

Medical / Dental / Life / Vision Enrollment Application

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CaliforniaChoice 51+
Your Health. Your Choice.®

Application must be COMPLETED in FULL, SIGNED and DATED for processing.
IF YOU ARE WAIVING COVERAGE, YOU MUST COMPLETE, SIGN AND DATE WAIVER ON PAGE 4 OF THIS APPLICATION.

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 page 4.)</i> <input type="checkbox"/> Domestic Partner			
Employee Last Name		Employee Social Security Number		
Employee First Name		Date of Birth MO DAY YEAR		Group Number
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			PPO
Health Net	Kaiser Permanente	Western Health Advantage	Health Net Life Insurance Company
<input type="checkbox"/> CalChoice® 51+ HMO 15 <input type="checkbox"/> CalChoice 51+ HMO 15 Value <input type="checkbox"/> CalChoice 51+ HMO 25 <input type="checkbox"/> CalChoice 51+ HMO 25 Value <input type="checkbox"/> CalChoice 51+ HMO 40 <input type="checkbox"/> CalChoice 51+ HMO 40 Value <input type="checkbox"/> Elect Open Access	<input type="checkbox"/> CalChoice 51+ HMO 15 <input type="checkbox"/> CalChoice 51+ HMO 20/\$500 Value <input type="checkbox"/> CalChoice 51+ HMO 25 <input type="checkbox"/> CalChoice 51+ HMO 40 <input type="checkbox"/> HDHP 1500* *HSA-Qualified High Deductible Health Plan	<input type="checkbox"/> CalChoice 51+ HMO 15 <input type="checkbox"/> CalChoice 51+ HMO 25 <input type="checkbox"/> CalChoice 51+ HMO 40 <input type="checkbox"/> HSA 1800	<input type="checkbox"/> PPO 250 <input type="checkbox"/> PPO 500 <input type="checkbox"/> PPO 1000 <input type="checkbox"/> PPO 1500 <input type="checkbox"/> HSA 1500 <input type="checkbox"/> HSA 2000 <input type="checkbox"/> Flex Net (Out of Area Only)

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

Sections A, C, D & F must be completed for life coverage

Life Insurance	
Full Name of Beneficiary	Date of Birth for Beneficiary
Relationship of Beneficiary	Life Amount

Dental Coverage			
<input type="checkbox"/> FDH 100 (no charge)	<input type="checkbox"/> Prepaid 1000 [†]	<input type="checkbox"/> EPO 3000	<input type="checkbox"/> PPO 4000
	<input type="checkbox"/> Prepaid 3000 [†]	<input type="checkbox"/> EPO 3500	<input type="checkbox"/> PPO 5000
[†] If you choose Prepaid 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 Coverage	
<input type="checkbox"/> Vision (no charge)	<input type="checkbox"/> Voluntary Vision (additional charge)

Premium Only Plan (P.O.P.)
<input type="checkbox"/> I want my portion of eligible insurance premiums paid on a pre-tax basis

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

D. ENROLLMENT INFORMATIONComplete 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

 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 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 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 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 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.

F. YOUR LEGAL ACKNOWLEDGEMENT (continued)

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 I, 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 a 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 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 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, 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 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 I am enrolled in a group that is subject to ERISA, certain benefit-related disputes) any dispute between myself, my heirs, relatives or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, 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.

WESTERN HEALTH ADVANTAGE ENROLLEES:

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 arbitration 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.

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 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:
 COBRA Cal-COBRA

Indicate Qualifying Event:

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

Date of Qualifying Event

Staff Use Only

New Group-employee New Hire
 Renewal

Effective Date:

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, **CHOICE Administrators® Insurance Services, Inc.** can impose up to a 12 month period of exclusion as well as a 6 month pre-existing condition exclusion, both of which would begin at the time of my later decision to elect coverage.

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
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