PacifiCare®

Oklahoma Small Group Employee Enrollment Form and Declination of Coverage

Effective April 1, 2005

■ Instructions

Section 1: Personal Information

Please complete information requested. When completing the optional ethnicity information, please use the following key.

C = Caucasian or White
B = African American or Black
H = Hispanic or Latino
A = Asian, Native Hawaiian or Pacific Islander
I = Native Indian
N = not disclosed

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 & Dependent Information

- List yourself and family members to be covered. You may attach additional sheets if necessary.
- Select a Primary Care Physician (PCP) from the *Provider Directory* for you and each of your family members by writing the PCP name and Provider number in the area provided. You may choose a different PCP for each member in your family.

  PCP selection is only required if a PacifiCare SignatureValue℠ (HMO) plan is selected. If you do not select a PCP when selecting one of these plans, a PCP will be automatically assigned to you.
- Over age Dependents require 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, if applicable.

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: Signature Required

Please read this section carefully and provide your signature(s) 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 section of this 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 Evidence of Coverage/ Group Subscriber Agreement ("Agreement")/Certificate if I have chosen the PacifiCare SignatureValue℠ (HMO) plan or the PacifiCare Group Health Insurance Policy ("Policy") if I have chosen the PacifiCare SignatureOptions℠ (PPO), PacifiCare SignatureFreedom℠ (SDHP) or PacifiCare SignatureIndependence℠ 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, 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 enrollment form may result in the reduction or denial of benefits under the member's insurance Policy/Agreement 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 *Evidence of Coverage or Certificate of Coverage, Provider Directory* and a copy of this Enrollment Form.
7. My Dependents and I must reside in Oklahoma and live or work in PacifiCare's service area if enrolling in the PacifiCare SignatureValue (HMO) Plan.
8. If my Dependent(s) or I elect PacifiCare SignatureValue (HMO), I understand that it is recommended that we select a Primary Care Physician within 30 miles of our Primary Residence or Primary Workplace.
9. 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.

Detach here

PacifiCare SignatureValue (HMO)
P.O. Box 400046
San Antonio, TX 78229
1-800-825-9355
1-800-557-7595 (TDHI)

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

EMPLOYEE ENROLLMENT FORM (Please Print)

OKLAHOMA

1. Personal Information

Company Name	Occupation/Title	Date of Hire	Date of Rehire

Last Name	First Name	MI	Suffix	☐ Male ☐ 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? ☐ Yes ☐ No	Home Telephone ( )	Work Telephone ( )

Date of Birth (mm-dd-yy)	Social Security #	Marital Status ☐ Single ☐ Widow ☐ Married ☐ Divorced ☐ Domestic Partner

Are you currently on COBRA? ☐ Yes ☐ No
If yes, qualifying event and original start date:

E-Mail	Annual Salary	Would you like to receive information via E-mail? ☐ Yes ☐ No

Preferred Language (Optional) ☐ English ☐ Spanish Ethnicity (Optional) ☐ C ☐ B ☐ H ☐ A ☐ I ☐ N

Employer Required to Complete This Section

Group #/Plan Code	
Dental/Vision Group #	
Source of Enrollment: ☐ Open Enrollment ☐ New Hire ☐ QMCSO ☐ Transfer ☐ 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	Dental	Vision	Life/Disability
Plan Options: ☐ PacifiCare SignatureValue (HMO) ☐ PacifiCare SignatureOptions (PPO) ☐ High Option/☐ Low Option (if applicable) ☐ PacifiCare SignatureOptions (HSA-Compatible) ☐ PacifiCare SignatureIndependence (Indemnity) ☐ PacifiCare SignatureFreedom (SDHP) Please complete the Declination of Coverage form if declining coverage for Self and/or Eligible Dependent(s)	Plan Options: ☐ PacifiCare SignatureOptions (Dental Network) ☐ PacifiCare SignatureIndependence (Dental Indemnity) Please complete the Declination of Coverage form if declining coverage for Self and/or Eligible Dependent(s)	Plan Options: ☐ PacifiCare SignatureOptions (Vision PPO – Full Service) ☐ PacifiCare SignatureOptions (Vision PPO – Eyewear Only) Please complete the Declination of Coverage form if declining coverage for Self and/or Eligible Dependent(s)	☐ Life/AD&D Individual(s) to be covered: ☐ Self Only ☐ Self and Eligible Dependent(s)

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? ☐ Yes ☐ No

Height: Ft. In. Weight: lbs.

Spouse

☐ 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	Provider #	Existing Patient? ☐ Yes ☐ No

Height: Ft. In. Weight: lbs. Ethnicity ☐ C ☐ B ☐ H ☐ A ☐ I ☐ N

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	Provider #	Existing Patient? ☐ Yes ☐ No

Height: Ft. In. Weight: lbs. Ethnicity (Optional) ☐ C ☐ B ☐ H ☐ A ☐ I ☐ N

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	Provider #	Existing Patient? ☐ Yes ☐ No

Height: Ft. In. Weight: lbs. Ethnicity ☐ C ☐ B ☐ H ☐ A ☐ I ☐ N

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	Provider #	Existing Patient? ☐ Yes ☐ No

Height: Ft. In. Weight: lbs. Ethnicity (Optional) ☐ C ☐ B ☐ H ☐ A ☐ I ☐ N

☐ Check box if additional enrollment page is attached for dependents.

Overage dependents require proof of full-time student status or permanent disability status within 31 days of enrollment.

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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#

■ **Does anyone listed have other dental insurance?** ☐ Yes ☐ No If yes, complete boxes o–p:

m. Name	n. Insurance Company Name	o. Policy #	p. Effective Date

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

I wish coverage ☐ Yes ☐ No	Job Title	Employee's Benefits – Life: $	AD&D: $	Supp. Life: $
# of hours worked per week	Salary/Wages ☐ Hourly ☐ Monthly ☐ 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	Telephone ( )	Relationship
Contingent Beneficiary (full name)	Percentage	Telephone ( )	Relationship

Evidence of Insurability may be required.

Spouse Signature X	Date

* 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.

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6. 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)

Employee Name _____ Social Security # _____

Company Name _____

Source Code	Tracking #

Declination of Coverage Form

Complete this section if any coverage is to be declined by you or your eligible dependents

Unless one of the these 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 and to impose a twelve-month waiting period at the time you decide to enroll.

I certify that the reason I am declining enrollment in PacifiCare's Group □ Health Plan □ Dental Plan □ Vision Plan is: (check, as applicable)

□ I am covered under another group □ health plan □ dental plan □ vision plan offered to my spouse.

□ I am covered under another group □ health plan □ dental plan □ vision plan offered by my EMPLOYER.

□ I am covered under an Individual health plan.

□ I am declining because _____

□ I am declining the □ health plan □ dental plan □ vision plan for my spouse, name _____,

because _____

□ I am declining for my child/children:

□ health plan □ dental plan □ vision plan, name _____, because _____

□ health plan □ dental plan □ vision plan, name _____, because _____

□ health plan □ dental plan □ vision plan, name _____, 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 a period of twelve (12) months after the date we enroll, or 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, and thus will not have to wait for a period of twelve (12) months after we enroll in PacifiCare:

1. OTHER EMPLOYER health plan COVERAGE. You and your dependents (collectively "You") shall not be considered Late Enrollees if:
   a. You are currently covered under another employer health plan ("Plan") although You are also eligible to enroll in a PacifiCare plan;
   b. You certify 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) the legal separation or divorce; or
      (7) you declined 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-one (31) 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 not have to wait twelve (12) months after You enroll.
2. COURT ORDER. You and your spouse and/or minor child will not be classified as Late Enrollees, if a court has ordered that coverage be provided for a spouse or minor child under an employee's health plan. PacifiCare will enroll a Dependent child with thirty-one (31) days after receipt of a court order or request from the district attorney, either parent or the person having custody of the child as defined in Section 3751.5 of the Family Code, the employer or the group administrator. In the case of children who are eligible for Medicaid, the State Department of Health Services may also make the request.

My signature on the inside of this form represents that I have read, understand and agree to the terms and conditions listed above.

Signature – I have read, understand and agree to the above Declination of Coverage.

Signature (Required)	Date (Required)
X	