



PacAdvantage

EMPLOYEE ENROLLMENT APPLICATION

Complete this form carefully. Incomplete information will delay your enrollment. To verify provider availability, contact the the carrier's customer service department or check their website for a provider directory. 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. Keep a copy of this information for your records.

APPLICATION CHECKLIST

1. Company name
2. Personal information
 - First and last name
 - Physical home address
 - Mailing address, if different
 - Social security number
 - Date of birth
3. Hours worked per week
4. Date of hire:
 - The date you began working 30 hours or more per week. If your employer offers coverage for part-time employees, the date you began working 20 hours or more per week.
5. Employee classification (Check with your employer for this information (choices may include the following: full tme, part time, management, non-management, union, non-union, exempt, non-exempt).)
6. Medical plan section (see PacAdvantage *employee handbook*), plan number should match plan name
7. Coverage Choice
 - If enrolling dependents, please complete dependent section.
 - If enrolling a domestic partner please complete a "domestic partnership" form.
 - If you are waiving medical coverage, please complete a Waive / Decline form.
8. Co-payment option
9. Dental plan selection (selected plan number and name)
10. Vision plan and co-payment option (selected plan number and name)
11. Complementary medicine plan and co-payment option (selected plan number and name)

SIGNATURES REQUIRED

12. Employee
13. Dependent(s) age 18 or older
14. Employer (Authorized representative)

DEPENDENT SECTION

All dependents age 2 or older are required to take the options selected by the main applicant.

15. First and last name
16. Social security number, if available
17. Date of birth
18. Gender and relationship



EMPLOYEE ENROLLMENT APPLICATION

PacAdvantage

CHECK PURPOSE OF APPLICATION:

- NEW GROUP ENROLLMENT
 NEW EMPLOYEE
 CHANGE
 COBRA

EMPLOYER INFORMATION

Group number _____ Requested effective date ____ / ____ / ____
 Company name _____

EMPLOYEE INFORMATION

Mr. Mrs. Ms. SUFFIX (Jr., Sr., etc.)
 First name _____ M.I. _____ Last name _____
 Date of birth ____ / ____ / ____ Social Security Number ____ - ____ - _____ Gender Male Female
 Physical home address _____ Apt. _____
 City _____ County _____ State _____ Zip _____
 Mode of correspondence Mail Fax E-mail
 Mailing address (If different from physical address) _____ Apt. _____
 City _____ State _____ Zip _____
 Home telephone ____ / ____ / ____ Fax number ____ / ____ / ____
 E-mail address _____
 Hours worked per week ____ Date of hire ____ / ____ / ____
 Employee Classification _____

MEDICAL PLAN / CARRIER SELECTION

Are you waiving medical coverage? Yes No
Carrier selection
Plan number _____ **Selected medical plan name** _____
Coverage Choice (If enrolling dependent(s), please complete Dependent Section)
 Employee only Employee and spouse Employee and domestic partner Employee and child(ren) Family
Co-pay option Preferred \$10.00 Plus \$20.00 Standard \$30.00
 Primary care physician first name _____ Primary care physician last name _____
 Physician / medical group I.D. number _____
 Are you an existing patient? Yes No

EMPLOYEE ENROLLMENT APPLICATION

PRIOR MEDICAL PLAN

Group insurance Medi-Cal MediCare None (Uninsured) Individual insurance

Prior medical coverage name

Start date of prior insurance

End date of prior insurance

___ / ___ / _____ ___ / ___ / _____

Are you keeping other medical insurance coverage along with PacAdvantage? Yes No

Other medical insurance you are keeping along with PacAdvantage (leave blank if none)

DENTAL PLAN /CARRIER SELECTION (if applicable)

Plan number **Selected dental plan name**

Waiving coverage for dependent under age 2 (Must be checked if enrolling a dependent under age 2, or coverage will be included for the dependent.)

Coverage choice Employee only Employee and spouse Employee and domestic partner Employee and child(ren) Family

Dentist/Dental group ID number Are you a current patient? Yes No

Dentist's last name (required for prepaid dental plans)

First name

Prior dental coverage name

Start date

End date

___ / ___ / _____ ___ / ___ / _____

Private insurance Medi-Cal MediCare None (Uninsured) Other _____

VISION PLAN (if applicable)

Plan number **Selected vision plan name**

Waiving coverage for dependent under age 2 (Must be checked if enrolling a dependent under age 2, or coverage will be included for the dependent.)

Coverage choice Employee only Employee and spouse Employee and domestic partner Employee and child(ren) Family
Copay choice Plus Preferred

COMPLEMENTARY MEDICINE (if applicable)

Plan number **Selected complementary medicine plan name**

Waiving coverage for dependent under age 2 (Must be checked if enrolling a dependent under age 2 or coverage will be included for the dependent.)

Coverage choice Employee only Employee and spouse Employee and domestic partner Employee and child(ren) Family
Copay choice Plus Standard

EMPLOYEE ENROLLMENT APPLICATION (Dependent Section)

DEPENDENT SECTION

Dependent's first name _____ M.I. _____ Dependent's last name _____

Suffix (Jr., Sr., etc.) _____ Date of birth _____ / _____ / _____ Dependent's social security number _____ - _____ - _____

Gender Male Female Relationship Spouse Domestic Partner Child Other (please specify) _____

Dependent's residential address, if different than enrolling member's Address _____ Apt. _____

City _____ State _____ Zip _____

Primary care physician last name _____ Primary care physician first name _____

Physician / medical group I.D. number _____

Prior medical coverage name _____ Start date _____ / _____ / _____ End date _____ / _____ / _____

Prior dental coverage name _____ Start date _____ / _____ / _____ End date _____ / _____ / _____

DEPENDENT SECTION

Dependent's first name _____ M.I. _____ Dependent's last name _____

Suffix (Jr., Sr., etc.) _____ Date of birth _____ / _____ / _____ Dependent's social security number _____ - _____ - _____

Gender Male Female Relationship Spouse Domestic Partner Child Other (please specify) _____

Dependent's residential address, if different than enrolling member's Address _____ Apt. _____

City _____ State _____ Zip _____

Primary care physician last name _____ Primary care physician first name _____

Physician / medical group I.D. number _____

Prior medical coverage name _____ Start date _____ / _____ / _____ End date _____ / _____ / _____

Prior dental coverage name _____ Start date _____ / _____ / _____ End date _____ / _____ / _____

EMPLOYEE ENROLLMENT APPLICATION (Dependent Section)

DEPENDENT SECTION

Dependent's first name _____ M.I. _____ Dependent's last name _____

Suffix (Jr., Sr., etc.) _____ Date of birth _____ / _____ / _____ Dependent's social security number _____ - _____ - _____

Gender Relationship
 Male Female Spouse Domestic Partner Child Other (please specify) _____

Dependent's residential address, if different than enrolling member's Address _____ Apt. _____

City _____ State _____ Zip _____

Primary care physician last name _____ Primary care physician first name _____

Physician / medical group I.D. number _____

Prior medical coverage name _____ Start date _____ / _____ / _____ End date _____ / _____ / _____

Prior dental coverage name _____ Start date _____ / _____ / _____ End date _____ / _____ / _____

DEPENDENT SECTION

Dependent's first name _____ M.I. _____ Dependent's last name _____

Suffix (Jr., Sr., etc.) _____ Date of birth _____ / _____ / _____ Dependent's social security number _____ - _____ - _____

Gender Relationship
 Male Female Spouse Domestic Partner Child Other (please specify) _____

Dependent's residential address, if different than enrolling member's Address _____ Apt. _____

City _____ State _____ Zip _____

Primary care physician last name _____ Primary care physician first name _____

Physician / medical group I.D. number _____

Prior medical coverage name _____ Start date _____ / _____ / _____ End date _____ / _____ / _____

Prior dental coverage name _____ Start date _____ / _____ / _____ End date _____ / _____ / _____

EMPLOYEE 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 eligibility, disenrollment by PacAdvantage and 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 there may be waiting periods for certain dental services.
- 6) I declare that I will abide by the rules of participation of any participating 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) As an employee applying for the Program, I understand my eligibility is based on my employer's continuing qualification to participate.
- 10) 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 on this application may be reason for loss of eligibility, disenrollment, and other sanctions.

ARBITRATION NOTICE

PacAdvantage is a purchasing pool offering a variety of health/dental/vision/complementary medicine options. Enrollment in many of the plans constitutes an agreement to have certain disputes decided by binding arbitration and waiver of any right to a jury or court trial. Such disputes could include medical malpractice and other claims related to the delivery of health services. 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 may be waiving any right to a jury or court trial.

SIGNATURES

Signature of employee

Date signed

Signature of dependent age 18 or older

Date signed

Signature of dependent age 18 or older

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

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