UnitedHealthcare®
PacifiCare®

Enrollment Form

Instructions

Section 1: Personal Information
Please complete information requested.

Section 2: Selected Coverage
- Select only the plans offered by your Employer.
- For each plan your Employer offers, select the individual to be covered.

Section 3: Employee and Dependent Information
- List yourself and family members to be covered. You may attach additional sheets if necessary.
- Select a Primary Care Physician (PCP) from the *Provider Directory* for you and each of your family members by writing the PCP name and Provider number in the area provided. You may choose a different PCP for each member in your family.

  PCP selection is only required if a PacifiCare SignatureValue® (HMO) or PacifiCare SignaturePOS® plan is selected. If you do not select a PCP when selecting one of these plans, a PCP will be automatically assigned to you.
- 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.

Section 4: Benefit Coordination/Other Insurance Carrier Information
Please complete information requested, if applicable.

Employee Signature

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 Medical and Hospital Group Subscriber Agreement ("Agreement") if I have chosen the PacifiCare SignatureValue® (HMO), PacifiCare SignatureValue® Direct (Open Access), PacifiCare SignaturePOS® (POS), PacifiCare SignaturePOS Direct (Open Access POS) PacifiCare SignatureElite℠ (PPO), PacifiCare SignatureElite℠ (HDHP), PacifiCare SignatureFreedom® (SDHP) or PacifiCare SignatureIndependence® (Indemnity) plan.
2. My Employer may deduct from my earnings the employee contribution required to cover my share of the premium, if any.
3. 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.

4. 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 in the insurance policy with PacifiCare.
5. 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.
6. I have received, read and understand the PacifiCare Disclosure Form, Directory of Participating Medical Groups and a copy of this Enrollment Form.
7. My Dependents and I must reside in Nevada and live or work in PacifiCare's service area if enrolling in the PacifiCare SignatureValue or PacifiCare SignaturePOS plan.
8. If my Dependents or I elect PacifiCare SignatureValue or PacifiCare SignaturePOS, we will select a Primary Care Physician within a 30 mile radius of our Primary Residence or Primary Workplace.

Detach here

PacifiCare SignatureValue (HMO) and PacifiCare SignatureValue Direct (HMO Open Access)
P.O. Box 30981
Salt Lake City, UT 84130
1-800-347-8600
1-800-360-1797 (TDHI)
1-866-372-1316 (Fax)

PacifiCare SignaturePOS and PacifiCare SignaturePOS Direct (Open Access POS)
P.O. Box 30981
Salt Lake City, UT 84130
1-800-347-8600
1-800-360-1797 (TDHI)
1-866-372-1316 (Fax)

PacifiCare SignatureElite (PPO), PacifiCare SignatureElite (HDHP) and PacifiCare SignatureIndependence (Indemnity)
P.O. Box 30981
Salt Lake City, UT 84130
1-866-316-9776
1-866-816-2018 (TDHI)
1-866-372-1316 (Fax)

PacifiCare SignatureFreedom (SDHP)
PacifiCare Health Plan Administrators, Inc.
P.O. Box 30981
Salt Lake City, UT 84130
1-866-867-0700
1-866-867-0701 (TDHI)
1-866-372-1316 (Fax)

Visit our Web site @ www.pacificare.com

Form #: ENROLLFRM-Mid/LG–Med-5/08

Employee Enrollment Form (Please Print)

Nevada

1. Personal Information

Company Name			Date of Hire	
Last Name	First Name	M.I.	Suffix	☐ Male ☐ Female
Residence Mailing Address				
City		State	ZIP	
Home Telephone	Work Telephone	Date of Birth (mm-dd-yy)		
Social Security #		Marital Status ☐ Single ☐ Married ☐ Widow ☐ Divorced		
Are you currently on COBRA? ☐ Yes ☐ No If yes, qualifying event:		COBRA Qualifying Event Effective Date		
Preferred Language (optional) ☐ English ☐ Spanish				
Ethnicity (optional) ☐ Caucasian	☐ Black or African American ☐ Asian, Native Hawaiian, other Pacific Islander ☐ American Indian or Alaskan Native	☐ Hispanic or Latino ☐ Not provided by member		

Employer Required to Complete This Section
Group #/Plan Code
Source of Enrollment: ☐ Open Enrollment ☐ QMCSO ☐ New Hire ☐ Employee Status Change ☐ Rehire
Requested Effective Date
Employer Verification/Signature
Employee Class

2. Selected Coverage (Select only the plans offered by your Employer)

Medical Plan Options:
☐ PacifiCare SignatureValue (HMO) ☐ High ☐ Low
☐ PacifiCare SignatureValue Direct (Open Access)
☐ PacifiCare SignaturePOS
☐ PacifiCare SignaturePOS Direct (Open Access POS)
☐ PacifiCare SignatureElite (HDHP) (HSA-Compatible)
☐ PacifiCare SignatureElite (PPO) ☐ High ☐ Low
☐ PacifiCare SignatureFreedom (SDHP)
☐ PacifiCare SignatureIndependence (Indemnity)

Individual(s) to be covered:
☐ Self
☐ Self + Spouse
☐ Self + Dependent(s)
☐ Self + Family
☐ Waive Medical (Complete Waiver Form)

3. Employee and Dependent Information (List yourself and family members to be covered – attach additional sheets if necessary)

Self	Primary Care Physician (PCP) Name			Provider #	Existing Patient? ☐ Yes ☐ No
Spouse/ Domestic Partner*	☐ Male ☐ 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				Provider #	Existing Patient? ☐ Yes ☐ No
Dependent 1	☐ Male ☐ 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				Provider #	Existing Patient? ☐ Yes ☐ No
Dependent 2	☐ Male ☐ 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				Provider #	Existing Patient? ☐ Yes ☐ No
Dependent 3	☐ Male ☐ 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				Provider #	Existing Patient? ☐ Yes ☐ No

4. Benefit Coordination/Other Insurance Carrier Information

Does anyone listed have other health insurance? ☐ Yes ☐ No If yes, complete section boxes a–e

a. Name	b. Insurance Company Name	c. Policy #	d. Effective Date	e. Other Employer Name and Address

Is anyone listed eligible for Medicare? ☐ Yes ☐ No If yes, complete section boxes f–g

f. Name	g. Medicare ID#

Employee Signature

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

Signature (Required)	Date (Required)
X	

Form #: ENROLLFRM-Mid/LG–Med-5/08

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Enrollment Identification Card

UnitedHealthcare
PacifiCare

Name

Employer Name | Group Code

Doctor | Phone

- ☐ PacifiCare SignatureValue (HMO)/ PacifiCare SignatureValue Direct (HMO) 1-800-347-8600
- ☐ PacifiCare SignaturePOS (POS) / PacifiCare SignaturePOS Direct (Open Access POS) 1-800-347-8600
- ☐ PacifiCare SignatureElite (PPO)*/ PacifiCare SignatureElite (HDHP)/ PacifiCare SignatureIndependence (Indemnity)* 1-866-316-9776
- ☐ PacifiCare SignatureFreedom *(SDHP) 1-866-867-0700

Coverage shall not begin until acceptance of your enrollment by PacifiCare of Nevada, Inc. or PacifiCare Life Assurance Co. Upon acceptance of your enrollment, PacifiCare of Nevada, Inc. or PacifiCare Life Assurance Co. shall be bound by the terms of the Agreement or Policy and any Amendments thereto.

* Underwritten by PacifiCare Life Assurance Company

Enrollment Identification Card

UnitedHealthcare
PacifiCare

Name

Employer Name | Group Code

Doctor | Phone

- ☐ PacifiCare SignatureValue (HMO)/ PacifiCare SignatureValue Direct (HMO) 1-800-347-8600
- ☐ PacifiCare SignaturePOS (POS) / PacifiCare SignaturePOS Direct (Open Access POS) 1-800-347-8600
- ☐ PacifiCare SignatureElite (PPO)*/ PacifiCare SignatureElite (HDHP)/ PacifiCare SignatureIndependence (Indemnity)* 1-866-316-9776
- ☐ PacifiCare SignatureFreedom *(SDHP) 1-866-867-0700

Coverage shall not begin until acceptance of your enrollment by PacifiCare of Nevada, Inc. or PacifiCare Life Assurance Co. Upon acceptance of your enrollment, PacifiCare of Nevada, Inc. or PacifiCare Life Assurance Co. shall be bound by the terms of the Agreement or Policy and any Amendments thereto.

* Underwritten by PacifiCare Life Assurance Company

Complete the temporary Enrollment Identification Cards below, and keep until you receive your permanent ID card.

Detach here

Detach here

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