CaliforniaChoice
Your Health. Your Choice.®

Medical / Dental / Life / Vision Enrollment Application

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 ❑ M ❑ F **Marital Status** ❑ Married ❑ Single

Note: *• If you or any of your dependents are not enrolling, you must also complete and sign the waiver section on back.*
• Even if you have a domestic partner, you are still required to select one of these options

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 *(if different from above)*

B. Medical Benefit (select one plan only)

HMO

❑ Cal Choice 10 ❑ Cal Choice 25 ❑ Cal Choice 40

Choose an HMO Health Care Service Plan:

❑ ELECT Open Access (Health Net)

PPO

❑ PPO 500 ❑ PPO 2400 ❑ HSA 2400
❑ PPO 1000 ❑ HSA 1500 ❑ Active Choice℠ 500

PPO PLAN AVAILABILITY WILL BE BASED ON GROUP ELIGIBILITY AND MAY BE SUBJECT TO CHANGE

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	Relationship of Beneficiary	Date of Birth for Beneficiary	Life Amount

DENTAL COVERAGE

❑ Dental Plan 1000 ❑ Dental Plan 3000 ❑ Voluntary Dental 3000
❑ Dental Plan 3500 ❑ Dental Plan 4000 ❑ Dental Plan 5000

If you choose plans 1000 or 3000, you must select a dentist: **Dentist:** **ID#:**

❑ Check if dentist chosen is current provider ❑ Check if you would like a dentist assigned

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 Information (Complete this section ONLY if you are electing medical, dental and/or vision for yourself or dependents)

	Employee	Spouse	Child	Child	Child
Last Name	❑ Life only				
First Name					
Relationship to Employee		❑ Spouse ❑ Domestic Partner			
Social Security No.					
Gender		❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female
Date of Birth		/ /	/ /	/ /	/ /
Primary Care Physician*					
Physician ID# & City					
Current Patient of PCP?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Disabled?			❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Enrolling For?	❑ Med ❑ Dent ❑ Vision	❑ Med ❑ Dent† ❑ Vision	❑ Med ❑ Dent† ❑ Vision	❑ Med ❑ Dent† ❑ Vision	❑ Med ❑ Dent† ❑ Vision

❑ 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).*

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

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Family Coverage Eligibility Requirements

Who can be covered?	Effective dates	Requirements that MUST be met:
New Spouse/ New Stepchild	If marriage occurred before the 16th of the month, coverage begins on date of marriage† If marriage occurred on the 16th of the month or after, coverage begins on the first of month following date of marriage	■ New spouse must be legally married to the employee
New Baby, Adopted Child, Non-Temporary Legal Ward, and Dependent Children	If birth/date of placement occurred before the 16th of the month, coverage begins on the date of their birth/placement† 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 following month	■ 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 (effective 7/1/06) Verification of eligibility will occur annually at the child's birthday Disabled Dependents: Children 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 proof may be requested. Once the child reaches the age limit for coverage, re-verification of disability will be required annually. **Dependents must meet all requirements listed in order to be eligible for enrollment**
Domestic Partner	During Initial Enrollment or Group's Annual Open Enrollment: Coverage begins on group's effective date Involuntary Loss of Other Coverage: Domestic Partner can be added outside of Open Enrollment only if he/she loses other coverage involuntarily. Coverage is effective the first of following month Mid-Year Addition: Mid-year additions of a Domestic Partner will require a State stamped copy of the Certificate of Registered Domestic Partnership within 30 days of issue or a qualifying event (such as involuntary loss of coverage) and a signed affidavit	For a Domestic Partner to qualify, Employee and Domestic Partner must: ■ Share a common residence ■ Not be married under either statutory or common law ■ Both be 18 years of age or older ■ Agree to be jointly responsible for each other's basic living expenses incurred during the domestic relationship ■ Both be mentally competent ■ Not be related by blood to a degree of closeness that would prohibit marriage in this state ■ Agree to file a Statement of Termination of Domestic Partnership with the Plan should any of these attestations cease to be true Employee and Domestic Partner must also submit a signed affidavit attesting that the above conditions have been met. **Employee and Domestic Partner must meet all requirements listed in order to be eligible for enrollment**
Children of Domestic Partner	See Domestic Partner above	Domestic Partner must meet requirements listed above, and Children of Domestic Partner must be: ■ 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 (effective 7/1/06) Verification of eligibility will occur annually at the child's birthday Disabled Dependents: Children 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 proof may be requested. Once the child reaches the age limit for coverage, re-verification of disability will be required annually. **Dependents must meet all requirements listed in order to be eligible for enrollment**

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

E. Your LEGAL Acknowledgement (Read, Sign & Date Below)

By submitting this signed application, I agree and understand that the health plan I have chosen through the California*Choice* 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, copayments, 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 California*Choice* 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 California*Choice* 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 for 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.
- 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 partner.

I understand that the above statements are subject to audit at any time and **agree** to provide California*Choice* 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 California*Choice* benefits 15 days following the date of the notice of termination and I will be held responsible for all services and charges incurred through California*Choice* 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 myself and my dependents have met all of the eligibility requirements listed on the second page 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.

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. Additionally, specific requirements for health plans that require binding arbitration to resolve claims for professional negligence and medical malpractice are set out below.

HEALTH NET/UNIVERSAL CARE/CHAMPIONHEALTH ENROLLEES: I 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 Health Net of CA and/or Health Net Life regarding the construction, interpretation, performance or breach of the Health Net Plan Contract, Insurance Policy or Certificate, or regarding other matters relating to or arising out of my Health Net 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 Health Net of CA and/or Health Net Life, are giving up their constitutional right to the extent permitted by law to have their dispute decided in a court of law before a jury. I also understand that disputes that I may have with Health Net of CA and/or Health Net Life involving claims for medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) are also subject to final and binding arbitration.

Members who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. § 1001 et seq., a federal law regulating benefit plans, are not required to submit disputes about certain "adverse benefit determinations" made by Health Net to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by Health Net to deny, reduce, terminate or not pay for all or a part of a benefit. However, I and Health Net may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

Kaiser Foundation Health Plan 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 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, 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 my 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.

A more detailed arbitration provision is included in my health plan contract or insurance policy. By signing and submitting this application, I hereby agree to the above terms and conditions, and confirm that the information contained in this application is true and correct.

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

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

Employer/California*Choice* Use Only

❑ New Group-employee ❑ New Hire ❑ Open Enrollment Effective Date:

F. 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
- 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 _____

Medical / Dental Waiver

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 First Name

Employee Social Security Number

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—not required if waiving coverage for dependents only

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, California*Choice* 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 **SIGN HERE TO WAIVE COVERAGE:** ➡	Date