# EMPLOYEE ENROLLMENT FORM (Please Print)

PacifiCare®

## Personal Information

| Last Name | First Name | MI | Suffix | ☐ Male ☐ Female |
|---|---|---|---|---|
| | | | | |

| Social Security # | Company Name | Date of (Re)Hire | Job Title |
|---|---|---|---|
| | | | |

| Number of hours worked per week | Salary/Wages ☐ Hourly ☐ Monthly ☐ Annual $ | Marital Status ☐ Single ☐ Widow ☐ Married ☐ Divorced ☐ Domestic Partner |
|---|---|---|
| | | |

| Are you currently on COBRA? ☐ Yes ☐ No<br>If yes, qualifying event: | COBRA Qualifying Event<br>Effective Date |
|---|---|
| | |

| Residence Mailing Address | | | |
|---|---|---|---|
| | | | |
| **City** | **State** | **ZIP** | **Date of Birth (mm-dd-yy)** |
| | | | |
| **Home Telephone** ( ) | **Work Telephone** ( ) | | |
| | | | |

## Your Employer Completes This Section

| Group #/Plan Code | |
|---|---|
| | |
| **Dental/Vision Group #** | |
| | |
| **Life/STD/LTD Group and Policy #s** | |
| | |
| **Source of Enrollment:** ☐ Open Enrollment ☐ New Hire ☐ QMCSO ☐ Employee Status Change ☐ Rehire | |
| **Employee Class** | |
| | |
| **Requested Effective Date** | |
| | |
| **Employer Verification** | |
| | |

## Selected Coverage (Select only the plans offered by your Employer)

**Medical** Individual(s) to be covered: ☐ Self ☐ Self + Spouse ☐ Self + Dependent(s) ☐ Self + Family ☐ Waive Medical
Plan Options: ☐ PacifiCare SignatureValue (HMO) – High ☐ PacifiCare SignatureOptions (PPO) – High ☐ PacifiCare SignatureIndependence (Indemnity)
☐ PacifiCare SignatureValue (HMO) – Low ☐ PacifiCare SignatureOptions (PPO) – Low ☐ PacifiCare SignatureFreedom (SDHP)

**Dental** Individual(s) to be covered: ☐ Self ☐ Self + Spouse ☐ Self + Dependent(s) ☐ Self + Family ☐ Waive Dental
Plan Options: ☐ PacifiCare SignatureIndependence (Dental Indemnity)

**Vision** Individual(s) to be covered: ☐ Self ☐ Self + Spouse ☐ Self + Dependent(s) ☐ Self + Family ☐ Waive Vision
Plan Options: ☐ PacifiCare SignatureOptions (Vision PPO)

**Life/Disability** ☐ Life/AD&D ☐ Short Term Disability ☐ Long Term Disability ☐ Waive STD ☐ Waive LTD ☐ Waive Life

**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.
Initials: _____

- Primary Care Physician (PCP) selection is only required if a PacifiCare SignatureValue plan is selected **(if you do not select a PCP, one will be assigned)**.
- Please select a PCP from the Provider Directory for you and each of your family members by writing the PCP name and number below.
- **You may choose a different PCP for each member of your family.**

## Employee & Dependent Information (List yourself and family members to be covered – attach additional sheets if necessary)

**Self**

| Primary Care Physician (PCP) Name & # (for PacifiCare SignatureValue only) | Medical Group # (if applicable) | Existing Patient? ☐ Yes ☐ No |
|---|---|---|
| | | |

| OB/GYN Name (for PacifiCare SignatureValue only) | Dentist Name & City (for PacifiCare SignatureValue only) | Dental Facility # | Existing Patient? ☐ Yes ☐ No |
|---|---|---|---|
| | | | |

**Spouse/Domestic Partner*** ☐ 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 & # (for PacifiCare SignatureValue only) | Medical Group # (if applicable) | Existing Patient? ☐ Yes ☐ No |
|---|---|---|
| | | |

| OB/GYN Name (for PacifiCare SignatureValue only) | Dentist Name & City (for PacifiCare SignatureValue only) | Dental Facility # | Existing Patient? ☐ Yes ☐ No |
|---|---|---|---|
| | | | |

**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 & # (for PacifiCare SignatureValue only) | Medical Group # (if applicable) | Existing Patient? ☐ Yes ☐ No |
|---|---|---|
| | | |

| OB/GYN Name (for PacifiCare SignatureValue only) | Dentist Name & City (for PacifiCare SignatureValue only) | Dental Facility # | Existing Patient? ☐ Yes ☐ No |
|---|---|---|---|
| | | | |

**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 & # (for PacifiCare SignatureValue only) | Medical Group # (if applicable) | Existing Patient? ☐ Yes ☐ No |
|---|---|---|
| | | |

| OB/GYN Name (for PacifiCare SignatureValue only) | Dentist Name & City (for PacifiCare SignatureValue only) | Dental Facility # | Existing Patient? ☐ Yes ☐ No |
|---|---|---|---|
| | | | |

**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 & # (for PacifiCare SignatureValue only) | Medical Group # (if applicable) | Existing Patient? ☐ Yes ☐ No |
|---|---|---|
| | | |

| OB/GYN Name (for PacifiCare SignatureValue only) | Dentist Name & City (for PacifiCare SignatureValue only) | Dental Facility # | Existing Patient? ☐ Yes ☐ No |
|---|---|---|---|
| | | | |

* Please verify that domestic partner coverage is available through your Employer.
** Over age Dependents require proof of full-time student status or permanent disability status within 31 days of enrollment.