

APPLICATION & ENROLLMENT FORM

New Enrollment: Requested Effective Date **12 | 1 | 94**
 Month Day Year

Addition of Dependent(s)

Change of CMG/IPA Physician

Check Desired Plan as Offered by Employer: Full Network ChampionHEALTH P.O.S.



Applicant Information: Applicant must complete this section.

Last Name Smith	First Name Richard	M.I. W	Home Phone (310) 555-1212
Home Address 8121 S. Main Street, Apt 121B		Date of Marriage 6 12 86	Work Phone (310) 555-1212 x199
City Los Angeles	State CA	Zip Code 92691	E-Mail Address email@internet.com
Employer Acme Consolidated Corporation	Group # (if assigned) 1200	Occupation Group Manager	Date of Hire 7 15 92

Date of hire, even if it's open enrollment

Applicant/Family Information: List yourself and all eligible family members to be enrolled. If a listed family member's last name is different from yours, please explain below.

Provider Selection: Please select a Primary Care Physician for each family member to assure prompt processing of this application.

Last Name	First Name	M.I.	Date of Birth	Social Security Number	Name of Primary Care Physician	PCPI/CMG#	Current Physician?
Smith	Richard	W	2 12 63	567891234	John Adams, DO	320-2000	<input checked="" type="checkbox"/>
Smith	Amanda	L	4 19 64	678912345	John Adams, DO	320-2000	<input checked="" type="checkbox"/>
Smith	Jonathan	R	5 10 89	789123456	John Adams, DO	320-2000	<input checked="" type="checkbox"/>
Smith	Ashley	M	11 4 92	891234567	John Adams, DO	320-2000	<input checked="" type="checkbox"/>

Indicate physician number and contracted medical group number

List the name of your Primary Care Physician(s) selection here.

If available, I would prefer to receive materials in the following language _____
 The following information is voluntary and will help us to better serve your needs. Please check the ethnicity with which you most closely identify.
 Alaskan/Native American Caucasian African American Hispanic Asian/Pacific Islander Other _____

Other Health Insurance:

Please fill out this section if you and any of your eligible family members are currently covered by other medical insurance, or had previous health insurance.

Name of Member(s)	Previous Insurer	Policy Number	Policy Effective Date	Employer's Name
Amanda Smith	Consolidated Health	88-14321	8 1 92	Acme Industrial

Let us know about additional health care coverage.

Are you or any member(s) of your family eligible for Medicare? Yes No

Authorization to Obtain or Release Medical Information: I hereby authorize my physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish an agent, designee, or representative of Universal Care and all records pertaining to medical history, services rendered, or treatment given to anyone enrolled hereunder or added hereunder for purpose of review, investigation, or evaluation of an application or claim. I authorize Universal Care or its agents, designee, or representatives 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 as long as is necessary to enable Universal Care to process claims.

Don't forget your signature and the date.

Subscriber Signature (Applicant) **Richard W. Smith** **Date** **1 | 8 | 94**

Coverage Declaration
 To be completed if any Universal Care coverage is declined or refused by an eligible employee and/or their eligible family members.
 I decline coverage for:
 Myself Children Only
 Spouse Only Spouse and Children

2. Reason for Declining Health Plan Coverage (check one)
 Covered by Spouse's Group Coverage
 Spouse covered by Employer's Group Medical Coverage
 Covered by CHAMPUS or CHAMPVA
 Enrolled in another Group Plan
 Medicare Other (explain): _____

I acknowledge that the eligible coverages have been explained to me by my employer, and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage. **I know that if I later decide to elect coverage, and I was not covered under another employer health benefit plan during the initial enrollment period, I and/or my dependents will be considered a late Enrollee and will be subject to a 12 month waiting period from the date I later decide to elect coverage.** I may also be subject to a six-month pre-existing condition exclusion. My decision not to apply for coverage now could leave me without coverage later.

Complete this section only if you or any of your eligible dependents are not enrolling.

Employee Signature (Sign only if declining coverage for yourself or eligible family member) _____ **Date** _____

Keep the pink copy of this application. It is your temporary member ID card. Be sure to read the helpful instructions on the reverse of the pink copy.

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Check Desired Plan as Offered by Employer: Full Network ChampionHEALTH P.O.S.



Universal Care®

Healthcare you can feel good about.

1600 E. Hill Street • Signal Hill, CA 90755

(800) 635-6668 ext. 4848

www.universalcare.com

Applicant Information: Applicant must complete this section.

Last Name		First Name		M.I.	Home Phone	
					() ()	
Home Address <small>Must be complete. P.O. Box not acceptable.</small>			<input type="checkbox"/> Single <input type="checkbox"/> Married		Date of Marriage	
					Month Day Year	
City		State	Zip Code	E-Mail Address		
Employer		Group # (if assigned)		Occupation		Date of Hire
						Month Day Year

Applicant/Family Information: List yourself and all eligible family members to be enrolled. If a listed family member's last name is different from yours, please explain below.

Provider Selection: Please select a Primary Care Physician for each family member to assure prompt processing of this application.

Last Name	First Name	M.I.	Date of Birth	Social Security Number	Name of Primary Care Physician	PCP#/CMG#	Current Doctor?
<small>Applicant</small> <input type="checkbox"/> M <input type="checkbox"/> F			Month Day Year				Y N
<small>Spouse</small> <input type="checkbox"/> M <input type="checkbox"/> F							
<small>Dependent</small> <input type="checkbox"/> M <input type="checkbox"/> F							
<small>Dependent</small> <input type="checkbox"/> M <input type="checkbox"/> F							
<small>Dependent</small> <input type="checkbox"/> M <input type="checkbox"/> F							
<small>Dependent</small> <input type="checkbox"/> M <input type="checkbox"/> F							

Different last name explanation:

If available, I would prefer to receive materials in the following language _____.

The following information is voluntary and will help us to better serve your needs. Please check the ethnicity with which you most closely identify.

Alaskan/Native American Caucasian African American Hispanic Asian/Pacific Islander Other _____

Other Health Insurance:

Please fill out this section if you and any of your eligible family members are currently covered by other medical insurance, or had previous health insurance.

Name of Member(s)	Previous Insurer	Policy Number	Policy Effective Date	Employer's Name
			Month Day Year	
Name of Member(s)	Current Insurer	Policy Number	Policy Effective Date	Employer's Name
	Name		Month Day Year	
	Address			
	City State Zip			
Are you or any member(s) of your family eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	Name	Name	Name	

Universal Care may require prior medical records and that the applicant agrees to sign a Medical Records Release form so we can obtain the records.

Authorization to Obtain or Release Medical Information: I hereby authorize my physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish an agent, designee, or representative of Universal Care and all records pertaining to medical history, services rendered, or treatment given to anyone enrolled hereunder or added hereunder for purpose of review, investigation, or evaluation of an application or claim. I authorize Universal Care or its agents, designee, or representatives 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 as long as is necessary to enable Universal Care to process claims.

This authorization shall become effective immediately and shall remain in effect as long as is necessary to enable Universal Care to process claims.

Subscriber Signature (Applicant)	Date
	Month Day Year

Coverage Declination

To be completed if any Universal Care coverage is declined or refused by an eligible employee and/or their eligible family members.

1. Health Plan Coverage (check if declined)

I decline coverage for:

Myself Children Only
 Spouse Only Spouse and Children

2. Reason for Declining Health Plan Coverage (check one)

- Covered by Spouse's Group Coverage
Carrier Name & ID Number
- Spouse covered by Employer's Group Medical Coverage
- Covered by CHAMPUS or CHAMPVA
- Enrolled in another Group Plan
Carrier Name
- Medicare Other (explain): _____

I acknowledge that the eligible coverages have been explained to me by my employer, and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage. **I know that if I later decide to elect coverage, and I was not covered under another employer health benefit plan during the initial enrollment period, I and/or my dependents will be considered a late Enrollee and will be subject to a 12 month waiting period from the date I later decide to elect coverage.** I may also be subject to a six-month pre-existing condition exclusion. My decision not to apply for coverage now could leave me without coverage later.

Employee Signature (Sign only if declining coverage for yourself or eligible family member.)	Date
	Month Day Year

Universal Care Coverage For Emergency Services is as Follows:

EMERGENCIES WITHIN UNIVERSAL CARE'S SERVICE AREA

Emergency Services – An emergency is defined as a sudden, serious and unexpected illness, injury or condition requiring medical attention. It is of the utmost importance that your Contracting Medical Group (CMG) or Individual Practice Association (IPA) physician be contacted prior to seeking emergency services. The only permissible exception is that you are unable to contact your CMG or IPA physician because of unconsciousness or the catastrophic nature of the illness or accident and immediate emergency treatment is essential.

In the event that, due to immediate medical necessity, emergency medical care must be provided by physicians or hospitals not connected with Universal Care, the member's CMG or IPA physician must be notified at the earliest possible time **no later than 24 hours after care is sought**. A Universal Care physician will be available to either authorize or take over care.

- If you notify your CMG or IPA physician before emergency care is sought and receive authorization, all doctor and hospital services will be covered in accordance with the schedule of covered services and Copayments in your **Evidence of Coverage and Disclosure Form**.
- If you cannot contact your CMG or IPA physician because you are unconscious, or due to the catastrophic nature of illness or injury, services will be covered as if you had notified your CMG or IPA physician, provided you call them as soon as reasonably possible and care is authorized. You or a family member must contact your CMG or IPA physician within 24 hours or as soon as possible.
- If you do not contact your CMG or IPA physician, or your condition is not determined by Universal Care to be an emergency, you will be responsible for payment of all services.

EMERGENCIES OUTSIDE UNIVERSAL CARE'S SERVICE AREA

The covered services provided outside your CMG or IPA physician's 20-Mile Service Area are limited to care for accidental injury or emergency illness. You must contact your CMG or IPA physician and, if necessary, go to the nearest emergency room (colds, flus and chronic conditions are not emergencies). Only bona fide emergencies, as defined by Universal Care, are covered.