California PacifiCare SignatureValue® HMO
Individual Plan Enrollment Application

PacifiCare SignatureValue® A select group of physicians

❑ New Business ❑ Change in Benefits (specify requested date below in Coverage Information section) ❑ Dependent Add

This application is to be completed by the applicant applying for coverage. For child only, application is to be completed by the child's parent or legal guardian if child is not of legal age.

Applicant's Social Security Number ____________________ **Group No.** (Home Office to assign) ____________________

APPLICANT INFORMATION

Last Name ____________________ First Name ____________________ Initial ________

Home Address ____________________ City ____________ State _____ Zip _______ County ____________
(PO Box, not acceptable)

Billing Address ____________________ City ____________ State ____________ Zip ____________

Home Phone No. (____) ____________ Best Time to Call____________ Alternate Phone No. (if applicable) (____) ____________

Gender ❑ M ❑ F Date of Birth____________ Height ___________ Weight ___________ ❑ Single ❑ Married ❑ Domestic Partner

Chosen Primary Care Physician's (PCP) Name & Provider # (10 digits)____________________ Network (PMG) ____________

Language (Optional) ❑ English ❑ Spanish ❑ Other____________

Ethnicity (Optional) ❑ Caucasian or White ❑ Hispanic or Latino ❑ Black or African-American ❑ Not Provided ❑ American Indian or Alaskan Native ❑ Asian, Native Hawaiian, other Pacific Islander

Applicant's Occupation: ____________________ **Spouse/Domestic Partner's Occupation:** ____________________

❑ Yes ❑ No Are you a U.S. citizen? If no, list how long in the U.S.:____________________**(Attach copy of valid permanent resident card)**

DEPENDENT ENROLLMENT INFORMATION

(If more space is needed, attach an additional sheet of paper, sign and date it.)

Spouse or
Domestic Partner (First Name & M.I., last name if different): ____________ Soc. Sec. No. ____________ Date of Birth ____________
Gender ❑ M ❑ F Height ______ Weight ______ Chosen PCP Name & Provider # (10 digits) ____________ Network (PMG) ____________

Child (First Name & M.I., last name if different): ____________ Soc. Sec. No. ____________ Date of Birth ____________
Gender ❑ M ❑ F Height ______ Weight ______ Chosen PCP Name & Provider # (10 digits) ____________ Network (PMG) ____________

Child (First Name & M.I., last name if different): ____________ Soc. Sec. No. ____________ Date of Birth ____________
Gender ❑ M ❑ F Height ______ Weight ______ Chosen PCP Name & Provider # (10 digits) ____________ Network (PMG) ____________

Child (First Name & M.I., last name if different): ____________ Soc. Sec. No. ____________ Date of Birth ____________
Gender ❑ M ❑ F Height ______ Weight ______ Chosen PCP Name & Provider # (10 digits) ____________ Network (PMG) ____________

Dependents (age 19 through 23) attending school full-time, include name of dependent, name/address of school, and number of credits:____________________

❑ Yes ❑ No Do all dependents reside with the primary applicant? If no, please indicate name & mailing address of dependents: ____________________

ELIGIBILITY

❑ Yes ❑ No Are you or any family members covered by or eligible for Medicare/Medicaid? If yes, list family members and their effective date:____________

❑ Yes ❑ No Are you, any family member, or significant other pregnant or in the process of adoption or surrogacy (including those not applying for coverage)? ____________

❑ Yes ❑ No Are you or any eligible dependent disabled, receiving disability payments, or hospital confined? ____________

COVERAGE INFORMATION

Medical: ❑ Applicant ❑ Applicant/Family ❑ Applicant/Spouse or Domestic Partner ❑ Applicant/Child(ren) ❑ Child only

Plan Name ____________________ Network Name (Optional) ____________________

PCP Copay__________ IP Hosp Copay____________ **Requested effective date** ____/____/____________(Actual effective date is determined by PacifiCare)

Upon signature of this application, I am indicating that I have selected the health plan within this Coverage Information section and that I fully understand the benefit levels of this plan.

❑ I am a HIPAA Eligible Individual as defined in the Prior Coverage section on page 3 of this application and I choose to apply for (HIPAA Eligible medical plan indicated): ____________________

❑ I am a HIPAA Eligible Individual as defined in the Prior Coverage section on page 3 of this application but I choose to apply for the Non-HIPAA Eligible medical plan indicated. I understand there is no guarantee of coverage of the selected non-HIPAA plan regardless of my status as a HIPAA eligible individual.

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH CARE SERVICE PLANS AND INSURANCE COMPANIES AS A CONDITION OF OBTAINING COVERAGE.

Home Office Use Only	Reviewed by: Date:	Effective date: Plan:	Approved/Denied: Premium:

Depending upon state law, this information may be used in determining whether your application is approved for coverage.

MEDICAL HISTORY

A. Within the past five years, has any person to be covered ever had any symptoms that would cause an ordinarily prudent person to seek medical care; had any conditions, diagnosis, consultation, routine follow-up, treatment, or therapy; been prescribed any medication; been monitored; or received counseling for any of following? (Provide details to "Yes" answers below.)

1) Digestive Disorder	**Yes**	**No**
a. Irritable Bowel, Spastic Colon	❑	❑
b. Colitis, Crohn's Disease	❑	❑
c. Gastric Reflux, Heartburn	❑	❑
d. Gallbladder Disease	❑	❑
e. Hepatitis, Other Liver Disorder	❑	❑
f. Other Digestive or Intestinal Disorder	❑	❑

2) Cardiovascular/Circulatory	**Yes**	**No**
a. High Blood Pressure, Hypertension	❑	❑
b. Mitral Valve Prolapse, Heart Murmur	❑	❑
c. Chest Pain, Heart Attack, Arrhythmia, Angina, Palpitations	❑	❑
d. Vascular Abnormality, Poor Circulation	❑	❑
e. Stroke, Transient Ischemic Attack	❑	❑
f. Other Heart Condition or Disease	❑	❑

3) Respiratory/Lung	**Yes**	**No**
a. Allergies, Asthma	❑	❑
b. Bronchitis, COPD, Emphysema	❑	❑
c. Sleep Apnea, Tuberculosis	❑	❑
d. Other Respiratory or Lung Disorder	❑	❑

4) Musculoskeletal/Nerve	**Yes**	**No**
a. Arthritis or Rheumatism, Carpal Tunnel	❑	❑
b. Neck, Back, Spinal Condition	❑	❑
c. Bone, Muscles, Joint Condition	❑	❑
d. Fracture, Dislocation, Internal Fixation	❑	❑
e. Lupus, Connective Tissue Disease	❑	❑
f. Osteoporosis, Osteopenia	❑	❑

5) Cyst/Tumor/Polyp/Malignancy	**Yes**	**No**
a. Cancer, Leukemia	❑	❑
b. Cyst, Growth, Lump, Tumor, Polyp	❑	❑
c. Hodgkin's or Non-Hodgkin's Lymphoma	❑	❑

6) Genitourinary	**Yes**	**No**
a. Fibrocystic Breast, Implants, Other Breast Condition	❑	❑
b. Ovarian Cyst, Uterine Fibroid	❑	❑
c. Infertility Testing or Treatment	❑	❑
d. Menstrual, Reproductive Organ Disorder	❑	❑
e. Abnormal Pap Smear	❑	❑
f. Prostate Gland Disorder, Abnormal PSA Test	❑	❑
g. Sexually Transmitted Disease	❑	❑
h. Urinary Tract, Bladder, Kidney Disorder	❑	❑

7) Eyes/Ears/Nose/Throat/Skin	**Yes**	**No**
a. Acne, Skin Disorder	❑	❑
b. Ear, Nose, Sinus, Throat, Mouth	❑	❑
c. Eye, Cataracts, Glaucoma, Other	❑	❑
d. Loss of Hearing, Deafness	❑	❑
e. Jaw Condition or TMJ	❑	❑
f. Vision Impairment, Blindness	❑	❑

8) Endocrine/Gland/Lymph/Blood	**Yes**	**No**
a. Blood Abnormality, Anemia	❑	❑
b. Elevated Cholesterol/Triglycerides	❑	❑
c. Diabetes, Pancreas, Elevated Glucose	❑	❑
d. Hormonal Disorder, Adrenal	❑	❑
e. Lymph Gland Disorder, Immune System	❑	❑
f. Thyroid, Goiter	❑	❑

9) Alcohol/Drug	**Yes**	**No**
a. Alcoholism, Alcohol Use (3+ drinks/day)	❑	❑
b. Drug or Substance Abuse, Illicit Use	❑	❑

10) Psychological	**Yes**	**No**
a. Anxiety, Panic Disorder	❑	❑
b. Depression, Major Depressive Disorder	❑	❑
c. Bipolar Disorder	❑	❑
d. Obsessive Compulsive Disorder	❑	❑
e. Schizophrenia, Schizoaffective Disorder	❑	❑
f. Anorexia, Bulimia Nervosa	❑	❑
g. Other Psychological Condition	❑	❑

11) Neurological	**Yes**	**No**
a. Cerebral Palsy, Muscular Dystrophy	❑	❑
b. Epilepsy, Seizures, Convulsions	❑	❑
c. Headaches, Migraines	❑	❑
d. Mental Retardation, Down Syndrome	❑	❑
e. Multiple Sclerosis, Paralysis	❑	❑
f. Other Neurological Disease or Disorder	❑	❑
g. Alzheimer's Disease, Dementia	❑	❑
h. Parkinson's Disease	❑	❑
i. Autism, Pervasive Develop. Disorder	❑	❑

12) General	**Yes**	**No**
a. Abnormal Test Results	❑	❑
b. Burns	❑	❑
c. Congenital Abnormality, Loss of Limb	❑	❑
d. Edema	❑	❑
e. Fibromyalgia, Chronic Fatigue	❑	❑
f. Hernia	❑	❑
g. Organ or Tissue Transplant	❑	❑
h. Pain Disorder	❑	❑
i. Surgical Implants	❑	❑
j. Chronic Infection	❑	❑
k. Ulcer	❑	❑

13) Other	**Yes**	**No**
a. Health disorders not listed above	❑	❑

B. ❑ Yes ❑ No Have you or any eligible dependent ever been declined, postponed, ridered, rescinded, or rated up for medical, disability, critical illness, or life insurance with another health plan or insurance carrier? If yes, explain: _____

C. ❑ Yes ❑ No In the past five years, have you or any person to be covered received treatment, received therapy, taken medication, or consulted a health care provider for any reason? If yes, explain: _____

D. ❑ Yes ❑ No Are you or any person to be covered currently taking any prescription medication, over-the-counter medication, vitamin therapy or alternative remedies? Please indicate the reason for use: _____

E. ❑ Yes ❑ No In the past five years, have you or any person to be covered been advised to have a test or treatment, been advised to obtain equipment or service or been advised of a condition that may require attention or treatment? If yes, was this prompted by complaints or symptoms? Explain: _____

F. ❑ Yes ❑ No Within the past five years, has any person to be covered been advised to seek treatment for or been advised to limit alcohol or drug use, been a member of any alcohol or drug abuse support group or used any controlled drug not prescribed by a doctor? If yes, explain: _____

G. ❑ Yes ❑ No Has any person to be covered ever been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex by a physician or member of the medical profession, or had a T-cell abnormality? If yes, list names: _____

H. ❑ Yes ❑ No Has anyone to be covered used tobacco products during the previous 12 months? If yes, list names: _____

Provide details to "YES" answers (If more space is needed, attach an additional sheet of paper, sign and date it.)

Question No./Letter	Name	Illness/Impairment	Dates Treated	Medications/Treatment/Surgery/Physician's Name & Address

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PRIOR COVERAGE

HIPAA Eligible Individual Determination - Please indicate yes or no to the following:

Yes	No	
❑	❑	1. As of the date on which you are applying for coverage, have you been covered under creditable coverage for at least 18 months with no more than a 63-day lapse in coverage?
❑	❑	2. Was your most recent period of coverage under a group health plan (employer-sponsored), a governmental plan, or a church plan?
❑	❑	3. If you were offered the option of continuation of coverage under COBRA, Cal-COBRA or a similar state continuation program, did you complete the allowable period of coverage?
❑	❑	4. Are you eligible for any of the following: a group health plan (employer-sponsored plan); Part A or Part B of Medicare; or a state plan under Medicaid, Medi-Cal, or any successor program?
❑	❑	5. Do you have other health insurance or coverage?
❑	❑	6. Was your most recent health insurance or coverage terminated for fraud, intentional misrepresentation of material fact, or individual nonpayment of premium?

If you answered YES to questions 1 through 3 and NO to questions 4 through 6, you or your dependents may qualify as a HIPAA Eligible Individual, and we may waive the pre-existing limitation for you and your dependents on selected plans. If qualifying as a HIPAA Eligible Individual, please attach a Certificate of Creditable Coverage from the prior plan, or any other documents to prove that you or your dependents had prior coverage.

❑ Yes ❑ No Are you or any dependents replacing coverage that was in effect within the last 63 days?

❑ Yes ❑ No Do you or any dependents to be covered have or intend to keep any health coverage, including COBRA and/or state continuation currently in force?

❑ Yes ❑ No Have you or any dependents ever been previously covered by PacifiCare?

If you answered "Yes" to any of the above questions, please complete the following section. If you answered "No" to all questions, please proceed to the Terms and Conditions of Coverage section.

Name(s) of covered individual	Insurance Company/Health Plan Name, Address and Phone	Policy or Group Number	Type of Coverage (individual, employer group, short term, COBRA, Medicare, other)	Effective Date	Termination Date

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TERMS AND CONDITIONS OF COVERAGE

1) I understand that all health care services under the PacifiCare SignatureValue (HMO) coverage options must be provided or arranged for by PacifiCare, except for Emergency or Urgently Needed Services.

2) I understand that this application is not a contract. The contract consists of the PacifiCare Health Plan Individual Subscriber Agreement or Policy, including but not limited to all applications, health questionnaires and information submitted by the Subscriber or Insured and his or her Dependents in applying for coverage, appropriate attachments and addenda, and any amendments hereto. Should my application be accepted, PacifiCare will send me a Subscriber Agreement or Policy which details the exact terms and conditions of coverage to which I will be legally bound.

3) I understand that any agent or broker or other producer selling PacifiCare coverage does not have the authority to approve my application, change any terms of the agreement or waive any PacifiCare requirements.

4) I agree that PacifiCare may terminate or rescind membership for any person covered under this plan, if I intentionally provided incomplete or incorrect material misstatements, omissions or false information or intentionally mispresent a material fact on this form, if I intentionally fail to provide PacifiCare with updated material changes to this form prior to enrollment.

5) If the applicant is a minor, as the parent/legal guardian of the minor child (the "applicant") and on behalf of the applicant, I request PacifiCare to provide health care coverage under its Individual Plan to the applicant. I hereby assume responsibility for the applicant's compliance with the terms and conditions of the PacifiCare Individual Plan selected as set forth in the applicable Subscriber Agreement or Policy and agree to be responsible for making Health Plan Premium and Copayments, on behalf of the applicant.

6) I hereby authorize any "Provider of health care" to disclose or provide to PacifiCare, its agents or employees, all information and medical records pertaining to any examination or treatment, including treatment for alcohol abuse, substance abuse, psychiatric disorders and/or acquired immune deficiency syndrome (AIDS), regarding myself or any applying applicant. I understand this information is collected for purposes of evaluating my application and determining both initial and continuing eligibility for benefits. This authorization will remain valid for 30 months from the date below. A photocopy of this authorization is valid as the original. I understand that I may revoke this authorization in writing at any time before I become a PacifiCare member, except for instances where PacifiCare has already taken action based on the authorization. I agree to send my revocation to PacifiCare Individual Underwriting, M/S CA120-0155, P.O. Box 3069, Cypress CA 90630-9962. I understand that if my information is shared with someone who is not required to follow state or federal privacy laws, my information may no longer be protected. I understand that if I refuse to provide this authorization, PacifiCare will not make an eligibility determination, and I will not be considered for membership in a PacifiCare plan.

7) I understand that PacifiCare is not liable for bills incurred before the effective date.

8) By signing below, I attest and agree that all of the information is correct and that the submission of this application to PacifiCare constitutes an offer to obtain the PacifiCare individual coverage summarily described in the Subscriber Agreement or Policy. I have read the disclosure brochure outlining the benefits, limitations and exclusions and other elements of the disclosure, the above terms and conditions and the authorization to disclose personal information.

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Arbitration Disclosure - By signing below, I acknowledge that I have read, understand and agree to the Arbitration Disclosure and the Terms and Conditions on all the pages of this application.

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), BETWEEN ME AND MY DEPENDENTS ENROLLED IN THE PLAN (INCLUDING ANY HEIRS OR ASSIGNS) AND PACIFICARE OF CALIFORNIA 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.

REQUIRED SIGNATURES

Applicant's Signature **X**_____Date___/___/_____

Signature of applicant, authorized representative or if child only and not of legal age, signature of parent or legal guardian.

_____
(Print Name of Parent, Legal Guardian, or Authorized Representative)

If signed by a representative of Applicant, please indicate the representative's authority to act on behalf of Applicant. _____

Spouse/Domestic Partners Signature **X**_____Date_____
(If spouse/domestic partner is to be covered)

Dependent's Signature (age 18 or older) **X**_____Date_____
(If dependents are to be covered)

X_____Date_____

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AGENT, BROKER, OR PRODUCER INFORMATION

PacifiCare compensates agents, brokers, or producers for the sale of certain products. Your premium is the same if you purchase coverage directly from PacifiCare or if you use a producer. Please contact your agent, broker, or producer, if applicable, regarding the amount of compensation. In addition, you may request information regarding agent, broker, or producer commissions attributable to your policy by contacting PacifiCare Membership Accounting.

Writing Agent, Broker, or Producer Name _____ Carrier ID Number Assigned _____
(Please print)

Writing Agent, Broker, or Producer Address _____
(Please include firm name if applicable)

Phone _____ Fax _____ E-mail _____

Best way to contact _____

General Agent Name (if applicable) _____ Carrier ID Number Assigned _____

General Agent Address _____

Writing Agent, Broker, or Producer Signature **X** _____ Date: _____

Payee Name and Address _____
(if other than the writing agent, broker, or producer)

If first individual application with PacifiCare: Dept. of Insurance License No. _____ State of License Issuance _____

❑ Yes ❑ No Are you aware of any information not disclosed in the Medical History Section of this Enrollment Application which may have a bearing on this risk? If yes, explain _____

❑ Yes ❑ No Did you see the applicant and did you ask each question on the Medical History Section of this Enrollment Application exactly as set forth? If no, explain _____

❑ Yes ❑ No Was the Medical History Section of this Enrollment Application completed by the applicant?

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Payment Authorization Form

(For use with HMO/MCO products only)

A. APPLICANT INFORMATION

Last Name_____ First Name _____ SS#_____

B. INITIAL METHOD OF PAYMENT

❑ Credit Card (Complete Credit Card Authorization below)

CREDIT CARD AUTHORIZATION (AVAILABLE FOR FIRST MONTH PAYMENT ONLY)

❑ VISA ❑ MasterCard

Cardholder's First Name _____ Middle Initial _____ Last Name _____
(As it appears on credit card)

Cardholder's Address _____ Cardholder's Phone Number_____

Credit Card Number:_____ Verification Code_____ Expiration Date: _____
(16 digits required) (3 digits required from back of credit card) (MM/YYYY)

As a convenience, I request and authorize PacifiCare to charge my credit card account, identified above, for the payment of my health plan premium and any fees for the payment option(s) designated. In submitting this payment authorization with my application, I understand that the initial premium for my coverage may be adjusted based on my medical history (or that of any dependent to be covered) and agree that the additional amount(s) required may be charged to this account. I further agree that should this card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, PacifiCare will attempt to contact me, but shall be under no liability whatsoever, including any fees imposed by the card issuer, even though such dishonor may ultimately result in forfeiture of coverage.

Signature of Credit Cardholder **X** _____Date_____
(As it appears on credit card)

If the VISA/Mastercard request for payment is declined, a $25 nonrefundable service fee may be applied when allowed by state law.

C. ONGOING METHOD OF PAYMENT

❑ Automatic Monthly Bank Draft (Complete Bank Draft Authorization below)

❑ Monthly Direct Bill

BANK DRAFT AUTHORIZATION

Type of Account: ❑ Checking ❑ Savings

Account Holder Name _____ Financial Institution _____
(As it appears on financial institution records)

Routing/Transit # (9 digits required) _____ Account Number (9 digits required) _____

I hereby authorize PacifiCare to initiate debit entries to my account and the financial institution named above. PacifiCare will not be held responsible for coverage lapse or cancellation due to nonpayment of premium if the withdrawal is presented and not honored for any reason and the amount due is not paid. PacifiCare is not responsible for charges I may incur from my bank due to late notification of the termination or change. This authorization is to remain in full force and effect until PacifiCare has received written notice of my intention to terminate this authorization. I understand that I must give at least 30 days advance notice to terminate or change this authorization. I understand that PacifiCare retains the right to revoke or change my authorization at any time.

If the automatic bank draft or direct payment by check transaction is returned for any reason, a $25 nonrefundable service fee will be applied when allowed by state law.

Signature of Primary Applicant/Parent or Legal Guardian **X** _____Date_____

Home Office Use Only

Authorization Date:_____ Transaction #: _____ ID #: _____