGNED

_____ / _____ / _____

COBRA/Cal-COBRA APPLICANT DECLARATIONS

I, the COBRA/Cal-COBRA applicant, declare as follows:

- 1) I understand that by signing this application, I am responsible for the Declarations set forth above and where the term "employee" is used, the Declarations apply to me as the COBRA/Cal-COBRA applicant.
- 2) I will abide by the Program premium requirements.
- 3) I must meet the Program requirements and the requirements of federal or state law for continuation of coverage under COBRA or Cal-COBRA.
- 4) If my former employer terminates its participation in the Program, my coverage under the Program will cease, although I may have continuation coverage through a successor plan with the former employer.

COBRA START DATE

I, the COBRA/Cal-COBRA applicant, certify that the information provided on this application is true and correct.

SIGNATURE OF COBRA APPLICANT

DATE SIGNED

_____ / _____ / _____