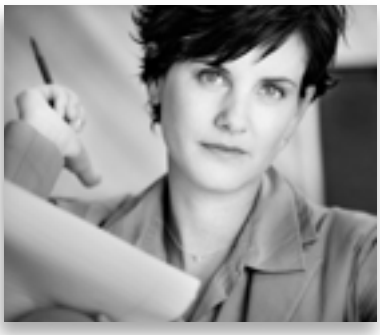
PacifiCare®



Enrollment Form (Washington)

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), PacifiCare SignaturePOS℠ (POS), PacifiCare SignatureOptions℠ (PPO), PacifiCare SignatureIndependence℠ (Indemnity) or PacifiCare SignatureFreedom℠ (SDHP) plan.
2. My Employer may deduct from my earnings the employee contribution required to cover my share of the premium, if any.
3. 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 designee may access and/or use my medical records and the medical records of my enrolled Dependents, including mental health records and medical records from drug and alcohol abuse treatment or prevention (not including psychotherapy notes as defined by the HIPAA Privacy Rule), for purposes of utilization review, quality assurance, surveys, processing 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.

Employee Enrollment Form (Please Print)

PacifiCare®

Personal Information

Last Name	First Name	MI	Suffix	☐ Male ☐ Female
Social Security #	Company Name	Date of (Re)Hire	Job Title	
Number of hours worked per week	Salary/Wages ☐ Hourly ☐ Monthly ☐ Annual $ _____	Marital Status ☐ Single ☐ Widow ☐ Married ☐ Divorced ☐ Domestic Partner		
Are you currently on COBRA? ☐ Yes ☐ No If yes, qualifying event:		COBRA Qualifying Event Effective Date		
Residence Mailing Address				
City	State	ZIP	Date of Birth (mm-dd-yy)	
Home Telephone ( )	Work Telephone ( )			

Your Employer Completes This Section

Group #/Plan Code
Dental/Vision Group #
Life/STD/LTD Group and Policy #s
Source of Enrollment: ☐ Open Enrollment ☐ New Hire ☐ QMCSO ☐ Employee Status Change ☐ Rehire
Employee Class
Requested Effective Date
Employer Verification

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

Medical Individual(s) to be covered: ☐ Self ☐ Self + Spouse ☐ Self + Dependent(s) ☐ Self + Family ☐ Waive Medical
Plan Options: ☐ PacifiCare SignatureValue (managed care plan) ☐ PacifiCare SignaturePOS ☐ PacifiCare SignatureOptions (PPO) ☐ PacifiCare SignatureIndependence (Indemnity) ☐ PacifiCare SignatureFreedom (SDHP)

Dental Individual(s) to be covered: ☐ Self ☐ Self + Spouse ☐ Self + Dependent(s) ☐ Self + Family ☐ Waive Dental
Plan Options: ☐ PacifiCare SignatureIndependence (Dental Indemnity)

Vision Individual(s) to be covered: ☐ Self ☐ Self + Spouse ☐ Self + Dependent(s) ☐ Self + Family ☐ Waive Vision
Plan Options: ☐ PacifiCare SignatureOptions (Vision Supplement) ☐ PacifiCare SignatureOptions (Vision Stand-alone)

Life/Disability ☐ Life/AD&D ☐ Short Term Disability ☐ Long Term Disability ☐ Waive STD ☐ Waive LTD ☐ Waive Life

I desire to participate in the coverages selected above and hereby authorize my Employer to make the necessary deduction(s) from my wage/salary to pay my portion of the premium.
Initials: _____

- 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 & Dependent Information (List yourself and family members to be covered – attach additional sheets if necessary)

Self

Primary Care Physician (PCP) Name & # (for PacifiCare SignatureValue/PacifiCare SignaturePOS only)	Medical Group #	Existing Patient? ☐ Yes ☐ No
Dentist Name & City (for PacifiCare SignatureValue only)	Dental Facility #	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 than Employee's	
Primary Care Physician (PCP) Name & # (for PacifiCare SignatureValue/PacifiCare SignaturePOS only)	Medical Group #	Existing Patient? ☐ Yes ☐ No	
Dentist Name & City (for PacifiCare SignatureValue only)	Dental Facility #	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 than Employee's		
Primary Care Physician (PCP) Name & # (for PacifiCare SignatureValue/PacifiCare SignaturePOS only)	Medical Group #	Existing Patient? ☐ Yes ☐ No		
Dentist Name & City (for PacifiCare SignatureValue only)	Dental Facility #	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 than Employee's		
Primary Care Physician (PCP) Name & # (for PacifiCare SignatureValue/PacifiCare SignaturePOS only)	Medical Group #	Existing Patient? ☐ Yes ☐ No		
Dentist Name & City (for PacifiCare SignatureValue only)	Dental Facility #	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 than Employee's		
Primary Care Physician (PCP) Name & # (for PacifiCare SignatureValue/PacifiCare SignaturePOS only)	Medical Group #	Existing Patient? ☐ Yes ☐ No		
Dentist Name & City (for PacifiCare SignatureValue only)	Dental Facility #	Existing Patient? ☐ Yes ☐ 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.

Employee Name	Social Security #

Benefit Coordination/Other Insurance Carrier Information

1. Does anyone listed have other health insurance?
☐ Yes ☐ No
If yes, complete section below ↓

2. Is anyone listed permanently disabled?
☐ Yes ☐ No
If yes, complete the following:
2a. Name _____
2b. Date disability began _____

3. Is anyone listed eligible for Medicare?
☐ Yes ☐ No
If yes, complete the following:
3a. Name _____
3b. Medicare ID# _____

1a. Name	1b. Insurance Company Name	1c. Policy #	1d. Effective Date	1e. Other Employer Name and Address

* Group Life Insurance (Complete only if your Employer is offering this benefit)

I apply for coverage for: ☐ Self Only ☐ Self and Eligible Dependents	Employee's Benefits – Life: $ AD&D: $ Supp. Life:** $
Spouse – Date of Birth (mm-dd-yy) Amount: $	**Children** – ☐ One child ☐ Two or more Per child amount: $

As a covered employee, you have the right to select and/or change your beneficiary(ies) in accordance with the provisions of your policy.

Life Insurance Primary Beneficiary (full name)***	Phone Number ( )	Relationship***
Contingent Beneficiary (full name)	Phone Number ( )	Relationship

** Evidence of Insurability may be required.
*** Your spouse MUST sign this form if: (a) you are a resident of AZ, CA, ID, LA, NV, NM, TX, WA or WI **and** (b) you designate someone other than your spouse as beneficiary

Spouse Signature	Date

* Group Long Term Disability (LTD) & Group Short Term Disability (STD) Insurance
(Complete only if your Employer is offering this benefit)

Job Duties

I understand that a medical examination, at my own expense, may be required if I want to participate at a later date.

Employee Signature **X**	Date
LTD/STD Insurance Beneficiary (full name)	Relationship

* Life coverage is underwritten by Continental Assurance Company or CNA Group Life Assurance Company. Long Term Disability and Short Term Disability are underwritten by Continental Casualty Company or CNA Group Life Assurance Company. The issuing company is identified on the group policy.

Signature

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

Signature (Required) **X**	Date (Required)

PacifiCare SignatureValue
P.O. Box 6092
Cypress, CA 90630-0092
1-800-932-3004
1-800-786-7387 (TDHI)

PacifiCare SignaturePOS
P.O. Box 6092
Cypress, CA 90630-0092
1-800-932-3004
1-800-786-7387 (TDHI)

PacifiCare SignatureOptions, PacifiCare SignatureFreedom and PacifiCare SignatureIndependence
P.O. Box 6098
Cypress, CA 90630
1-866-316-9776
1-866-816-2018 (TDHI)

PacifiCare Dental & Vision Administrators
P.O. Box 25187
Santa Ana, CA 92799
1-800-228-3384

CNA Group Life and Disability
1-866-262-7316 (CNA benefits)
1-888-726-3449 (CNA claims)

Visit our Web site @ www.pacificare.com

CM-403-43620.100
PCW-ENRLFM-04
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