

Medical / Dental / Life / Vision Enrollment Application



CaliforniaChoice 51+
Your Health. Your Choice.®

721 South Parker, Suite 200
Orange, CA 92868

A. Personal Information

Name of Company		Employer Phone #	Employee Job Title	Full-time Employment Date
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Status <input type="checkbox"/> Married <input type="checkbox"/> Single (Note: If you or any of your dependents are <u>not</u> enrolling, you must also complete and sign the waiver section on back.)			
Employee Last Name	<input type="checkbox"/> Domestic Partner		Employee Social Security Number	
Employee First Name	Date of Birth		Group Number	
	MO / DAY / YEAR			
Residence Address	Apt #	City	State	Zip Code
Home Telephone ()	Mailing Address (if different)			

B. Medical Benefit (select one plan only)

CalChoice® 51+ HMO <input type="checkbox"/> CalChoice® 51+ HMO 15 <input type="checkbox"/> CalChoice® 51+ HMO 25 <input type="checkbox"/> CalChoice® 51+ HMO 40		Choose an HMO Health Care Service Plan: <input type="text"/>	Health Net of CA <input type="checkbox"/> ELECT SM Open Access Kaiser Permanente <input type="checkbox"/> HDHP 1500* * HSA-qualified High Deductible Health Plan	Health Net Life Insurance Company <input type="checkbox"/> PPO 250 <input type="checkbox"/> HSA 1500 <input type="checkbox"/> PPO 500 <input type="checkbox"/> HSA 2000 <input type="checkbox"/> PPO 1000 <input type="checkbox"/> Flex Net <input type="checkbox"/> PPO 1500 (out of state only)
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PPO only: A Full-time Student Verification Form must be completed for each child age 19-23

C. Optional Benefits — Ask your health plan administrator if any of the optional benefits below are being offered by your employer

Life Insurance			
Full Name of Beneficiary	Relationship of Beneficiary	Date of Birth for Beneficiary	Life Amount
Dental			
<input type="checkbox"/> Dental 100 (no charge) <input type="checkbox"/> Dental 1000 <input type="checkbox"/> Dental 3000 <input type="checkbox"/> Dental 5000 <input type="checkbox"/> Dental 3500 <input type="checkbox"/> Dental 4000	If you choose plans 1000 or 3000, you must select a dentist: Dentist: _____ ID#: _____	<input type="checkbox"/> Check if dentist chosen is current provider <input type="checkbox"/> Check if you would like a dentist assigned	
Vision		Premium Only Plan (P.O.P.)	
<input type="checkbox"/> Vision (no charge) <input type="checkbox"/> Voluntary Vision (additional charge)		<input type="checkbox"/> I want my portion of eligible insurance premiums paid on a pre-tax basis	

D. Enrollment Information (Complete this section ONLY if you are electing medical, dental and/or vision for yourself or dependents)

	Employee	Spouse	Child	Child	Child
Last Name	<input type="checkbox"/> Life only				
First Name					
Relationship to Employee		<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner			
Social Security No.					
Gender		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth		/ /	/ /	/ /	/ /
Primary Care Physician*					
Physician ID# & City					
Current Patient of PCP?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Disabled?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Enrolling For?	<input type="checkbox"/> Med <input type="checkbox"/> Dent <input type="checkbox"/> Vision	<input type="checkbox"/> Med <input type="checkbox"/> Dent† <input type="checkbox"/> Vision	<input type="checkbox"/> Med <input type="checkbox"/> Dent† <input type="checkbox"/> Vision	<input type="checkbox"/> Med <input type="checkbox"/> Dent† <input type="checkbox"/> Vision	<input type="checkbox"/> Med <input type="checkbox"/> Dent† <input type="checkbox"/> Vision
<input type="checkbox"/> Check here if you would like your Health Care Service Plan to assign you a Primary Care Physician.					
* Please be sure to verify that your PCP is contracted with your selected carrier prior to enrolling. New Hire applications added to existing groups will automatically be assigned a PCP if one is not chosen or PCP is not contracted with the selected health plan. For Kaiser Permanente enrollees, no PCP selection is required.					
† Dependents enrolled for dental must match dependents enrolled for medical (except voluntary dental or children under Age 3).					

E. Coordination of Benefits

Will you or any of your dependents enrolling for medical coverage in CaliforniaChoice 51+ maintain additional medical coverage through another plan? Yes No
If yes, please provide the following plan information. Include Medicare, if applicable.

Full Name of Insured	Name of Other Insurance Carrier/Health Plan	Policy ID#	Employer

F. Your LEGAL Acknowledgement (Read, Sign & Date Below)

By submitting this signed application, I agree and understand that the health plan I have chosen through the CaliforniaChoice 51+ Program shall automatically have a lien on any payment of monies from any source, for services rendered in conjunction with an injury caused by the acts or omissions of a third party.

I agree for myself and my dependents to be bound by the benefits, copays, deductibles, exclusions, limitations and other terms of the health plan's small group contract.

I authorize my physician, healthcare provider, hospital, clinic or other medically related facility to furnish my, and my dependent's, protected health information, including medical records, to the health plan I have chosen through the CaliforniaChoice 51+ Program or its authorized agents for the purpose of review, investigation, or evaluation of an application or claim, and for quality assurance and utilization review. I authorize CaliforniaChoice 51+ and the health plan I have chosen, and their agents, designees or representatives, to disclose to a hospital, health plan, insurer, or healthcare provider any protected health information if such disclosure is necessary to allow the performance of any of those activities. This authorization shall become effective immediately and shall remain in effect for up to 30 months from the date the authorization was signed. I understand that I, or a person authorized to act on my behalf, is entitled to receive a copy of this authorization form.

I have read and understand the information provided to me pertaining to the Premium Only Plans and the tax consequences.

I declare under the penalty of perjury under the laws of the state of California that the following statements are true, correct and pertain to the employer named on this application, myself and my dependents named on this application:

- I am either actively, permanently working for the employer and considered eligible by my employer because I work 30+ hours per week, or I am an eligible COBRA/Cal-COBRA participant.
- I am not a temporary, seasonal, per diem or a 1099 employee or insured by or eligible to be insured by the employer's union policy.
- My children's dates of birth are accurate. My children are: unmarried or not involved in a domestic partnership, and are financially dependent upon me per the IRS guidelines. My children are born to me or my spouse/domestic partner, or legally adopted and/or a non-temporary legal ward of me or my spouse/domestic partner.

I understand that the above statements are subject to audit at any time and agree to provide CaliforniaChoice 51+ with any and all information necessary to prove the above statements.

I understand that false statements and/or failure to provide the information upon request will cause the termination of all CaliforniaChoice 51+ benefits 15 days following the date of the notice of termination and I will be held responsible for all services and charges incurred through CaliforniaChoice 51+ program providers thereafter.

I understand that any persons, business, or health plan that suffers a loss because of false-declarations contained in this statement may take legal action against me to recover their losses.

- The representations made are the basis upon which coverage may be issued.
- If any Material fact was omitted or misrepresented, the coverage may be cancelled or the employer's contract rescinded.
- I have READ, UNDERSTAND and ATTEST that myself and my dependents have met all of the eligibility requirements.

California law prohibits an HIV test from being required or used by Health Care Service Plans and health insurance companies as a condition of obtaining coverage.

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

ARBITRATION: I understand that any dispute or controversy that may arise regarding the performance, interpretation or breach of the agreement between myself (and/or any enrolled dependent) and my health plan, whether arising out of tort or otherwise, must be submitted to binding arbitration and in lieu of a jury or court trial if not satisfactorily resolved through my health plan's grievance process.

HEALTH NET ENROLLEES: BINDING ARBITRATION AGREEMENT: Subject to the terms of the Plan Contract or Insurance Policy (which may prohibit mandatory arbitration of certain disputes if the Plan Contract or Insurance Policy is subject to ERISA, 29 U.S.C. section 1001, et seq.),

I, the Employee, understand and agree that any and all disputes or disagreements between me (including any of my enrolled family members or heirs or personal representatives) and the Health Net Entities, the Safeguard Entities and/or the Fidelity Entities, regarding the construction, interpretation, performance or breach of the Plan Contract or Insurance Policy, or regarding other matters relating to or arising out of my Health Net Entities, the Safeguard Entities and/or the Fidelity Entities membership, whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or employees, are also involved, must be submitted to final and binding arbitration in lieu of a jury or court trial. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties, including the Health Net Entities, the Safeguard Entities and/or the Fidelity Entities, are giving up their constitutional right to have their dispute decided in a court of law before a jury. I also understand that disputes that I may have with the Health Net Entities, the Safeguard Entities and/or the Fidelity Entities involving claims for medical malpractice are also subject to final and binding arbitration. A more detailed arbitration provision is included in the Plan Contract or Insurance Policy. My signature below indicates that I agree to submit any dispute to binding arbitration.

KAISER FOUNDATION HEALTH PLAN ENROLLEES: ARBITRATION AGREEMENT: I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs, relatives or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

CIGNA ENROLLEES: CALIFORNIA RESIDENTS ONLY: CIGNA HealthCare uses binding arbitration to settle disputes, including claims of medical malpractice and disputes relating to the delivery of service under the plan. It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. The parties to this contract, by entering into it, are giving up their constitutional right to have any dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. It is understood that this agreement to arbitrate shall apply and extend to any dispute for medical malpractice, relating to the delivery of service under the plan, and to any claims in tort, contract or otherwise, between Group, any individual(s) seeking services under the plan, whether referred to as a Member, Subscriber, Dependent, Enrollee or otherwise (whether a minor or an adult), or the heirs-at-law or personal representatives of any such individual(s), as the case may be, and CIGNA HealthCare (including any of their agents, successors- or predecessors-in-interest, employees, or providers).

Employee SIGN HERE FOR MEDICAL, DENTAL, LIFE OR VISION COVERAGE: _____ Print Name _____ Date: _____

My signature acknowledges both the arbitration disclosures of the HMO I selected in Part B and my decision to enroll in the medical, dental, life or vision coverage that I selected in Part C.

COBRA Applicants: Please check COBRA type: <input type="checkbox"/> COBRA <input type="checkbox"/> Cal-COBRA	Indicate Qualifying Event:	Date of Qualifying Event
	<input type="checkbox"/> Termination of employment <input type="checkbox"/> Reduction of hours	<input type="checkbox"/> Child no longer eligible <input type="checkbox"/> Divorce/legal separation <input type="checkbox"/> Medicare entitlement <input type="checkbox"/> Death of employee

Staff Use Only	<input type="checkbox"/> New Group-employee <input type="checkbox"/> Renewal	<input type="checkbox"/> New Hire Effective Date: <input type="text"/>	www.calchoiceplus.com
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Medical / Dental Waiver



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Complete this form only if you do not want medical or dental coverage for yourself and/or your eligible dependents. **If offered by your employer, the life coverage benefit cannot be waived and you are required to complete an Enrollment Application.** Chiropractic coverage cannot be waived when enrolling for medical coverage.

A. Personal Information

Name of Company	Employer Phone Number
Employee Last Name	Employee Social Security Number
Employee First Name	Group Number

B. Type of Waiver

I have been offered coverage by my employer, but at this time I wish to **DECLINE** coverage as follows:

- 1) **Medical for:** Myself and dependents Spouse/Domestic Partner Child(ren)
- 2) **Dental for:** Myself and dependents Spouse/Domestic Partner Child(ren)

C. Reason

Required only if employee waiving coverage

- 1) **Reason waiving Medical:**
- Other group coverage Carrier Name: _____ Group # _____
- Medicare
- Medi-cal
- Individual Policy
- Other Reason: _____ (explanation required)
- 2) **Reason waiving Dental:**
- Other group coverage Carrier Name: _____ Group # _____
- Medicare
- Medi-cal
- Individual Policy
- Other Reason: _____ (explanation required)

D. Signature

- I understand that by failing to elect coverage now, CaliforniaChoice 51+ can impose up to a 12 month period of exclusion should I request coverage at a later date.
- I also understand that if my employer is offering life coverage, I CANNOT WAIVE LIFE COVERAGE.

This waiver provision will not apply if: 1) Court orders coverage of a spouse or child and the request for enrollment occurs within 30 days of the court order; or 2) Employee meets ALL of the following: A) Was covered under another employer-sponsored health plan at the time of initial eligibility; B) Lost coverage as a result of termination of employment, change in employment status, involuntary termination of other plan's coverage, cessation of employer's contribution, or death or divorce of spouse; C) Requests enrollment within 30 days of loss of coverage.

Employee **SIGN HERE TO WAIVE COVERAGE:**

Date

