

EMPLOYEE ENROLLMENT FORM (Please Print)

1. Personal Information

Company Name		Date of Hire			
Last Name	First Name	MI	Suffix	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Residence Mailing Address			City		
State	ZIP	Home Telephone ()	Work Telephone ()		
Date of Birth (mm-dd-yy)	Social Security #	Marital Status		<input type="checkbox"/> Single <input type="checkbox"/> Widow <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner	
Are you currently on COBRA? <input type="checkbox"/> Yes <input type="checkbox"/> No		COBRA Qualifying Event			
If yes, qualifying event:		Effective Date			

Employer Required to Complete This Section

Group #/Plan Code
Dental/Vision Group #
Source of Enrollment: <input type="checkbox"/> QMCSO <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> Employee Status Change <input type="checkbox"/> Rehire
Requested Effective Date
Employer Verification/Signature
Employee Class

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

Medical Plan Options: <input type="checkbox"/> PacifiCare SignatureValue (HMO) <input type="checkbox"/> High <input type="checkbox"/> Low <input type="checkbox"/> PacifiCare SignatureValue Advantage (HMO) <input type="checkbox"/> PacifiCare SignatureOptions (PPO) <input type="checkbox"/> High <input type="checkbox"/> Low <input type="checkbox"/> PacifiCare SignaturePOS <input type="checkbox"/> PacifiCare SignatureIndependence (Indemnity) <input type="checkbox"/> PacifiCare SignatureFreedom (SDHP) <input type="checkbox"/> PacifiCare SignatureValue Access (EPO) Individual(s) to be covered: <input type="checkbox"/> Self <input type="checkbox"/> Self + Spouse/Domestic Partner <input type="checkbox"/> Self + Dependent(s) <input type="checkbox"/> Self + Family <input type="checkbox"/> Waive Medical (Complete Waiver Form)	Dental Plan Options: <input type="checkbox"/> PacifiCare SignatureValue (Dental HMO) <input type="checkbox"/> PacifiCare SignatureOptions (Dental PPO) <input type="checkbox"/> PacifiCare SignatureIndependence (Dental Indemnity) Individual(s) to be covered: <input type="checkbox"/> Self <input type="checkbox"/> Self + Spouse/Domestic Partner <input type="checkbox"/> Self + Dependent(s) <input type="checkbox"/> Self + Family <input type="checkbox"/> Waive Dental (Complete Waiver Form)	Vision Plan Options: <input type="checkbox"/> PacifiCare SignatureOptions (Vision PPO - Full Service) <input type="checkbox"/> PacifiCare SignatureOptions (Vision PPO - Eyewear Only) Individual(s) to be covered: <input type="checkbox"/> Self <input type="checkbox"/> Self + Spouse/Domestic Partner <input type="checkbox"/> Self + Dependent(s) <input type="checkbox"/> Self + Family <input type="checkbox"/> Waive Vision (Complete Waiver Form)	Life/Disability <input type="checkbox"/> Life/AD&D <input type="checkbox"/> Short Term Disability <input type="checkbox"/> Long Term Disability 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	Primary Care Physician (PCP) Name	Provider #	Existing Patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Dentist Name & City	Dental Provider Group #	Existing Patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Male <input type="checkbox"/> 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	Provider #	Existing Patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Dentist Name & City	Dental Provider Group #	Existing Patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent 1	Last Name	First Name	M.I.	Date of Birth (mm-dd-yy)
<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security #	Address, if different than Employee's		
	Primary Care Physician (PCP) Name	Provider #	Existing Patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Dentist Name & City	Dental Provider Group #	Existing Patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent 2	Last Name	First Name	M.I.	Date of Birth (mm-dd-yy)
<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security #	Address, if different than Employee's		
	Primary Care Physician (PCP) Name	Provider #	Existing Patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Dentist Name & City	Dental Provider Group #	Existing Patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent 3	Last Name	First Name	M.I.	Date of Birth (mm-dd-yy)
<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security #	Address, if different than Employee's		
	Primary Care Physician (PCP) Name	Provider #	Existing Patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Dentist Name & City	Dental Provider Group #	Existing Patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Detach here

Group # _____

Employee Name _____

Social Security # _____

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 eligible for Medicare? Yes No If yes, complete boxes k + l:

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

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

Job Title	Employee's Benefits - Life: \$	AD&D: \$	Supp. Life: \$
Number of hours worked per week	Salary/Wages <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Annual \$	Spouse - 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	Relationship
Contingent Beneficiary (full name)	Percentage	Relationship

6. * 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/AD&D, LTD & STD underwritten by The Hartford. The Hartford* is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Accident Insurance Company and CNA Group Life Assurance Company. Any and all disputes related to coverage provided by The Hartford are not subject to arbitration.

7. Signature Required on Arbitration Disclosure - Read Carefully

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.

- 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.
- II. 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 CLAIMS SUBJECT TO ERISA, BETWEEN MYSELF 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.

Signature (Required) X	Date (Required)
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