

Use blue or black ink pen • Do not shrink this form

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 <i>(Note: If you or any of your dependents are <u>not</u> enrolling, you must also complete and sign the waiver section on back.)</i> <input type="checkbox"/> Domestic Partner			
Employee Last Name <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		Employee Social Security Number <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Employee First Name <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		Date of Birth MO / DAY / YEAR <input type="text"/> / <input type="text"/> / <input type="text"/>	Group Number <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Residence Address	Apt #	City	State Zip Code
Home Telephone ()	Email Address	Mailing Address <i>(if different from above)</i>	

B. MEDICAL BENEFIT (select one plan only)
HMO

Blue Shield	Health Net	Kaiser Permanente	Sharp Health Plan	Western Health Advantage
<input type="checkbox"/> CalChoice® HMO 15 <input type="checkbox"/> CalChoice® HMO 25 <input type="checkbox"/> CalChoice® HMO 25 Value <input type="checkbox"/> CalChoice® HMO 30 <input type="checkbox"/> CalChoice® HMO 40 <input type="checkbox"/> CalChoice® HMO 40 Value	<input type="checkbox"/> CalChoice® HMO 15 <input type="checkbox"/> CalChoice® HMO 25 <input type="checkbox"/> CalChoice® HMO 25 Value <input type="checkbox"/> CalChoice® HMO 30 <input type="checkbox"/> CalChoice® HMO 30 Value <input type="checkbox"/> CalChoice® HMO 40 <input type="checkbox"/> CalChoice® HMO 40 Value <input type="checkbox"/> Elect Open Access	<input type="checkbox"/> CalChoice® HMO 15 <input type="checkbox"/> CalChoice® HMO 25 <input type="checkbox"/> CalChoice® HMO 30 <input type="checkbox"/> CalChoice® HMO 40	<input type="checkbox"/> CalChoice® HMO 15 <input type="checkbox"/> CalChoice® HMO 25 <input type="checkbox"/> CalChoice® HMO 30 <input type="checkbox"/> CalChoice® HMO 40	<input type="checkbox"/> CalChoice® HMO 15 <input type="checkbox"/> CalChoice® HMO 25 <input type="checkbox"/> CalChoice® HMO 30 <input type="checkbox"/> CalChoice® HMO 40 <input type="checkbox"/> CalChoice® HMO 40 Value

PPO

- | | | |
|-----------------------------------|------------------------------------|--|
| <input type="checkbox"/> PPO 750 | <input type="checkbox"/> PPO 2400 | <input type="checkbox"/> HSA 2400* |
| <input type="checkbox"/> PPO 1000 | <input type="checkbox"/> HSA 1500* | <input type="checkbox"/> Active Choice SM 500 |

PPO PLAN AVAILABILITY WILL BE BASED ON GROUP ELIGIBILITY AND MAY BE SUBJECT TO CHANGE
**HSA-Qualified High Deductible Health Plan*
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	Date of Birth for Beneficiary
Relationship of Beneficiary	Life Amount

Dental Coverage

<input type="checkbox"/> Dental Plan 1000 [†] <input type="checkbox"/> Dental Plan 3000 [†] <input type="checkbox"/> Voluntary Dental 3000 <input type="checkbox"/> Dental Plan 3500 <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
[†] If you choose plans 1000 or 3000, you must select a dentist: Dentist: _____ ID#: _____	

Vision Coverage

-
- Vision (discount plan)
-
- Voluntary Vision (additional charge)

Premium Only Plan (P.O.P.)

-
- I want my portion of eligible insurance premiums paid on a pre-tax basis

D. ENROLLMENT INFORMATIONComplete this section **ONLY** if you are electing medical, dental and/or vision for yourself and 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 Healthcare Service Plan to assign you a Primary Care Physician. ➔ For additional dependent enrollment, complete sections A & D on a separate application.					
* 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. FULL TIME STUDENT VERIFICATION

If you wish to include a dependent between the ages of 19 and 24 under your medical and/or dental coverage, your dependent must meet the following eligibility requirements:

- Unmarried or not involved in a domestic partnership
- Financially dependent upon the Employee per IRS guidelines
- Enrolled full-time in an accredited secondary school or college (12 or more units)

This form must be completed and signed by the employee. Failure to complete and submit this verification may result in the denial of service/claims submitted on behalf of the dependent.

Student's Name	Date of Birth
Name of School	
Address	
Employee Signature	Date

F. YOUR LEGAL ACKNOWLEDGEMENT (Read, sign and date where indicated on next page)

By submitting this signed application, I agree and understand that the health 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 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® 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® 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 either 20+ or 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.

(continued on next page)

F. YOUR LEGAL ACKNOWLEDGEMENT (continued)

- 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 partners.

I understand that the preceding statements are subject to audit at any time and **agree** to provide CaliforniaChoice® 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® 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® 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 I myself and my dependents have met all of the eligibility requirements listed on page 5 of this application.

California law prohibits an HIV test from being required or used by health care service plans as a condition of obtaining coverage.

HEALTH NET ENROLLEES:	KAISER FOUNDATION HEALTH PLAN ENROLLEES:	SHARP ENROLLEES:	WESTERN HEALTH ADVANTAGE ENROLLEES:
<p>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.</p>	<p>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.</p>	<p>It is understood that any dispute or controversy between the Member and the Plan arising out of or in connection with this Group Agreement, excluding a claim of medical malpractice, will be determined by submission to final and binding arbitration in accordance with the provisions of Article XIII of this Group Agreement, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this Group Agreement, by entering into it, are giving up their constitutional right to have any such dispute or controversy decided in a court of law before a jury, and instead are accepting the use of arbitration.</p>	<p>Arbitration Agreement: I agree and understand that any and all disputes between myself (including any heirs or assigns) and Western Health Advantage, including 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 Small Claims Court cases and claims subject to ERISA, 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 California law provides for judicial review of arbitration proceedings. The parties, including any heirs or assigns, 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.</p>

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

➔ _____

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

<p>COBRA Applicants:</p> <p>Please check COBRA type:</p> <p><input type="checkbox"/> COBRA <input type="checkbox"/> Cal-COBRA</p>	<p>Indicate Qualifying Event:</p> <p><input type="checkbox"/> Termination of employment <input type="checkbox"/> Child no longer eligible <input type="checkbox"/> Medicare entitlement</p> <p><input type="checkbox"/> Reduction of hours <input type="checkbox"/> Divorce/legal separation <input type="checkbox"/> Death of employee</p>	<p>Date of Qualifying Event</p> <p><input type="text"/></p>
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Employer/CaliforniaChoice® Use Only	
<input type="checkbox"/> New Group-employee <input type="checkbox"/> New Hire <input type="checkbox"/> Renewal <input type="text"/> Effective Date:	CC 0310B 8/2008

Who can be covered?	Effective dates	Requirements that MUST be met:
New Spouse	<p>If marriage occurred before the 16th of the month, coverage begins on date of marriage[†]</p> <p>If marriage occurred on the 16th of the month or after, coverage begins on the first of month <u>following</u> date of marriage</p>	<ul style="list-style-type: none"> ■ New spouse must be legally married to the employee
New Baby, Adopted Child, New Stepchild, Non-Temporary Legal Ward, and Dependent Children	<p>If birth/date of placement occurred before the 16th of the month, coverage begins on the date of their birth/placement[†]</p> <p>If birth/date of placement occurred on the 16th or after, child is automatically covered at no cost under Subscriber between date of birth/placement and the first of the <u>following</u> month</p>	<ul style="list-style-type: none"> ■ Born to, a step-child of, adopted by, or non-temporary legal ward of the employee ■ Financially dependent upon the employee per IRS guidelines ■ Unmarried ■ Under age 19—unless disabled, disability occurring prior to age 25—or a full-time student and under age 25 <p>Disabled Dependents: Dependents who are incapable of self-support because of a continuous mental or physical disability that existed before the age limit are eligible for coverage until the incapacity ends. Documentation of disability will be requested. Once the child reaches the age limit for coverage, re-verification of disability will be required annually.</p> <p><u>Verification of eligibility will occur annually at the child's birthday.</u></p> <p style="text-align: center;">Dependents must meet <u>all</u> requirements listed in order to be eligible for enrollment</p>
Domestic Partner	<p><u>During Initial Enrollment or Group's Annual Renewal:</u> Coverage begins on group's effective date</p> <p><u>Involuntary Loss of Other Coverage:</u> Domestic Partner can be added outside of Renewal only if he/she loses other coverage involuntarily. Coverage is effective the first of following month</p> <p><u>Mid-Year Addition:</u> Mid-year additions of a domestic partner will require a state-stamped copy of the Certificate of Registration of Domestic Partnership from a state or local government agency authorized to perform such registrations within 30 days of issue or a signed affidavit for opposite sex and under age 62 domestic partnerships.</p>	<p><u>For a Domestic Partner to qualify, Employee and Domestic Partner must:</u></p> <ul style="list-style-type: none"> ■ Share a common residence ■ Neither is married under either statutory, common law or part of another domestic partnership ■ Both be 18 years of age or older ■ Share an intimate and committed relationship ■ Agree to be jointly responsible for each other's basic living expenses incurred during the domestic relationship ■ Both be mentally competent ■ Not related by blood to a degree of closeness that would prohibit marriage in this state ■ Agree to notify CaliforniaChoice[®] immediately upon termination of domestic partnership <p>Members who are in a same sex partnership or are over the age of 62 are required to submit a state-stamped Certificate of Registration of Domestic Partnership from a state or local government agency authorized to perform such registrations within 30 days of issue; all others must submit a signed Affidavit of Domestic Partnership.</p> <p style="text-align: center;">Employee and Domestic Partner must meet <u>all</u> requirements listed in order to be eligible for enrollment</p>
Children of Domestic Partner	See Domestic Partner above	<p><u>Domestic Partner must meet requirements listed above, and Children of Domestic Partner must be:</u></p> <ul style="list-style-type: none"> ■ Born to, a step-child of, adopted by, or non-temporary legal ward of the employee or domestic partner ■ Financially dependent upon the employee or domestic partner ■ Unmarried ■ Under age 19—unless disabled, disability occurring prior to age 25—or a full-time student and under age 25 <p>Disabled Dependents: Dependents who are incapable of self-support because of a continuous mental or physical disability that existed before the age limit are eligible for coverage until the incapacity ends. Documentation of disability will be requested. Once the child reaches the age limit for coverage, re-verification of disability will be required annually.</p> <p><u>Verification of eligibility will occur annually at the child's birthday.</u></p> <p style="text-align: center;">Dependents must meet <u>all</u> requirements listed in order to be eligible for enrollment</p>

[†] Although coverage may become effective at any time of the month based on date of marriage/domestic partnership/birth/adoption, full premium for increased coverage will be assessed as described in the Effective Dates column located above.