

Enrollment Form

▪ Instructions

You can either:

Accept the health care services coverage provided through your Employer by signing the space provided on the enrollment form. Your signature indicates that you have read, understand and agree to the terms and conditions below. Affixing your signature also indicates your acceptance of payroll deductions (if necessary) to pay your share of the cost.

OR

You can waive the health care services coverage provided through your Employer for yourself, your Spouse or your Dependents by signing the Declination of Coverage Form. We strongly recommend that you read through the entire form carefully before signing your name in ink and dating it. Please request the Declination of Coverage Form from your Employer.

▪ Terms and Conditions – Please read carefully before signing

On behalf of myself and my eligible Dependents, I hereby apply for health care services coverage indicated in PacifiCare's group health plan offered through my Employer, and agree to and understand the following:

1. To be bound by the PacifiCare group health plan documents ("Agreement" or "Policy") if I have chosen the PacifiCare SignatureValue® (managed care plan) or PacifiCare SignaturePOS® (POS).
2. My Employer may deduct from my earnings the employee contribution required to cover my share of the Premium, if any.
3. Any differences between myself and/or my Dependents and PacifiCare relating to PacifiCare or its performance may be subject to voluntary binding arbitration. Differences between myself and/or my Dependents and any health care providers, including Claims of medical malpractice are not governed by the Agreement or Policy.
4. PacifiCare or a designee may access and/or use my medical records and the medical records of my enrolled Dependents, including Mental Health medical records and medical records from drug and alcohol abuse treatment or prevention, for purposes of Utilization Review, Quality Assurance, Surveys, Processing of Claims, Financial Audit or other purposes reasonably related to the performance of treatment, payment or health care operations of the Agreement or Policy.
5. Any material omission or misrepresentation in answering the questions on this application may result in the denial of benefits and the termination of my and/or my Dependents' membership or grounds for rescission of the insurance Policy with PacifiCare.
6. Coverage shall not begin until acceptance of this enrollment by PacifiCare. Upon acceptance of this application, PacifiCare shall be bound by the terms of the Agreement or Policy, and any Amendments thereto.
7. I have received, read and understand the PacifiCare Disclosure Form, Directory of Participating Medical Groups and a copy of this Enrollment Form.
8. My Dependents and I must live or work in PacifiCare's service area if enrolling in the PacifiCare SignatureValue or PacifiCare SignaturePOS plan.

Products and services are offered by PacifiCare of Oregon, Inc, PacifiCare Health Plan Administrators, Inc., RxSolutions, Inc., SeniorCo, Inc., and PacifiCare Behavioral Health, Inc. Indemnity insurance products underwritten by PacifiCare Life Assurance Company. PacifiCare® is a federally registered trademark of PacifiCare Life and Health Insurance Company.

PacifiCare SignatureValue

P.O. Box 30981
Salt Lake City, UT 84130
1-800-932-3004
1-800-786-7387 (TDHI)
Fax: 1-866-372-1316

PacifiCare SignaturePOS

P.O. Box 30981
Salt Lake City, UT 84130
1-800-932-3004
1-800-786-7387 (TDHI)
Fax: 1-866-372-1316

**PacifiCare Dental & Vision
Administrators**

P.O. Box 25187
Santa Ana, CA 92799
1-800-228-3384

Visit our Web site @ www.pacificare.com

Employee Enrollment Form (Please Print)

PacifiCare®

A UnitedHealthcare Company

Personal Information				
Group Name				
Last Name	First Name	M.I.	Suffix	<input type="checkbox"/> Male <input type="checkbox"/> Female
Residence Mailing Address				
City		State	ZIP	
Home Telephone	Work Telephone	Date of Birth (mm-dd-yy)		
Social Security #	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Widow <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner			
Company Name	Date of (Re)Hire	Job Title		
Preferred Language (optional) <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other	Ethnicity (optional) <input type="checkbox"/> Caucasian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Asian, Native Hawaiian, other Pacific Islander <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Not provided by employee			
Number of hours worked per week	Salary/Wages <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	\$		
Are you currently on COBRA? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, qualifying event:		COBRA Qualifying Event Effective Date		

Your employer completes this section
Group #/Plan Code
Dental/Vision Group #
Source of Enrollment: <input type="checkbox"/> Open Enrollment <input type="checkbox"/> QMCSO <input type="checkbox"/> New Hire <input type="checkbox"/> Employee Status Change <input type="checkbox"/> New Group <input type="checkbox"/> Rehire
Date of Hire
Requested Effective Date
Employer Signature
Employee Class

Selected Coverage (Select only the plans offered by your Employer)	
Plans offered and underwritten by PacifiCare of Oregon	
Medical	Individual(s) to be covered: <input type="checkbox"/> Self <input type="checkbox"/> Self + Spouse <input type="checkbox"/> Self + Dependent(s) <input type="checkbox"/> Self + Family <input type="checkbox"/> Waive Medical Reason _____ Plan Options: <input type="checkbox"/> PacifiCare SignatureValue (managed care plan) <input type="checkbox"/> PacifiCare SignaturePOS
Dental	Individual(s) to be covered: <input type="checkbox"/> Self <input type="checkbox"/> Self + Spouse <input type="checkbox"/> Self + Dependent(s) <input type="checkbox"/> Self + Family <input type="checkbox"/> Waive Dental Reason _____ Plan Options: N/A
Vision	Individual(s) to be covered: <input type="checkbox"/> Self <input type="checkbox"/> Self + Spouse <input type="checkbox"/> Self + Dependent(s) <input type="checkbox"/> Self + Family <input type="checkbox"/> Waive Vision Reason _____ Plan Options: N/A
Life	Additional Enrollment Form Required

- Primary Care Physician (PCP) selection is only required if a PacifiCare SignatureValue/PacifiCare SignaturePOS plan is selected (if you do not select a PCP, one will be assigned).
- Please select a PCP from the Provider Directory for you and each of your Family members by writing the PCP name and number below.
- You may choose a different PCP for each member of your Family.

Employee Name	Social Security #
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Employee and Dependent Information (List yourself and family members to be covered – attach additional sheets if necessary)

Self	Primary Care Physician (PCP) Name and # (for PacifiCare SignatureValue/PacifiCare SignaturePOS only)		Medical Group #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dentist Name and City (for PacifiCare SignatureValue only)			Dental Facility #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Spouse/ Domestic Partner*	<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name	First Name	M.I.	
Date of Birth (mm-dd-yy)	Social Security #	Address, if different from Employee's			
Primary Care Physician (PCP) Name and # (for PacifiCare SignatureValue/PacifiCare SignaturePOS only)			Medical Group #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dentist Name and City (for PacifiCare SignatureValue only)			Dental Facility #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent 1	<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name	First Name	M.I.	Date of Birth (mm-dd-yy)**
Relationship	Social Security #	Address, if different from Employee's			
Primary Care Physician (PCP) Name and # (for PacifiCare SignatureValue/PacifiCare SignaturePOS only)			Medical Group #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dentist Name and City (for PacifiCare SignatureValue only)			Dental Facility #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent 2	<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name	First Name	M.I.	Date of Birth (mm-dd-yy)**
Relationship	Social Security #	Address, if different from Employee's			
Primary Care Physician (PCP) Name and # (for PacifiCare SignatureValue/PacifiCare SignaturePOS only)			Medical Group #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dentist Name and City (for PacifiCare SignatureValue only)			Dental Facility #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent 3	<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name	First Name	M.I.	Date of Birth (mm-dd-yy)**
Relationship	Social Security #	Address, if different from Employee's			
Primary Care Physician (PCP) Name and # (for PacifiCare SignatureValue/PacifiCare SignaturePOS only)			Medical Group #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dentist Name and City (for PacifiCare SignatureValue only)			Dental Facility #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

* Please verify that domestic partner coverage is available through your Employer.
 ** Over-age Dependents require proof of full-time student status or permanent disability status within 31 days of enrollment.

Benefit Coordination/Other Insurance Carrier Information

1. Does anyone listed have other health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete section below.		2. Is anyone listed permanently disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the following: 2a. Name _____ 2b. Date disability began _____		3. Is anyone listed eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the following: 3a. Name _____ 3b. Medicare ID# _____	
1a. Name	1b. Insurance Company Name	1c. Policy #	1d. Effective Date	Termination Date	1e. Other Employer Name and Address

Signature By signing below, I acknowledge that I have read, understand and agree to the Terms and Conditions on all the pages of this form. A reproduction of this authorization shall be as valid as the original.

Signature (Required) X	Date (Required)
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