

# Medical / Dental / Life / Vision Enrollment Application

## A. Personal Information

Name of Company	Employer Phone #	Employee Job Title	Full-time Employment Date
Sex <input type="checkbox"/> M <input type="checkbox"/> F    Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <small>(Note: If you or any of your dependents are <u>not</u> enrolling, you must also complete and sign the waiver section on back.)</small>			
Employee Last Name		Employee Social Security Number	
Employee First Name		Date of Birth	Group Number
		MO / DAY / YEAR	
Residence Address	Apt #	City	State      Zip Code
Home Telephone (      )	Mailing Address (if different)		

## B. Medical Benefit (select one plan only)

HMO	PPO
<input type="checkbox"/> Cal Choice 10 <input type="checkbox"/> Cal Choice 25 <input type="checkbox"/> Cal Choice 40 <input type="checkbox"/> Elect Open Access (Health Net)	<input type="checkbox"/> PPO 250 <input type="checkbox"/> PPO 1000 <input type="checkbox"/> PPO 500 <input type="checkbox"/> PPO 2400
Choose an HMO Health Care Service Plan:	<small>PPO PLAN AVAILABILITY WILL BE BASED ON GROUP ELIGIBILITY AND MAY BE SUBJECT TO CHANGE</small>

PPO only: a Full-time Student Verification Form must be completed for each child age 19-24

## C. Optional Benefits — Ask your health plan administrator if any of the optional benefits below are being offered by your employer

LIFE INSURANCE			
Full Name of Beneficiary	Relationship of Beneficiary	Date of Birth for Beneficiary	Life Amount
DENTAL COVERAGE			
<input type="checkbox"/> Dental Plan 1000 <input type="checkbox"/> Dental Plan 3000 <input type="checkbox"/> Voluntary Dental 3000 <input type="checkbox"/> Dental Plan 3500 <input type="checkbox"/> Dental Plan 4000 <input type="checkbox"/> Dental Plan 5000	<small>If you choose plans 1000 or 3000, you must select a dentist:</small> Dentist: _____    ID#: _____	<input type="checkbox"/> Check if dentist chosen is current provider <input type="checkbox"/> Check if you would like a dentist assigned	
VISION COVERAGE		PREMIUM ONLY PLAN (P.O.P.)	
<input type="checkbox"/> Vision (no charge) <input type="checkbox"/> Voluntary Vision (additional charge)		<input type="checkbox"/> I want my portion of eligible insurance premiums paid on a pre-tax basis	

## D. Enrollment Information (Complete this section ONLY if you are electing medical, dental and/or vision for yourself or dependents)

	Employee	Spouse	Child	Child	Child
Last Name	<input type="checkbox"/> Life only				
First Name					
Relationship to Employee		<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner			
Social Security No.					
Gender		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth		/ /	/ /	/ /	/ /
Primary Care Physician*					
Physician ID# & City					
Current Patient of PCP?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Disabled?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Enrolling For?	<input type="checkbox"/> Med <input type="checkbox"/> Dent <input type="checkbox"/> Vision	<input type="checkbox"/> Med <input type="checkbox"/> Dent† <input type="checkbox"/> Vision	<input type="checkbox"/> Med <input type="checkbox"/> Dent† <input type="checkbox"/> Vision	<input type="checkbox"/> Med <input type="checkbox"/> Dent† <input type="checkbox"/> Vision	<input type="checkbox"/> Med <input type="checkbox"/> Dent† <input type="checkbox"/> Vision

Check here if you would like your Health Care Service Plan to assign you a Primary Care Physician.

\* Please be sure to verify that your PCP is contracted with your selected carrier prior to enrolling. New Hire applications added to existing groups will automatically be assigned a PCP if one is not chosen or PCP is not contracted with the selected health plan. For Kaiser Permanente enrollees, no PCP selection is required.

† Dependents enrolled for dental must match dependents enrolled for medical (except voluntary dental or children under Age 3).

**E. Your LEGAL Acknowledgement (Read, Sign & Date Below)**

By submitting this signed application, I agree and understand that the health plan I have chosen through the CaliforniaChoice Program shall automatically have a lien on any payment of monies from any source, for services rendered in conjunction with an injury caused by the acts or omissions of a third party.

I agree for myself and my dependents to be bound by the benefits, copayments, deductibles, exclusions, limitations and other terms of the health plan's small group contract.

I authorize my physician, healthcare provider, hospital, clinic or other medically related facility to furnish my, and my dependent's, protected health information, including medical records, to the health plan I have chosen through the CaliforniaChoice Program or its authorized agents for the purpose of review, investigation, or evaluation of an application or claim, and for quality assurance and utilization review. I authorize CaliforniaChoice and the health plan I have chosen, and their agents, designees or representatives, to disclose to a hospital, health plan, insurer, or healthcare provider any protected health information if such disclosure is necessary to allow the performance of any of those activities. This authorization shall become effective immediately and shall remain in effect for up to 30 months for the date the authorization was signed. I understand that I, or a person authorized to act on my behalf, is entitled to receive a copy of this authorization form.

I have read and understand the information provided to me pertaining to the Premium Only Plans and the tax consequences.

**I declare under the penalty of perjury under the laws of the state of California that the following statements are true, correct and pertain to the Employer named on this application, myself and my dependents named on this application:**

- I am either actively, permanently working for the Employer and considered eligible by my Employer, because I work, either 20+ or 30+ hours per week, or I am an eligible COBRA/Cal-COBRA participant.
- I am not a temporary, seasonal, per diem or a 1099 employee or insured by or eligible to be insured by the Employer's union policy.
- My children's dates of birth are accurate. My children are: unmarried and financially dependent upon me per IRS guidelines. My children are born to me or my spouse or legally adopted by me and/or my spouse. Or if Domestic Partnership coverage is allowed by my Employer, my children are born to/adopted by my Domestic Partner.

I understand that the above statements are subject to audit at any time and agree to provide CaliforniaChoice with any and all information necessary to prove the above statements.

I understand that false statements and/or failure to provide the information upon request will cause the termination of all CaliforniaChoice benefits 15 days following the date of the notice of termination and I will be held responsible for all services and charges incurred through CaliforniaChoice program providers thereafter.

I understand that any persons, business, or health plan that suffers a loss because of false-declarations contained in this statement may take legal action against me to recover their losses.

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

ARBITRATION: 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 my health plan, whether arising out of tort or otherwise, must be submitted to binding arbitration and in lieu of a jury or court trial if not satisfactorily resolved through my health plan's grievance process. Additionally, specific requirements for health plans that require binding arbitration to resolve claims for professional negligence and medical malpractice are set out below.

HEALTH NET ENROLLEES: I understand and agree that any and all disputes or disagreements between me (including any of my enrolled family members or heirs or personal representatives) and Health Net of CA and/or Health Net Life regarding the construction, interpretation, performance or breach of the Health Net Plan Contract, Insurance Policy or Certificate, or regarding other matters relating to or arising out of my Health Net membership, whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or employees, are also involved, must be submitted to final and binding arbitration in lieu of a jury or court trial. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties, including Health Net of CA and/or Health Net Life, are giving up their constitutional right to the extent permitted by law to have their dispute decided in a court of law before a jury. I also understand that disputes that I may have with Health Net of CA and/or Health Net Life involving claims for medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) are also subject to final and binding arbitration.

Members who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. § 1001 et seq., a federal law regulating benefit plans, are not required to submit disputes about certain "adverse benefit determinations" made by Health Net to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by Health Net to deny, reduce, terminate or not pay for all or a part of a benefit. However, I and Health Net may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

KAISER FOUNDATION HEALTH PLAN ENROLLEES I understand that in compliance with the terms of my Kaiser Foundation Health Plan ("KFHP") membership agreement, any dispute or controversy relating to or arising from the membership agreement, its interpretation, or its performance between myself, or any enrolled family member, heir, or other associated party on the one hand and KFHP or the health care providers with whom KFHP contracts on the other hand, including but not limited to any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be submitted to binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my constitutional right to a jury trial and accept the use of binding arbitration. I understand that KFHP's full arbitration provision is contained in its Evidence of Coverage. As explained in the full provision, arbitration may not be required for benefit claims that are subject to exclusive federal remedies or claims that are within the jurisdiction of the small claims court.

UNIVERSAL CARE ENROLLEES: 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 Universal Care 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.

A more detailed arbitration provision is included in my health plan contract or insurance policy. By signing and submitting this application, I hereby agree to the above terms and conditions, and confirm that the information contained in this application is true and correct.

Employee **SIGN HERE FOR MEDICAL, DENTAL, LIFE OR VISION COVERAGE:** \_\_\_\_\_ Date: \_\_\_\_\_



Print Name \_\_\_\_\_

<b>COBRA Applicants:</b> Please check COBRA type: <input type="checkbox"/> COBRA <input type="checkbox"/> Cal-COBRA	<b>Indicate Qualifying Event:</b> <input type="checkbox"/> Termination of employment <input type="checkbox"/> Reduction of hours	<input type="checkbox"/> Child no longer eligible <input type="checkbox"/> Divorce/legal separation	<input type="checkbox"/> Medicare entitlement <input type="checkbox"/> Death of employee	<b>Date of Qualifying Event</b> _____
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# Medical / Dental Waiver

Complete this form only if you do not want medical or dental coverage for yourself and/or your eligible dependents. **If offered by your employer, the life coverage benefit cannot be waived and you are required to complete an Enrollment Application.** Chiropractic coverage cannot be waived when enrolling for medical coverage.

## A. Personal Information

Name of Company	Employer Phone Number
Employee Last Name	Employee Social Security Number
Employee First Name	Group Number

## B. Type of Waiver

I have been offered coverage by my employer, but at this time I wish to **DECLINE** coverage as follows:

- 1) **Medical for:**     Myself and dependents     Spouse/Domestic Partner     Child(ren)
- 2) **Dental for:**     Myself and dependents     Spouse/Domestic Partner     Child(ren)

## C. Reason

Required only if employee waiving coverage

- 1) **Reason waiving Medical:**
- Other group coverage    Carrier Name: \_\_\_\_\_ Group # \_\_\_\_\_
- Medicare
- Medi-cal
- Individual Policy
- Other Reason: \_\_\_\_\_ (explanation required)
- 2) **Reason waiving Dental:**
- Other group coverage    Carrier Name: \_\_\_\_\_ Group # \_\_\_\_\_
- Medicare
- Medi-cal
- Individual Policy
- Other Reason: \_\_\_\_\_ (explanation required)

## D. Signature

I understand that by failing to elect coverage now, CaliforniaChoice Benefit Administrators can impose up to a 12 month period of exclusion should I request coverage at a later date.

I also understand that if my employer is offering life coverage, I CANNOT WAIVE LIFE COVERAGE.

*This waiver provision will not apply if: 1) Court orders coverage of a spouse or child and the request for enrollment occurs within 30 days of the court order; or 2) Employee meets ALL of the following: A) Was covered under another employer-sponsored health plan at the time of initial eligibility; B) Lost coverage as a result of termination of employment, change in employment status, involuntary termination of other plan's coverage, cessation of employer's contribution, or death or divorce of spouse; C) Requests enrollment within 30 days of loss of coverage.*

Employee <b>SIGN HERE TO WAIVE COVERAGE:</b>	Date