



Medical / Dental / Life Enrollment Application

1 Use Blue or Black ink pen 2 Do not shrink this form 3 Fax paper is unacceptable

1. Personal Information

Name of Company			Employer Phone #			Employee Job Title			Full-time Employment Date		
Employee Last Name						Employee Social Security Number					
Employee First Name						Date of Birth (mo/day/year)			Sex		
Residence Address				Apt #	City			State		Zip Code	
Home Telephone			Mailing Address (if different)								

2. Medical Benefit Selection

Select one HMO or PPO Plan only											
HMO <input type="checkbox"/> Cal Choice 5 <input type="checkbox"/> Cal Choice 10 <input type="checkbox"/> Cal Choice 20 Choose an HMO Health Care Service Plan:			<input type="checkbox"/> Elect Open Access (Health Net)			PPO <input type="checkbox"/> PPO 15 <input type="checkbox"/> PPO 25 <input type="checkbox"/> PPO 45 <input type="checkbox"/> PPO 2250 PPO PLAN AVAILABILITY WILL BE BASED ON GROUP ELIGIBILITY AND MAY BE SUBJECT TO CHANGE			<i>PPO only: a Full-time Student Verification Form must be completed for each child age 19-24</i>		

3. Enrollment/Family Information (Medical and/or Dental)

Single Married **Medical Coverage:** Employee Only Emp & Spouse Emp & Family Emp & Children Emp & Domestic Partner (Affidavit required) Life coverage ONLY application

Do NOT complete this section for yourself or dependents if medical OR dental coverage is not elected. If member information provided and waiver not completed, members will automatically be enrolled.

M B R	Last Name	First Name	Sex	Relationship to Employee	Social Security Number	Date of Birth	Primary Care Physician*	Physician ID# & City	Current Patient?	Disabled?
EE									Y/N	
SP			M/F	<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	- -	/ /			Y/N	Y/N
CH			M/F		- -	/ /			Y/N	Y/N
CH			M/F		- -	/ /			Y/N	Y/N
CH			M/F		- -	/ /			Y/N	Y/N

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*

4. OPTIONAL BENEFITS

Before completing this Section, please ask your health plan administrator if any of the optional benefits below are being offered by your employer

LIFE INSURANCE

Employee's Date of Birth	Employee's Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Employee's Gender M / F	Job Title	Life Amount
Full Name of Beneficiary		Relationship of Beneficiary	Date of Birth for Beneficiaries	Full-time Student? (if son/daughter)
If beneficiary is someone other than spouse, spouse's signature is required: _____				

DENTAL COVERAGE

Dental Coverage: Employee Only Emp & Spouse Emp & Family Emp & Children Emp & Domestic Partner (Affidavit required)

Dependents for dental must match dependents for medical unless Voluntary 3000

<input type="checkbox"/> Dental Plan 1000 <input type="checkbox"/> Dental Plan 3000 <input type="checkbox"/> Voluntary Dental 3000	If you choose plans 1000 or 3000, you must select a dentist:	Dentist:	ID#:
SECURITY LIFE → <input type="checkbox"/> Dental Plan 4000 <input type="checkbox"/> Dental Plan 5000	<input type="checkbox"/> Check if dentist chosen is current provider <input type="checkbox"/> Check if you would like a dentist assigned		

PREMIUM ONLY PLAN (P.O.P.)

I want my portion of eligible insurance premiums paid on a pre-tax basis: YES NO

PLEASE SIGN AND DATE APPLICABLE SECTIONS ON THE REVERSE SIDE OF FORM

5. Read, Sign & Date Below

By submitting this signed application, I agree and understand that the participating plan I have chosen through the CaliforniaChoice 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 also understand that in compliance with the terms of the participating plan Contract, I agree to waive for myself and my dependents all rights to submit any controversy or dispute to a court or jury and that claims asserted by myself or a dependent, spouse, heir or personal representative are required to be submitted to binding arbitration after the participating plan's grievance procedure has been exhausted if such claim is asserted against the participating plan I have chosen through the CaliforniaChoice Program and/or any individual practice association or medical group and/or any employee, agent, or board member for these organizations. Furthermore, any dispute as to medical malpractice and/or the professional negligence of a primary care or specialist physician who has contracted with the individual practice association or medical group with which participating plan contracts shall be determined by submission to binding arbitration as agreed between the employer and the participating plan.

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

I agree and understand that the participating plan I have chosen through the CaliforniaChoice Program is authorized to obtain and release medical information for myself and my dependents in compliance with the terms of the Group Contract and the Insurance Information and Privacy Protection Act, Section 791 et. seq., of the California Insurance Code. Furthermore, I authorize the release of all my, and my dependent's medical records to the participating plan I have chosen through the CaliforniaChoice Program or its authorized agents for performance of any one or more of the following: a) the administration of this policy; b) peer review for quality assurance and utilization review by the participating plan I have chosen through the CaliforniaChoice Program or its authorized agents; c) bona fide medical emergencies; d) creation and provision of statistical data to the employer; and e) any other exceptions provided by law. Where the release of names or identifying demographic information is not necessary to the function being performed, such information will not be released. I have read the information provided to me pertaining to the Premium Only Plans and understand the tax consequences.

By signing and submitting this application, I hereby agree to the above terms and conditions, and confirm that I am working the number of hours considered to be full time by my employer, but not less than 20 hours per week.

Employee **SIGN HERE FOR MEDICAL, DENTAL OR LIFE COVERAGE:**

Date:



COBRA Applicants

- COBRA
 Cal-COBRA

Qualifying Event:

- Termination of employment
 Reduction of hours
 Child no longer eligible
 Divorce/legal separation
 Medicare entitlement
 Death of employee

Date of Qualifying Event

Employer/Cal Choice Use Only

- New Group - Employee
 New Hire
 Open Enrollment

Effective Date Div.

Group #

MEDICAL / DENTAL WAIVER

Employer Name:

Employer Phone #:

COMPLETE THIS SECTION ONLY IF YOU DO NOT WANT COVERAGE FOR YOURSELF AND/OR YOUR ELIGIBLE DEPENDENTS. IF YOUR EMPLOYER IS OFFERING LIFE COVERAGE, THIS BENEFIT CANNOT BE WAIVED. SECTIONS 1, 4 and 5 MUST BE COMPLETED TO ENROLL. CHIROPRACTIC COVERAGE CANNOT BE WAIVED WHEN ENROLLING FOR MEDICAL COVERAGE.

My dependents AND I have been offered coverage by my employer, but at this time I wish to DECLINE:

EMPLOYEE WAIVER

(Check applicable boxes and fill in necessary information below)

MYSELF and any eligible dependents for **MEDICAL** for the following REASON:

- Covered by another group plan through Group Carrier Name: _____ Policy # _____
 Medicare Medi-cal Individual Policy Other Reasons: _____ (explanation required)

MYSELF and any eligible dependents for **DENTAL** for the following REASON:

- Covered by another group plan through Group Carrier Name: _____ Policy # _____
 Medicare Medi-cal Individual Policy Other Reasons: _____ (explanation required)

DEPENDENT WAIVER

(Check applicable boxes below)

- SPOUSE for MEDICAL DOMESTIC PARTNER for MEDICAL CHILD(REN) for MEDICAL
 SPOUSE for DENTAL DOMESTIC PARTNER for DENTAL CHILD(REN) for DENTAL

I understand that by failing to elect coverage now, CaliforniaChoice Benefit Administrators 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 Last Name

Employee Social Security Number

Employee First Name

Employee **SIGN HERE IF WAIVING COVERAGE:**

Date:

