

TEXAS SMALL BUSINESS EMPLOYEE ENROLLMENT FORM AND DECLINATION OF COVERAGE



■ Instructions

Section 1: Personal Information

Please complete information requested.

When completing the optional Ethnicity question, please use the following key:

- C = Caucasian or White
- B = African American or Black
- H = Hispanic or Latino
- A = Asian, Native Hawaiian, other Pacific Islander
- I = American Indian or Alaskan Native
- N = Not provided by member

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.
- Over-age Dependents may be required to provide 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.

Section 5: Group Life Insurance

- Complete the information requested only if your Employer is offering this benefit.
- Evidence of Insurability may be required.

Section 6: Medical Questions

Please complete information requested.

Section 7: Signature Required

Please read this section carefully and provide your signature as required.

■ 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.

■ 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 Life Assurance Company Group Policy "Policy" if I have chosen the PPO, SDHP or Out-of-Network 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 shall have access to and use of my medical records and the medical records of my dependents, as required by law, 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 or purposes of diagnosis and treatment of patient billing, claims management, medical data processing and administrative or health care operations of the Agreement or Policy.
4. Any material omission or intentional 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 membership of the insurance policy with PacifiCare.

5. Coverage shall not begin until acceptance of this enrollment by PacifiCare. Upon acceptance of this enrollment form, 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 *Certificate of Insurance, Schedule of Benefits, Limitations and Exclusions, Directory of Participating Providers*, and a copy of this Enrollment Form.
7. I represent that the information supplied is true and I hereby authorize payroll deductions from my earnings for any contributions or fees required to maintain my eligibility.

PacifiCare SignatureOptions (PPO) and PacifiCare SignatureIndependence (Indemnity)

P.O. Box 6098
Cypress, CA 90630
1-866-316-9776
1-866-816-2018 (TDHI)
(714) 226-5622 (Fax)

PacifiCare SignatureFreedom (SDHP)

PacifiCare Health Plan Administrators
P.O. Box 63912
Harrisburg, PA 17106
1-866-867-0700
1-866-867-0701 (TDHI)
(714) 226-5622 (Fax)

PacifiCare Dental and Vision Administrators

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

American Medical Security Life Insurance Company

P.O. Box 19032
Green Bay, WI 54307-9032

Visit our Web site @
www.pacificare.com

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EMPLOYEE ENROLLMENT FORM (Please Print)

1. Personal Information					
Company Name		Occupation/Title		Date of Hire	Date of Rehire
Last Name		First Name		MI	Suffix <input type="checkbox"/> Male <input type="checkbox"/> Female
Residence Mailing Address			City	State	ZIP
# of hours you work in a normal week:	Have you or any of your dependents ever been a PacifiCare Member? <input type="checkbox"/> Yes <input type="checkbox"/> No		Home Telephone () ()	Work Telephone () ()	
Date of Birth (mm-dd-yy)		Social Security #		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Widow <input type="checkbox"/> Divorced	
Are you currently on COBRA? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, qualifying event and original start date:					
E-Mail		Annual Salary		Would you like to receive information via E-mail? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Preferred Language <input type="checkbox"/> English <input type="checkbox"/> Spanish (Optional)			Ethnicity <input type="checkbox"/> C <input type="checkbox"/> B <input type="checkbox"/> H <input type="checkbox"/> A <input type="checkbox"/> I <input type="checkbox"/> N (Optional)		

Employer Required to Complete This Section	
Group #/Plan Code	
Dental/Vision Group #	
Source of Enrollment: <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire	<input type="checkbox"/> QMCSO <input type="checkbox"/> Transfer <input type="checkbox"/> Rehire
Requested Effective Date	
Employer Verification/Signature	
Life Class	Group Life/AD&D Amount

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

Medical Plan Options: <input type="checkbox"/> PacifiCare SignatureOptions (PPO) <input type="checkbox"/> High Option/ <input type="checkbox"/> Low Option (if applicable) <input type="checkbox"/> PacifiCare SignatureOptions (HSA-Compatible) <input type="checkbox"/> PacifiCare SignatureFreedom (SDHP) <input type="checkbox"/> PacifiCare SignatureIndependence (Indemnity) Please complete the Declination of Coverage form if declining coverage for Self and/or Eligible Dependent(s)	Dental Plan Options: <input type="checkbox"/> PacifiCare SignatureOptions (Dental Network) <input type="checkbox"/> PacifiCare SignatureIndependence (Dental Indemnity) Please complete the Declination of Coverage form if declining coverage for Self and/or Eligible Dependent(s)	Vision Plan Options: <input type="checkbox"/> PacifiCare SignatureOptions (Vision PPO – Full Service) <input type="checkbox"/> PacifiCare SignatureOptions (Vision PPO – Eyewear Only) Please complete the Declination of Coverage form if declining coverage for Self and/or Eligible Dependent(s)	Life/Disability <input type="checkbox"/> Life/AD&D Individual(s) to be covered: <input type="checkbox"/> Self Only <input type="checkbox"/> Self and Eligible Dependent(s)
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3. Employee & Dependent Information (List yourself and family members to be covered – attach additional sheets if necessary)

Self	Height (Ft. In.)	Weight (lbs.)
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Spouse	<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name	First Name	M.I.
Date of Birth (mm-dd-yy)	Social Security #	Height (Ft. In.)	Weight (lbs.)	Ethnicity <input type="checkbox"/> C <input type="checkbox"/> B <input type="checkbox"/> H <input type="checkbox"/> A <input type="checkbox"/> I <input type="checkbox"/> N (Optional)
Address, if different than Employee's				

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 #	Height (Ft. In.)	Weight (lbs.)	Ethnicity <input type="checkbox"/> C <input type="checkbox"/> B <input type="checkbox"/> H <input type="checkbox"/> A <input type="checkbox"/> I <input type="checkbox"/> N (Optional)	
Address, if different than Employee's					

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 #	Height (Ft. In.)	Weight (lbs.)	Ethnicity <input type="checkbox"/> C <input type="checkbox"/> B <input type="checkbox"/> H <input type="checkbox"/> A <input type="checkbox"/> I <input type="checkbox"/> N (Optional)	
Address, if different than Employee's					

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 #	Height (Ft. In.)	Weight (lbs.)	Ethnicity <input type="checkbox"/> C <input type="checkbox"/> B <input type="checkbox"/> H <input type="checkbox"/> A <input type="checkbox"/> I <input type="checkbox"/> N (Optional)	
Address, if different than Employee's					

Check box if additional enrollment page is attached for dependents.
Overage dependents may be required to provide proof of full-time student status or permanent disability status within 31 days of enrollment.

Detach here

4. Benefit Coordination/Other Insurance Carrier Information

■ Does anyone listed have other health insurance? Yes No If yes, complete boxes a-j:

a. Name	b. Insurance Company Name	c. Policy #	d. Effective Date	e. Other Employer Name and Address
f. Name	g. Insurance Company Name	h. Policy #	i. Effective Date	j. Other Employer Name and Address

■ Is anyone listed permanently disabled? Yes No If yes, complete boxes k + l and submit a completed Individual Health Statement for each person:

k. Name	l. Date Disability Began
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■ Is anyone listed eligible for Medicare? Yes No If yes, complete boxes m + n:

m. Name	n. Medicare ID#
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■ Does anyone listed have other dental insurance? Yes No If yes, complete boxes o-r:

o. Name	p. Insurance Company Name	q. Policy #	r. Effective Date
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5. *Group Life Insurance (Complete only if your Employer is offering this benefit)

I wish coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	Job Title	Employee's Benefits – Life: \$	AD&D: \$	Supp. Life**: \$
# of hours worked per week	Salary/Wages <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Annual \$	Spouse – Amount: \$	Children – 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)	Percentage	Telephone ()	Relationship***
Contingent Beneficiary (full name)	Percentage	Telephone ()	Relationship

** Evidence of Insurability may be required.

*** Your spouse MUST sign this form if you designate someone other than your spouse as beneficiary.

Spouse Signature X	Date
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*Life/AD&D and STD underwritten by American Medical Security Life Insurance Company (AMSLIC). Any and all disputes related to coverage provided by AMSLIC are not subject to arbitration.

6. Small Group Employee Enrollment Form Medical Questions

1. Have you or any of your Dependents eligible for coverage incurred medical expenses in excess of \$5,000 for any medical treatment during the past 5 years? Yes No
2. Do you or any of your Dependents eligible for coverage have hospitalization, surgery, diagnostic test or other treatment pending or have been advised that hospitalization, surgery, diagnostic test or treatment is needed? Yes No
3. Within the last 5 years, have you or any of your eligible Dependents received treatment or been diagnosed by a registered Medical Practitioner for any of the following conditions: Cancer; heart disease; stroke; high blood pressure; high cholesterol; transplant (recommended, pending or completed); diabetes; physical or mental illness; alcoholism or drug abuse; arthritis; liver/kidney, lung or intestinal disorder; COPD; emphysema; sleep apnea; cystic fibrosis; or other progressive, disabling condition? (Attach separate sheet of paper for additional medical conditions) Yes No
4. Within the last 5 years, have you or any of your eligible Dependents received treatment or been diagnosed by a registered Medical Practitioner for any of the following conditions: Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), HIV or lupus (SLE)? Yes No
5. Are you or any of your eligible Dependents currently hospitalized or incapacitated due to illness or accident? Yes No
6. Are you or any of your eligible Dependents currently pregnant? Yes No
7. Are you or any of your eligible Dependents currently taking prescription drugs? Yes No
8. Are you or any of your eligible Dependents currently suffering or undergoing treatment for any condition(s) not listed above? Yes No

Detach here

IF YOU ANSWERED "YES" TO ANY OF THE MEDICAL QUESTIONS, YOU MUST COMPLETE THE FOLLOWING.
 Please provide us with FULL Details for each "Yes" answer to any condition(s). (Insert additional sheets if necessary.)

Ques. # [] Name of Applicant: _____ Date of Onset: _____
 Diagnosis: _____ Currently being treated: Yes No
 Medication/Treatment: _____

 Treatment ended? Yes No If yes, end date: _____

Ques. # [] Name of Applicant: _____ Date of Onset: _____
 Diagnosis: _____ Currently being treated: Yes No
 Medication/Treatment: _____

 Treatment ended? Yes No If yes, end date: _____

Ques. # [] Name of Applicant: _____ Date of Onset: _____
 Diagnosis: _____ Currently being treated: Yes No
 Medication/Treatment: _____

 Treatment ended? Yes No If yes, end date: _____

7. Signature Required for Terms and Conditions – Read Carefully

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.

I. 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.

Signature (Required) X	Date (Required)
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Source Code	Tracking #
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Declination of Coverage Name _____ SS# _____

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.

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.
- I am covered under another group health benefit plan offered by my EMPLOYER.
- I am covered under an Individual health plan.
- I am declining for my Spouse, name: _____, because _____
- I am declining for my child/children, 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 for the next Open Enrollment Period. I have been informed that under the following circumstances, I and my eligible Dependents will not be considered Late Enrollees, if:

1. OTHER EMPLOYER HEALTH BENEFIT PLAN COVERAGE.

- You and your Dependents (collectively "You") shall not be considered Late Enrollees:
- 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 provide in writing on this Declination 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) divorce; or
 - d. You request enrollment no later than thirty-one (31) days after termination of your coverage under the other Plan due to one of the reasons stated here in subsection 1(c).

- e. You are employed by an employer who offers multiple health benefit plans and you elect a different health benefit plan during an Open Enrollment Period;
 - f. A court has ordered coverage to be provided for a Spouse under a covered employee's Plan and the request for enrollment is made not later than the 31st day after the date on which the court order is issued;
 - g. A court has ordered coverage to be provided for a child under a covered employee's Plan and the request for enrollment is made not later than the 31st day after the date on which the employer receives the court order or notification of the court order;
 - h. You have a change in your family composition due to marriage, birth of a child, adoption of a child, or because an insured becomes a party in a suit for the adoption of the child;
 - i. An individual becomes a Dependent due to marriage, birth of a newborn child, adoption of a child, or because an insured becomes a party in a suit for the adoption of the child; and
 - j. The individual described in subparagraphs H and I of this paragraph requests enrollment no later than the 31st day after the date of the marriage, birth, adoption of a child, or within 31 days of the date an insured becomes a party in a suit for the adoption of the child.
2. The individual is a child of a covered employee who has lost coverage under Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928 of that Act, or under Chapter 62, Health and Safety Code, and the request for enrollment is made not later than the 31st day after the date on which the child loses coverage.

If You meet one of the requirements listed above, You will not be classified as a Late Enrollee.

My signature below represents that I have read, understand and agree to the terms and conditions listed above.

X _____
Signature Date

Detach here

Please open
to complete this form

