



QUESTIONS?
Call Customer Services:
(858) 637-6500 or
(800) 359-2002
FAX: (858) 637-6504

REASON FOR THIS APPLICATION

- DECLINE COVERAGE (MUST Complete Section - Bottom of Form)**
- New Hire _____ Rehire _____ Open Enrollment
Date of Hire _____ Date of Rehire _____
- Add Dependent: _____
Date of Marriage _____ Date of Birth _____ Date of Adoption _____
- Cal-COBRA Plan COBRA Conversion Plan

- Terminate Coverage
- Termination Date _____ Employer Signature _____
- Address Change (List Change Below) Name Change (List Change Below) Delete Dependent (List Names Below)

▼ **EMPLOYER'S USE** ▼

GROUP NAME _____

GROUP NUMBER _____ EFFECTIVE DATE _____

INDICATE COVERAGE BELOW (CHECK ALL THAT APPLY)

- HMO Plan FOCUS Other (Indicate): _____
- PPO Plan Out-of-Area Life/ AD&D: (Underwritten by Allianz Life Insurance Company of North America)

EMPLOYEE INFORMATION

SOCIAL SECURITY NO. _____ NAME (LAST, FIRST, MIDDLE INITIAL) _____ HOME PHONE NUMBER _____ WORK PHONE NUMBER _____ EXTENSION _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____ COUNTY _____ BIRTHDATE _____

MARRIED Yes No SEX M F PRIMARY CARE PHYSICIAN (IF BLANK, PLAN WILL ASSIGN PCP) _____ EXISTING PATIENT? Yes No PCP OFFICE LOCATION _____

EMPLOYER'S NAME _____ JOB TITLE / OCCUPATION _____ NO. OF WORK HOURS PER WEEK _____ ARE YOU ACTIVELY AT WORK? Yes No

DEPENDENT INFORMATION -- IF YOU ARE COVERING YOUR DEPENDENTS, PLEASE COMPLETE THE FOLLOWING INFORMATION

LAST NAME, FIRST, M.I.	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX M/F	PRIMARY CARE PHYSICIAN (IF BLANK, PLAN WILL ASSIGN PCP)	EXISTING PATIENT? YES NO
SPOUSE					
DEP.					
DEP.					
DEP.					
DEP.					

OTHER MEDICAL COVERAGE

DO YOU OR YOUR DEPENDENTS INTEND TO CONTINUE OTHER MEDICAL COVERAGE IF THE APPLICATION IS APPROVED?
 Yes No (If "yes" complete the following:) Self Spouse Dependent

NAME OF INSURED _____ SOCIAL SECURITY NO. _____

NAME OF OTHER INSURANCE COMPANY _____ GROUP NO. _____ EMPLOYER OF INSURED _____

EMPLOYER'S ADDRESS (STREET, CITY, STATE, ZIP CODE) _____

DEPENDENTS ENROLLED UNDER OTHER MEDICAL COVERAGE _____

LIFE INSURANCE (IF APPLICABLE)

LIFE INSURANCE ONLY

TOTAL LIFE AND AD & D AMOUNT \$ _____ ANNUAL SALARY \$ _____

LIFE INSURANCE BENEFICIARY

NAME (LAST, FIRST, MIDDLE INITIAL) _____

RELATIONSHIP _____

DECLINATION OF COVERAGE

I have been notified that I, and/or my eligible dependents, are eligible for enrollment in my employer's health benefits plan. By listing individuals for whom I am declining coverage and signing below, I voluntarily decline to enroll my self and/or individuals and acknowledge that my decision to not elect coverage permits my employer's health benefits plan (depending on carrier) to impose a 12 month exclusion from coverage following application, or until open enrollment, should I or these individuals later apply for coverage.

I AM DECLINING COVERAGE FOR:

NAME (LAST, FIRST, MIDDLE INITIAL) _____

NAME (LAST, FIRST, MIDDLE INITIAL) _____

NAME (LAST, FIRST, MIDDLE INITIAL) _____

ENTER 1 OR 2 FROM BELOW:

- #1 - The individual declining coverage DOES NOT have another employer health benefit plan.
#2 - The individual declining coverage DOES have another employer health benefit plan.

SIGN HERE IF DECLINING COVERAGE

EMPLOYEE SIGNATURE _____ DATE _____

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the reverse side of this application. Arbitration Agreement. I understand that any dispute or controversy that may arise regarding the performance, interpretation or breach of the agreement between myself (and/or any enrolled dependent) and Sharp Health Plan, whether arising in contract, tort or otherwise, must be submitted to arbitrator in lieu of a jury or court trial if not satisfactorily resolved through Sharp Health Plan's grievance process.

EMPLOYEE SIGNATURE _____ DATE _____

ACKNOWLEDGMENT

I authorize my employer to deduct from my earnings the contribution (if any) required to cover my share of the premium. I certify that I am working at the employer's place of business in permanent employment. For enrollment in Sharp Health Plan, I understand that my dependents and I must live or work in the Plan's service area.

I understand that my employer's application will determine coverage and that there is no coverage unless and until this application and an application made by my employer have been accepted and approved by Sharp Health Plan, and the applicable Companies identified on the front of this form, issuing coverage.

I understand that California law prohibits an HIV test from being required or used by health care plans as a condition of obtaining coverage.

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION. PLEASE READ CAREFULLY BEFORE SIGNING AT THE "X" ON THE REVERSE SIDE

Sharp Health Plan is authorized to obtain and release medical information in compliance with the Confidentiality of Medical Information Act, Section 56 et. seq. of the California Civil Code.

I hereby authorize any physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish an agent, designee or representative of Sharp Health Plan, or any of the Companies identified for coverage above, any and all records pertaining to medical history, services rendered, or treatment given to anyone enrolled hereunder or added hereafter for purpose of review, investigation, or evaluation of any application or a claim. I authorize Sharp Health Plan, or any of the Companies identified above, or agents, designees or representatives of either to disclose to a hospital or health care service plan, self-insurer or insurer, any such medical information obtained if such disclosure is necessary to allow the processing of any claim. This authorization shall become effective immediately and shall remain in effect for 30 months to permit evaluation of this application, or for the term of coverage to allow the processing of claims. A photocopy of this authorization shall be as valid as the original.

MISREPRESENTATION

I have read and understood the provisions outlined on the front and back of this form. All information I have provided on this form is true and correct. I understand that it is the basis on which coverage may be issued under the plan. Any misstatements or omissions may result in future claims being denied and/or the policy being rescinded. You are entitled to a copy of this signed Enrollment Form and Authorization for your files.