

ARIZONA ALL PLANS ENROLLMENT FORM



For PacifiCare Office Use Only

| | | | |
|-----------|--------------|-----------|----------|
| Tier Code | Process Date | Processor | Approval |
|-----------|--------------|-----------|----------|

Type or print with ballpoint pen. Incomplete information will delay the enrollment process.

Employer Information (To be completed by Employer)

| | | | | | | | | | | | |
|------------------------|-----------------------|---|--|-------------|--|-------------------|--|----------------------------|--|---|--|
| Employer Name | | Location | | HMO Group # | | Life Group # | | Subgroup/Location # | | PPO Group # | |
| Date of Full-Time Hire | Hours worked per week | Status (retired, full, part time, etc.) | | Job Title | | Employer Initials | | Effective Date of Coverage | | (If applicable) <input type="checkbox"/> High option <input type="checkbox"/> Low option | |

Employee/Dependent Information

| | | | | | | | | | | | |
|--------------------------------|--|--|-------------------|------------------|--|------------|--|--------------------------------|--|--------|--|
| Name (Last, First, Middle) | | | Social Security # | | | Home Phone | | Work Phone | | County | |
| Street Address (No P.O. Boxes) | | | | City, State, ZIP | | | | Mailing Address (if different) | | | |

Coverage Information

Medical Yes No **Which Type?** HMO POS Open Access PPO Indemnity **Individual(s) Covered** Self Spouse Dependents
Dental Yes No **Which Type?** HMO Indemnity **Individual(s) Covered** Self Spouse Dependents Dentist's Full Name: _____

List all Members to be covered

If electing HMO, list Primary Care Physician**

| Relationship | Last Name | First Name | MI | Sex | Social Security # | Birth Date (MM/DD/YYYY) | Network Code | Last Name | First Name | MI | Current Patient |
|--------------|-----------|------------|----|-----|-------------------|-------------------------|--------------|-----------|------------|----|--|
| Self | | | | | | | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Spouse | | | | | | | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Dependents | | | | | | | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Dependents | | | | | | | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Dependents | | | | | | | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Dependents | | | | | | | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Dependents | | | | | | | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N |

Coordination of Benefits

Will you or any dependent be covered by other Group Health in addition to PacifiCare? Yes No Name of Carrier _____
 If you or any of your dependents are eligible for Medicare, are you: Retired Active Part A only Part B only Part A & B
 Has anyone listed above been advised by a physician of any surgery or hospital confinement required within the next 60 days? Yes No If Yes, who? _____

Waivers

Waive Medical Dental
 Coverage for myself and dependents (if any) My dependents only **Reason for waiver of coverage** Covered by Spouse's Insurance Other (explain): _____

Life Insurance Information

| | | | |
|---|--|----------------------------------|--|
| Basic Life Insurance <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents | Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated | (If applicable) Annual Earnings: | Supplemental Life Insurance <input type="checkbox"/> 1x Salary <input type="checkbox"/> 2x Salary |
| Beneficiary's Name (Last, First, Middle) | | Social Security # | Relationship |
| Street Address | | City, State, ZIP | Home Phone |

I hereby authorize any health care facility, physician or surgeon, or any other health professional to disclose to PacifiCare of Arizona, Inc. or PacifiCare Life Assurance company, its agents or employees, all information from my medical records pertaining to any past or future examination or treatment including treatment for substance abuse and mental and emotional disorders furnished to me or my Dependents who are also applying for this coverage, and to any illness, injury or condition that I or these Dependents have had at any time in the past or in the future until the expiration of this authorization. I understand that this information is collected in connection with the evaluation and processing of an application for coverage, to determine continuing eligibility for benefits and to process claims, and may in certain circumstances be disclosed to third parties without authorization. This authorization also includes PacifiCare of Arizona, Inc. or PacifiCare Life Assurance Company disclosing any medical information they may have in their files to the same entities in connection with the advance consideration of providing services or subsequent payment for such services. I understand upon written request and within 30 business days of receipt by PacifiCare of Arizona, Inc. of that request, I have a right of access and correction with respect to all personal information collected. My authorized representative or I am entitled to receive a copy of this form as well as a separate notice that explains my right of access to recorded personal information and disclosure limitations and conditions. This authorization, for the purpose of collecting information in connection with application of insurance, is valid for thirty (30) months from the date signed and is valid until the termination of this policy for collecting information in connection with a claim for benefits. A photocopy or other reproduction of this authorization is as valid as the original. HMO product is offered/underwritten by PacifiCare of Arizona, Inc. PPO, Indemnity and Life Products are offered/underwritten by PacifiCare Life Assurance Company. Member shall complete and submit to PacifiCare or Group an enrollment application or other forms or statements as PacifiCare may reasonably require. Member agrees to promptly notify PacifiCare or Group of any changes in the information contained in the enrollment application packet. Member warrants that to the best of his or her knowledge, all information contained in such application, forms and statements is true and complete, and agrees that all rights to benefits under this Agreement are subject to the condition that all such information is true and complete.

*If you elected HMO or POS, Plan and did not select a primary care physician (PCP) and/or an HMO primary care dentist, PacifiCare will select one for you. You may select a new PCP by contacting PacifiCare Customer Service [1-800-347-8600].

| | |
|---------------------|------|
| Applicant Signature | Date |
|---------------------|------|

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White: PacifiCare

Yellow: PacifiCare Life Assurance Company

Pink: Employer

Green: Subscriber