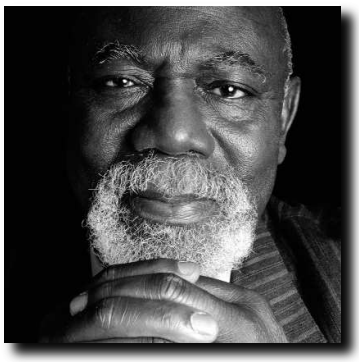
PacifiCare®


COLORADO

Small Business Employee Enrollment and Waiver of Coverage Form

Note: All eligible employees must complete, sign and forward this form to PacifiCare, whether accepting or declining coverage.

If you have questions, or need assistance with this form, call your employer or one of our toll-free helplines at
1-888-800-9540
1-303-714-3003 (Denver Metro)
1-866-316-9776 (PPO)

Employee Enrollment Form

IMPORTANT: PLEASE COMPLETE ALL SECTIONS

This form cannot be processed if information is incomplete.

PacifiCare
of Colorado
6455 South Yosemite Street
Greenwood Village, CO 80111
303-714-3003
303-714-3999 (FAX)

PacifiCare
Life Assurance Company
P.O. Box 6098
Cypress, CA 90630
1-866-316-9776
1-866-392-7071 (FAX)

Company Name	Group Number/Plan Code	Source of Enrollment: ☐ Open Enrollment ☐ New Hire ☐ Transfer ☐ Rehire	Date of Hire	Date of Rehire	Effective Date

Section One - To Be Completed by Employee

Social Security Number | Last Name | First Name | Initial | Bus. Phone

Mailing Address | Apt. No. | City | State

Zip Code | Home Phone | County

Section Two

Complete for employee and those family members to be covered by PacifiCare:

Check here if currently a patient of the chosen Primary Care Physician. ✓

Last Name / First Name / Initial	Relationship to Subscriber	Sex M/F	Check if Student over 19	Check if Disabled	Date of Birth Mo./Day/Yr.	Age	Primary Care Physician Full Name and Street Address	✓	PacifiCare HMO Dentist Full Name and Street Address
Employee 00	Self		N/A	N/A					
Spouse 02			N/A	N/A					
Social Security #									

If you and your Spouse are using different last names check the applicable box: ☐ wife retaining maiden/professional name ☐ common law marriage (complete affidavit)

Dependent 03									
Social Security #									
Dependent 04									
Social Security #									
Dependent 05									
Social Security #									

Overage (19 – 24 years) Dependents require proof of full-time student status or permanent disability status at enrollment.

Type of Coverage

☐ PacifiCare SignatureValue℠ (HMO)
☐ PacifiCare SignaturePOS℠
☐ PacifiCare SignatureOptions℠ (PPO)
☐ PacifiCare SignatureFreedom℠ (SDHP)
☐ Dental HMO (if applicable)
☐ Dental PPO (if applicable)
☐ PacifiCare SignatureOptions℠ (PPO) HSA-Compatible Plans

Section Three

Benefit Coordination

1. Is anyone listed permanently disabled? ☐ Yes ☐ No Name _____ Date disability began _____ (M - D - Y)
2. Does anyone listed have other health insurance? ☐ Yes ☐ No If yes, complete section below.

NAME	INSURANCE COMPANY NAME	POLICY NO. & EFFECTIVE DATE	OTHER EMPLOYER NAME & ADDRESS

3. If anyone to be covered is currently eligible for Medicare, the following information is required. Submit a copy of your Medicare card(s) with this application.

Subscriber		Spouse/Dependent	
☐ Employed	☐ Part A only	☐ Employed	☐ Part A only
☐ Retired	☐ Part B only	☐ Retired	☐ Part B only
☐ Part A and B		☐ Part A and B	
_____ Medicare Claim No.		_____ Medicare Claim No.	

4. Are you currently on State Continuation or COBRA coverage? ☐ Yes ☐ No
If yes, date continuation benefits began_____ Ending date_____

Terms and Conditions – Please Read Carefully Before Signing This Form

On behalf of myself and my Eligible Dependents, I hereby apply for the group health coverage indicated on this application, offered by my employer, through PacifiCare Health Plans ("PacifiCare") or PacifiCare Life Assurance Company ("PacifiCare Life and Health"), 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 HMO or POS plan or the PacifiCare Life and Health Group Policy ("Policy") if I have chosen the PPO 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 PacifiCare Life and Health or a designee shall have access to and use of my medical records and the medical records of my 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, rating, insurance or purposes reasonably related to the performance 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 Dependent's enrollment in PacifiCare or PacifiCare Life and Health.
5. Coverage shall not begin until acceptance of this enrollment form by PacifiCare or PacifiCare Life and Health. Upon acceptance of this enrollment form, PacifiCare or PacifiCare Life and Health shall be bound by the terms of the Agreement or Policy and any Amendments thereto.
6. I have received, read and understand the *PacifiCare Combined Evidence of Coverage and Disclosure Form*, *Schedule of Benefits*, Limitations and Exclusions, *Directory of Participating Physicians*, and a copy of this Enrollment Form.
7. I and/or my Dependents work or reside in the PacifiCare of Colorado HMO Service Area (if enrolling in PacifiCare's HMO or POS plans).
8. I (we) will cooperate as required in the general Coordination of Benefits and the Subrogation provisions of the master contract.
9. I (we) understand that **PacifiCare coordinates benefits with no-fault automobile insurance in the manner prescribed by the State and as explained in conspicuous fashion in PacifiCare printed materials and contracts.**
10. I (we) understand that my (our) identification cards are for identification only. The dates which may appear on the card reflect the effective date of the plan contract for which I (we) have enrolled, not necessarily my (our) dates of eligibility.
11. I (we) understand that by choosing the coverage specified in the *Combined Evidence of Coverage and Disclosure Form*, paying the Premium, or accessing benefits as described in the *Combined Evidence of Coverage and Disclosure Form*, I (we) or my (our) legal representative expressly agree to all terms, conditions and provisions of the *Combined Evidence of Coverage and Disclosure Form.*

Signatures are required on both Arbitration and Medical Release Statement.

Medical Records Release Authorization Statement

I hereby authorize any physician, health care practitioner, hospital or other health care facility, clinic, medical group, health care service plan, or any other person or entity to release to PacifiCare or PacifiCare Life or its designee my medical records and the medical records of my dependents, including mental health medical records and medical records from drug and alcohol abuse treatment or prevention, for the following purposes: diagnosis or treatment; payment of health care services rendered; billing, claims management, medical data processing, or other administrative functions of PacifiCare; peer review, including reviewing the competence or qualifications of health care professionals; utilization review and quality assurance, including reviewing health care services with respect to medical necessity, level of care, quality of care, or justification of charges; handling of member grievances or appeals, external independent review, or other health dispute resolution; coordination care with providers of health care or other health care service plans; administering the PacifiCare health benefit plan; chronic disease management programs, to monitor or administer care of a member for a covered benefit, other uses specifically authorized by law. This authorization is effective immediately and remains in effect for the duration of coverage under my PacifiCare health plan. I understand that I have a right to receive a copy of this authorization upon request.

SIGNATURE I have read, understand and agree to the above Medical Records Release Authorization Statement.

X _____

Signature (Required) Date

Arbitration Disclosure

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 DISPUTES OVER BENEFIT DENIALS SUBJECT TO ERISA, BETWEEN ITSELF, MEMBERS (INCLUDING ANY HEIRS OR ASSIGNS) AND PACIFICARE OF COLORADO, INC., 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. RIGHTS AFFORDED UNDER THE INTERNAL APPEALS PROCESS AND INDEPENDENT EXTERNAL REVIEW ARE NOT AFFECTED BY THIS PROVISION. DISPUTES NOT FULLY RESOLVED THROUGH THE INDEPENDENT EXTERNAL REVIEW PROCESS ARE SUBJECT TO THIS PROVISION.

SIGNATURE 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.

X _____

Signature (Required) Date

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

ENROLLMENT IDENTIFICATION CARD

Name

Employer Name

Doctor

Group Number

Phone

❑ PacifiCare SignatureValue/ PacifiCare SignaturePOS 1-800-877-9777

❑ PacifiCare SignatureOptions 1-866-316-9776

❑ PacifiCare SignatureFreedom 1-866-867-0700

PacifiCare®

PacifiCare® Life Assurance Company

ENROLLMENT IDENTIFICATION CARD

Name

Employer Name

Doctor

Group Number

Phone

❑ PacifiCare SignatureValue/ PacifiCare SignaturePOS 1-800-877-9777

❑ PacifiCare SignatureOptions 1-866-316-9776

❑ PacifiCare SignatureFreedom 1-866-867-0700

PacifiCare®

PacifiCare® Life Assurance Company

Waiver of Coverage

Unless one of the circumstances set forth below applies to you, failure to enroll during the initial enrollment period will permit the plan to treat you as a Late Enrollee. You will not be able to enroll until your group's next OPEN ENROLLMENT period.

I certify that the reason I am declining enrollment is: (check, as applicable)

□ I am covered under another group health benefit plan offered to my spouse. (Please submit copy of I.D. card showing coverage.)

□ I am covered under an Individual health plan. (Please submit copy of I.D. card showing coverage.)

□ I am declining for my Spouse, name:_____

because _____

□ I am declining coverage for my Dependents, name(s): _____ , _____ , _____

because _____

□ I am declining because _____

If I or one of my Dependents have declined coverage as listed above:

I understand that in the event I and/or my Eligible Dependents choose to enroll in a PacifiCare plan at a later date, we may be considered "Late Enrollees" and may have to wait for coverage until the group's next Open Enrollment Period.

I have been informed that under the following circumstances, I and my Eligible Dependents will not be considered Late Enrollees:

1. OTHER EMPLOYER HEALTH BENEFIT PLAN COVERAGE. You and your dependents (collectively "You") shall not be considered Late Enrollees if:
   a. You are currently covered under another employer health benefit plan ("Plan") although You are also eligible to enroll in a PacifiCare plan;
   b. You certify in writing on this Waiver of Coverage that You are declining PacifiCare coverage because You are already covered under another group Plan;
   c. You learn at a later date that You have lost or will lose coverage under the other Plan because of:
      (1) the termination of your employment or the employment of the person through whom You are covered as a Dependent;
      (2) a change in your employment status or the employment status of the person through whom You are covered as a Dependent;
      (3) the termination of coverage under the other Plan;
      (4) the termination of an employer's monetary contribution toward your coverage under the other Plan;
      (5) the death of the person through whom You are covered as a Dependent;
      (6) legal separation or divorce; or
      (7) your declination of coverage when enrollment was previously offered and you subsequently acquired a Dependent;
      (8) the termination of coverage under the other Plan for your Dependent(s); and
   d. You request enrollment no later than thirty (30) days after termination of your coverage under the other Plan due to one of the reasons stated here in subsection 1(c).

   If You meet each of the requirements listed above, You will not be classified as a Late Enrollee, and will be eligible to enroll in PacifiCare.
2. COURT ORDER. If a court has ordered that You obtain health care coverage for your Spouse or minor child, and You submit an application for enrollment within thirty (30) days after issuance of the court order, You and your Spouse and/or minor child will not be classified as Late Enrollees.

I have read, understand and agree to the terms and conditions listed above.

X _____ _____ _____

Signature | Name (please print) | Date

_____ _____

Group Name | Group No.

PacifiCare®
6455 South Yosemite Street
Greenwood Village, CO 80111

PacifiCare®
Life Assurance Company
P.O. Box 6098
Cypress, CA 90630

Customer Service:
800-877-9777 PacifiCare SignatureValue (HMO)/PacifiCare SignaturePOS
800-360-1797 (TDD)
866-316-9776 PacifiCare SignatureOptions (PPO)
866-867-0700 PacifiCare SignatureFreedom (SDHP)
800-442-8833 (TDHI)
www.pacificare.com

ENROLLMENT IDENTIFICATION CARD

Additional People Covered

Name _____

Doctor _____ Phone _____

Name _____

Doctor _____ Phone _____

Name _____

Doctor _____ Phone _____

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

ENROLLMENT IDENTIFICATION CARD

Additional People Covered

Name _____

Doctor _____ Phone _____

Name _____

Doctor _____ Phone _____

Name _____

Doctor _____ Phone _____

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

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

COLORADO

PacifiCare®

Statement of Health

Important: Please print or type all sections in black ink

☐ New Enrollment ☐ Transfer from HMO to PPO Coverage ☐ Other _____

A. Employer Information

Employer	Group #

This Statement of Health is for: ☐ Employee ☐ Spouse ☐ Child

B. Employee and Dependent Information

Name	Date of Birth	Sex	Height	Weight	Used tobacco in last 12 months?
Employee		☐ M ☐ F			☐ Y ☐ N
Spouse		☐ M ☐ F			☐ Y ☐ N
Child		☐ M ☐ F			☐ Y ☐ N
Child		☐ M ☐ F			☐ Y ☐ N
Child		☐ M ☐ F			☐ Y ☐ N

If more Dependents are enrolling, attach a separate sheet of paper. Sign and date all additional papers.

C. Medical Information

Note: If you answer **yes** to any question in this section, your application could be delayed unless you complete the "**Details**" section below.

The medical information on this form may not be used to deny coverage to the individuals applying for coverage.

Answer questions 1 through 10 with respect to the employee and Dependent(s) for any condition which has been treated in the last five years.

1. Have you or a Dependent been treated for or had any known indications of: **(in addition to checking yes or no, circle the applicable condition/s in each question)**

1a. Disease or disorder of eyes, ears, nose or throat? . . . . . ☐ Y ☐ N

1b. Dizziness, fainting, convulsions, paralysis or stroke; mental or nervous disease or disorder? . . . . . ☐ Y ☐ N

1c. Shortness of breath; blood spitting; bronchitis or other chronic respiratory disease or disorder? ☐ Y ☐ N

1d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disease or disorder of the heart or blood vessels? . . . . . ☐ Y ☐ N
If you answer yes to 1d, please complete the Supplementary Medical Information (Sections 1 and 3) on the reverse side of this form.

1e. Ulcer, hernia, colitis, intestinal bleeding; jaundice, hemorrhoids, or other disease or disorder of the stomach, intestines, liver or gall bladder? . . . . ☐ Y ☐ N

1f. Sugar, albumin, blood or pus in urine; stone or other disease or disorder of bladder, prostate or reproductive organs? . . . . . ☐ Y ☐ N

1g. Disorder of the kidney or kidney disease? . . . . ☐ Y ☐ N
If you answer yes to 1g, please complete the Supplementary Medical Information (Section 1) on the reverse side of this form.

1h. Cancer, cyst or tumor? Undergone chemotherapy or radiation treatment? . . . . . ☐ Y ☐ N
If you answer yes to 1h, please complete the Supplementary Medical Information (Section 1) on the reverse side of this form.

1i. Diabetes; thyroid or glandular disorder; skin disease or disorder? . . . . . ☐ Y ☐ N
If you answer yes to 1i, please complete the Supplementary Medical Information (Sections 1 and 2) on the reverse side of this form.

1j. Neuritis, arthritis, gout, or disease or disorder of the muscles or bones, including the back or joints? . . . . . ☐ Y ☐ N

1k. Deformity, congenital anomaly, or amputation? . . . . . ☐ Y ☐ N

1l. Allergies; anemia, other blood or lymph disease or disorder? . . . . . ☐ Y ☐ N

1m. Disorder of menstruation, infertility, pregnancy, multiple or premature births, female organs or breasts? . . . . . ☐ Y ☐ N

2. Have you or a Dependent been treated for or diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or any AIDS-related condition? . . . . . ☐ Y ☐ N

3. Are you or a Dependent now under observation or treatment by a physician or practitioner? . . . . . ☐ Y ☐ N

4. Have you or a Dependent been evaluated or considered for any type of transplant? . . . . . ☐ Y ☐ N
If you answer yes to question 4, please complete the Supplementary Medical Information (Section 1) on the reverse side of this form.

5. Other than as stated in answers to questions 1, 2, 3 and 4, have you or a Dependent within the past 5 years:

5a. Been attended by physician/practitioner for consultation, examination, diagnosis or treatment? . . . . . ☐ Y ☐ N

5b. Been a patient in a hospital, clinic or other medical facility? . . . . . ☐ Y ☐ N

5c. Had electrocardiogram, X-ray or other diagnostic test? . . . . . ☐ Y ☐ N

5d. Been advised to have any diagnostic test, hospitalization, treatment or surgery which was not completed? . . . . . ☐ Y ☐ N

6. Have you or a Dependent been addicted to alcohol, drugs or any other substance? . . . . . ☐ Y ☐ N

7. Have you or a Dependent been advised of an elevated cholesterol problem? . . . . . ☐ Y ☐ N

8. Are you or a Dependent currently pregnant? . . ☐ Y ☐ N

9. Within the past two (2) years, has any person listed above had any symptoms of, or received medical or surgical advice or treatment for any serious or chronic condition other than mentioned above? . . . . . ☐ Y ☐ N

Details

Question #	Covered Person: Employee, Spouse or Child	Disease/ Diagnosis	Onset MM/YY	Duration	Treatment and result (mention any surgery performed)	Names of Physicians/Hospitals

C. Medical Information (Continued)

	Y	N
10. Does any applicant listed on this application currently take prescription drugs? If yes, list applicant's name(s), drug name(s), dosage and date started	☐	☐

Applicant's Name	Drug	Dosage	Date Started
Applicant's Name	Drug	Dosage	Date Started
Applicant's Name	Drug	Dosage	Date Started

D. Authorization

1. **I agree:** All information on this form is correct and true.

2. **Authorization to obtain or release medical information:**
I hereby authorize any health care facility, physician or surgeon, or any other health care professional to disclose to PacifiCare, its agents or employees, all information from my medical records pertaining to any past or future examination or treatment including treatment for substance abuse and mental and emotional disorders (except psychotherapy notes) furnished to me or my dependents who are also applying for this coverage, and to any illness, injury or condition that I or these dependents have had at any time. PacifiCare requests this information to conduct underwriting and risk rating activities so PacifiCare can determine your eligibility and, if applicable, determine the rates offered to you for coverage. 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 I am entitled to receive a signed copy of this authorization. I understand that this authorization shall be valid for 30 months from the date of my signature, and a photocopy or other reproduction of this authorization is as valid as the original. If you refuse to provide this authorization, PacifiCare will not make an eligibility determination, and you will not be considered for membership of a PacifiCare plan. I understand that I may revoke this authorization 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 written revocation to PacifiCare Underwriting, M/S CO 84-441, 6455 South Yosemite Street, Greenwood Village, CO 80111. On behalf of myself and the eligible persons listed herein, I acknowledge that I have read and understand this form in its entirety. Please note an additional valid authorization or Power of Attorney is required for personal representatives.

Employee Signature	Date
Name of Custodian or Personal Representative (If applicable)(Please print)	Date

COLORADO

PacifiCare®

Supplemental Medical Information

Important: Please print or type all sections in black ink. If more space is required, use an additional form or separate sheet of paper. Please sign and date all additional pages.

I. Answer the following only if questions 1d, 1g, 1i, or 4 on the Statement of Health were answered with a "Yes".

Employee Name	Employer

The Statement of Health is for: ☐ Employee ☐ Spouse ☐ Child

1. Diagnosis or symptoms: _____
2. Underlying cause: _____
3. Age and date diagnosed: _____
4. Date first treated: _____
5. What type of treatment was performed? Provide dates of treatment. _____

   _____
6. Have there been any hospitalizations or emergency room treatments in the last five years? If yes, dates and reason for confinement/visit. _____

   _____

   _____
7. Are there any complications or residual problems? If so, please describe. _____

   _____

II. Diabetic Applicants

If question "1i" on the Statement of Health was answered with a "YES," answer the following questions in addition to 1-7 above.

8. Type of Diabetes: ___ Type 1 ___ Type II Units of Insulin per day _____

   Date of Onset _____
9. Is there any history of eye, kidney, cardiovascular, circulatory or skin disorders? If so please describe, including date of occurrence, treatment and present condition. _____

   _____

   _____

III.Cardiac/Circulatory/Elevated Blood Pressure Applicants

If question "1d" on the Statement of Health was answered with a "YES," answer the following questions in addition to 1-7 above.

10. In the last five years, have you had a heart attack? If yes, provide date of attack, dates of hospitalization, was any surgery performed, pended or recommended? _____

    _____
11. Have you been treated in the last five years for any other heart condition? If yes, provide condition, date of onset and treatment.

    _____

    _____

IV. Signature

Employee Signature	Date

PCO131550-000 Rev. 2/05
4917-012805-CO-PCCO/PLAC