PacifiCare®

How to Apply for PacifiCare Individual Plans

Please follow these steps to ensure your application is processed as quickly as possible.

1. Complete the Enrollment Application

Be sure to answer all questions completely and provide all the requested information. Incomplete information may result in a processing delay.

- ***Print clearly using black ink.*** Please don't type on your form. You, as the applicant, must complete the application in your own handwriting.
- ***Select the date you wish coverage to become effective.*** PacifiCare allows effective dates beginning on the 1st or the 15th of the month. Please submit your application by the **1st of the month** to be considered for the 15th of the same month or the **15th of the month** to be considered for the 1st of the following month. Actual effective dates are determined by PacifiCare. **Do not cancel any existing coverage until you are notified by PacifiCare Life Assurance Company that you have been accepted.**
- ***Select your method of payment – monthly debit or monthly direct bill.*** Determine the amount of premium you need to submit with your application by referring to the rate table enclosed with this form.
  - Complete your EZPay authorization form.
  - Include your first month's premium payment with this application.
- ***Complete the Enrollment Information section and list each family Member applying.***
- ***Read and sign page 5 of the application.***
- ***Complete the Determination of Self-Employed Business Group of One Form (page 6).***
- ***Complete and sign the Individual Plan Waiver of Coverage Form (page 7).***
- ***Complete and sign the Authorization for Eligibility Determination.***

2. Complete the Health Questionnaire

Answer every question in full. Otherwise, your application may be returned to you, resulting in a delay in processing.

- ***Be sure to disclose all health history on the Health Questionnaire for all family Members listed on the application.*** Even if your application is approved, any omissions or false statements may result in future claims being denied and/or termination of your coverage.
- ***Include all requested details and explanations.*** If you need to include additional information or explanations, simply attach an extra sheet.
- If you do not meet the standard PacifiCare underwriting requirements for the plan you have applied for, you may be offered a different option. You are under no obligation to enroll.

3. Send Your Completed Enrollment Application to PacifiCare

- ***Review your application to be sure it is complete.***
- ***Sign and date your application.*** You, your Spouse (if applying) and any listed Dependent age 18 or over must sign and date the application.
- ***Mail your application to:***

  Oleg Skurskiy
  18375 Ventura Blvd. # 226
  Tarzana ,CA 91356
  Tel. 818-987-5000 . Fax : 818-776-9865

  Before sealing the envelope be sure to enclose:

  – Your completed Enrollment Application

  – Your first premium check

  – Your EZPay Form

Please note: Coverage does not become effective under any circumstances until an application has been underwritten and approved by PacifiCare Life Assurance Company.

COLORADO

Enrollment Application

PacifiCare®

Print in black ball-point pen

Requested Effective Date: ***Subject to Approval***

1. Application, Plan & Payment Information

Application for:
- ☐ New Individual Plan Membership
- ☐ Current PacifiCare Member applying for Individual Plan
- ☐ Existing PacifiCare Individual Plan Member – adding Dependent
- ☐ Current PacifiCare Member transferring from another state

Note: Applicants/Dependents who are eligible for Medicare Benefits are not eligible for Individual Plan.

Plan Options:
- ☐ PacifiCare SignatureOptions℠ (PPO) – 25/80-60/500
- ☐ PacifiCare SignatureFreedom℠ (SDHP) – 70-50/3000
- ☐ PacifiCare SignatureFreedom℠ (SDHP) – 80-50/2000
- ☐ PacifiCare SignatureOptions℠ (PPO) – 35/80-50/1000
- ☐ PacifiCare SignatureOptions℠ (PPO) – 70-50/3000

Payment Options:
Choose your payment method for:
1. First month payment and;
2. Recurring Monthly
Payment will only be deducted if application is approved.

First Month Payment *(Please select one option)*
- ☐ Check Enclosed: Amount of $__________
- ☐ Credit Card
  For this payment method, you must enclose your completed credit card payment form.

Recurring Monthly Payment *(Please select one option. Credit Card payment is not available for monthly option)*
- ☐ Monthly Bill
- ☐ Monthly (EZ Pay)
  For this payment method (EFT), you must enclose:
  • Your completed Easy Pay form • A voided check.

2. Primary Applicant Information

Primary Applicant's Name ____________________ ☐ Married ☐ Single
Last First MI

Home Address ____________________
Street Apt # City County State ZIP

Home Phone __________ **Work Phone** __________ **Fax** __________

☐ **Mailing Address: If different from Home Address** ____________________
Street Apt # City State ZIP

☐ **Billing Address: If different from Mailing Address** ____________________
Street Apt # City State ZIP

If child-only policy, parent or legal guardian name ____________________

Applicant's Occupation __________ **Spouse's Occupation** __________

3. Enrollment Information

List yourself and all eligible family Members applying for coverage.

Relationship	Last Name	First Name	MI	Social Security #	Height	Weight	Birth Date (MM/DD/YY)	Sex
☐ Male ☐ Female	Applicant							
☐ Husband ☐ Wife	Spouse							
☐ Son ☐ Daughter								
☐ Son ☐ Daughter								
☐ Son ☐ Daughter								

1. Do all applying family members reside with applicant? ☐ Yes ☐ No
   If no, please indicate name and mailing address of Dependent(s): __________
2. Has the applicant or any applying family member ever been a PacifiCare Member? ☐ Yes ☐ No
   If yes, please provide the name used and the PacifiCare ID#, if known: __________
3. Can you qualify as a Business Group of One? ☐ Yes ☐ No
   If yes, complete the additional forms related to a Business Group of One.
4. Are you or any applicants a Corporate Officer or member of a limited liability company that has rejected Workers' Compensation coverage pursuant to Colo. Reg. 8-41-202(1))? ☐ Yes ☐ No
   If yes, please list the applicant(s) and their job title(s) if they want medical coverage of an employment-related Sickness or Injury:

Agent Information – To be completed by Agent only

Agent's Name & Company		Agent's Number		Agent's E-mail Address	
Oleg Skurskiy No Firm		NPI0256417		oleg@askoleg.com	

Agent's Address	City	State	ZIP	Agent's Phone #	Agent's Fax #
18375 Ventura Blvd. # 226	Tarzana	CA	91356	818 987-5000	818 776-9865

Office Use Only

Approved By	Date	Approved/Denied	Effective Date

(Please check one) ☐ 25/80-60/500 ☐ 35/80-50/1000 ☐ 70-50/3000 (PPO) ☐ 70-50/3000 (SDHP) ☐ 80-50/2000 (SDHP) ☐ Smoker ☐ Nonsmoker

4. Health Questionnaire

A. You must disclose any and all medical information regarding any of the general categories listed below. If you are not sure whether the information is relevant, include it so PacifiCare can make a determination. The information you provide will not necessarily cause a denial, but underwriting may depend on the items noted and medical information submitted by your doctor(s). **Note: Any illness, condition, or change in health status of any applicant that may occur or be discovered between the date of this application and the effective date of coverage must be reported. Please notify any changes in writing to the PacifiCare Individual Plans Individual Underwriting, Mail Stop CY24-155, P.O. Box 3069, Cypress, CA 90630-9962. An unreported illness, condition or change will be treated as a nondisclosure and may result in termination or rescission of coverage.**

Check "Yes" or "No" for each category below. Do not write N/A or leave any blanks. You must check "Yes" if any person named on this application has been aware of or has been evaluated, diagnosed, treated or received advice related to the following categories from any type of health care professional within the past ten (10) years.

All questions must be answered | **Incomplete information will result in a processing delay**

#	YES	NO	CONDITION
1	❍	❍	Immune System Disorder, AIDS/HIV+, AIDS Related Complex (ARC)
2	❍	❍	ADD (Attention Deficit Disorder)/ADHD
3	❍	❍	Alcoholism and/or Drug Abuse
4	❍	❍	Allergies and/or Asthma
5	❍	❍	Anemia
6	❍	❍	Arthritis, Gout, Rheumatism
7	❍	❍	Back, Neck, Spine, Disc Disease
8	❍	❍	Bacterial Infections, Multiple or Reoccurring
9	❍	❍	Birth/Physical Defect, Deformity, Congenital Disorder
10	❍	❍	Bladder Condition
11	❍	❍	Blood Condition
12	❍	❍	Blood Vessel/Circulation Disorder
13	❍	❍	Bone Infection or Disorder
14	❍	❍	Breast Disease, Implants Type: Silicone/Saline
15	❍	❍	Cancer
16	❍	❍	Chronic Fatigue
17	❍	❍	Colon, Colitis, Crohn's Disease, Rectal or Bowel Condition
18	❍	❍	Concussion, Head Injury
19	❍	❍	Cysts, Tumors, Polyps, Growths or Fibroids
20	❍	❍	Diabetes
21	❍	❍	Disability/Disabled
22	❍	❍	Ear Condition
23	❍	❍	Epilepsy, Convulsions, Seizures
24	❍	❍	Eye Condition
25	❍	❍	Female Organs, Abnormal Pap, Menstrual Disorder, Hysterectomy
26	❍	❍	Fibromyalgia
27	❍	❍	Gallbladder Condition
28	❍	❍	Headaches or Migraines
29	❍	❍	Heartburn/Gastroesophageal Reflux Disease (GERD)
30	❍	❍	Heart Problems or Disorders
31	❍	❍	Hemorrhoids
32	❍	❍	Hepatitis Type: A, B, C
33	❍	❍	Hernia
34	❍	❍	High Blood Cholesterol and/or Triglycerides
35	❍	❍	High Blood Pressure
36	❍	❍	Hormonal/Pituitary Disorder
37	❍	❍	Jaw Condition or TMJ
38	❍	❍	Joint Condition
39	❍	❍	Kaposi's Sarcoma
40	❍	❍	Kidney/Urinary Tract (Stones, Infections or Conditions)
41	❍	❍	Liver Condition
42	❍	❍	Lung or Respiratory Conditions, Emphysema, Chronic Obstructive Pulmonary Disease
43	❍	❍	Lupus
44	❍	❍	Male Sex Organs/Prostate/ Impotence
45			Mental Health Conditions
	❍	❍	Anorexia Nervosa
	❍	❍	Autism and other pervasive developmental disorders
	❍	❍	Bipolar Disorder
	❍	❍	Bulimia
	❍	❍	Depression/Anxiety/ Emotional Condition(s)
	❍	❍	Major Depressive Disorder
	❍	❍	Obsessive-Compulsive Disorder
	❍	❍	Panic Disorder
	❍	❍	Schizoaffective Disorder
	❍	❍	Schizophrenia
	❍	❍	Any other mental or nervous conditions? (If yes, please explain below.)
46	❍	❍	Muscle/Tendon Disorder
47	❍	❍	Neurological Condition
48	❍	❍	Non-Hodgkin's Lymphoma
49	❍	❍	Paralysis
50	❍	❍	Phlebitis or Blood Clot
51	❍	❍	Premature Birth # of weeks since conception at birth? ________
52	❍	❍	Prosthetic Implants, Artificial Limb
53	❍	❍	Reconstructive/Cosmetic Surgery
54	❍	❍	Sexually Transmitted Diseases
55	❍	❍	Skin Condition
56	❍	❍	Steroid Use (Anabolic, Prednisone)
57	❍	❍	Stomach or Abdominal Condition
58	❍	❍	Stroke/Transient Ischemic Attacks (TIA)
59	❍	❍	Thyroid Condition
60	❍	❍	**Do you or anyone listed on this application have any other conditions not described above?** (If yes, please explain below.)

B. Give details for ALL "YES" ANSWERS indicated above in Section A. If you need more space for explanation, please attach a separate piece of paper.

Condition #	Applicant/Family Member Name	Condition Description	Date First Diagnosed and/or Treated	Date of Most Recent Dr. Visit	Duration of Condition	Treatment/Medication		Name, Address & Phone # of Physician
						Type/Name	Date Discontinued	

C. Has any applicant listed on this application seen a medical practitioner, for any reason, in the past two years? ❍ Yes ❍ No
If yes, please provide details below:

Applicant(s) Name	Physician Name	Address/Telephone	Date	Reason/Result and Treatment/Recommendation

D. Please complete the following for ALL applicants listed on this application.
If you need more space for explanation, please attach a separate piece of paper.

Incomplete information will result in a processing delay

1. In the event one or more applicant(s) listed on this application is denied coverage, should PacifiCare continue the underwriting and enrollment process for the remaining eligible family Members? ❍ Yes ❍ No
2. Has surgery (major/minor, inpatient/outpatient) been performed for any applicant in the past ten years? ❍ Yes ❍ No If yes, state applicant's name(s) and explain (include date):
3. Has any applicant listed on this application been advised in the past ten years to have an operation or treatment (including dental work) **that has not yet been performed?** ❍ Yes ❍ No If yes, state individual's name(s) and explain (include date):
4. Has any applicant listed on this application been refused or restricted life or health insurance coverage within the last five years? ❍ Yes ❍ No If yes, state family Member's name(s) and give details:
5. Has any applicant listed on this application used tobacco products in the past 12 months? ❍ Yes ❍ No If yes, please provide the following information:

   NAME START DATE STOP DATE DAILY AMOUNT

   NAME START DATE STOP DATE DAILY AMOUNT
6. Does any applicant listed on this application presently consume alcoholic beverages? ❍ Yes ❍ No If yes, please provide the following information:

   NAME ❑ 0 – 1 drinks per day ❑ 2 – 3 drinks per day ❑ 4+ drinks per day

   NAME ❑ 0 – 1 drinks per day ❑ 2 – 3 drinks per day ❑ 4+ drinks per day
7. Has any applicant listed on this application used narcotics, hallucinogenics, amphetamines, barbiturates, other illegal drugs, or drugs other than in accordance with the instructions or prescription for use in the last ten years? ❍ Yes ❍ No If yes, state family Member's name(s) and explain **(include date and duration):**
8. Does any applicant listed on this application currently take prescription drugs? ❍ Yes ❍ No In the last six months? ❍ Yes ❍ No If yes, state name(s), drug name(s), dosage and date started:
9. Has any applicant listed on this application been hospitalized or been seen in an emergency room within the last five years? ❍ Yes ❍ No If yes, state applicant's name(s) and explain **(include date and duration):**
10. Has any applicant listed on this application been in therapy/ counseling (mental, physical or emotional) within the last five years? ❍ Yes ❍ No If yes, state applicant's name(s) and explain **(include date and duration):**
11. Has any applicant received any alternative, complementary, holistic or natural therapies within the last 12 months? Examples include acupuncture, ayurveda, biofeedback, chelation therapy, chiropractic, herbal medicines, homeopathy, imagery, reiki, shiatsu, and visualization? ❍ Yes ❍ No If yes, please explain:
12. Is any applicant listed on this application currently covered by medical insurance or a health care plan? ❍ Yes ❍ No ❍ Group or ❍ Individual If yes, provide the name of the insurance company or health care plan, policy number and effective date of coverage:

FEMALES ONLY (including Spouse and Dependents)

13. Has any female applicant listed on this application been treated in the last five years for infertility or any other female disorder? ❍ Yes ❍ No If yes, state applicant's name(s) and explain **(include date and duration):**
14. Please provide the date of last Pap smear: Results:
15. Please provide the date of last menstrual cycle for all females under age 45 (if no menstrual cycle, state reason).

    NAME MONTH DAY YEAR

    NAME MONTH DAY YEAR
16. Are any females applying for coverage currently pregnant? ❍ Yes ❍ No If yes, state applicant's name:

MALES ONLY (including Spouse and Dependents)

17. Is any male applicant listed on this application an expectant father, even if the mother is not listed on this application? ❍ Yes ❍ No If yes, state applicant's name:

Terms and Conditions

1. I certify that the answers in any part of this application are true and complete. I acknowledge that the discovery of facts known and not disclosed may result in the rescission of my PacifiCare Individual Plan Agreement. I alone am responsible for the accuracy and completeness of the application and related documents. I understand that neither I, nor my dependents, will be eligible for benefits if any known material information is false or incomplete, and that coverage may be rescinded based on such a finding. If rescinded, the contract will be deemed to never have existed and I will be financially responsible for any costs incurred while under the plan.
2. I understand that if I enroll in a PPO or SDHP plan, there will be a twelve (12)-month waiting period before coverage for pre-existing medical conditions will begin for either myself and/or my dependents who have these medical conditions, even if I am or my dependents are on another PacifiCare plan.
3. I understand that there is no coverage unless an application is approved by PacifiCare's Underwriting department. PacifiCare is not liable for bills incurred before the effective date of coverage. PacifiCare is not liable for the cost in obtaining medical records or the cost of special tests such as, but not limited to, X-rays, EKGs, or mammograms that may be required to determine eligibility.
4. If this application is approved, the date coverage begins will be provided to me by the PacifiCare Underwriting department.
5. The agent selling PacifiCare health coverage does not have the authority to approve my application and cannot change any terms of the PacifiCare Individual Plan Agreement or waive any requirements.
6. I understand that I am responsible for reporting to PacifiCare any changes in the health status which occur before the effective date of the PacifiCare Individual Plan Agreement. This applies to every person listed on the application.
7. I understand that any applicant listed herein may be required to undergo a basic physical and/or basic laboratory testing as part of the application process.
8. **Authorization for disclosure of personal information:** I hereby authorize any "Provider of health care" to disclose or provide to PacifiCare, its agent or employees, all information from medical records for myself or any of my dependents pertaining to any examination or treatments, including treatment for alcohol abuse, substance abuse, psychiatric disorders and/or acquired immune deficiency syndrome (AIDS), regarding myself or any applying family member. I understand his information is collected for purposes of evaluating my application and determining both initial and continuing eligibility for benefits. This authorization will remain valid for 30 months from the date below. A photocopy of this authorization is valid as the original.

   Contracted Physicians are listed in the *Provider Directory.* Please Note: If the Subscriber is not applying for coverage for his or her eligible dependents, all future applicants, including newborns who are not enrolled within 31 days of birth, will be required to submit Evidence of Insurability, which is subject to approval by PacifiCare. ***Important Notice*** PacifiCare will use the information provided in this application to make its determination about coverage for all persons named on the application. Read the application and the instructions very carefully.

   If any material information about any applicant's medical background is misstated or omitted, it may result in rescission of the contract. If your contract is rescinded, it will be deemed never to have been in effect. A rescinded application will result in the applicant being billed for any expenses incurred while under the Plan.
9. **I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN AND 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 DISPUTES OVER BENEFIT DENIALS SUBJECT TO ERISA, BETWEEN MYSELF, DEPENDENTS (INCLUDING ANY HEIRS OR ASSIGNS) AND PACIFICARE OF COLORADO, INC., OR ANY OF ITS PARENTS, SUBSIDIARIES OR AFFILIATES 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 THE FEDERAL ARBITRATION ACT PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. ALL PARTIES 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. RIGHTS AFFORDED UNDER THE INTERNAL APPEALS PROCESS AND INDEPENDENT EXTERNAL REVIEW ARE NOT AFFECTED BY THIS PROVISION. DISPUTES NOT FULLY RESOLVED THROUGH THE INDEPENDENT EXTERNAL REVIEW PROCESS ARE SUBJECT TO THIS PROVISION.**

PacifiCare compensates Agents/Brokers for the sale of certain products. Your premium is the same if you purchase coverage directly from PacifiCare or if you use an Agent/Broker. Please contact your Agent/Broker, if applicable, regarding the amount of compensation. In addition, you may request information regarding broker commissions attributable to your policy by contacting PacifiCare Membership Accounting.

By my signature below, I have read and understand the above conditions.

Signature of Applicant (if younger than 18, signature of parent or legal guardian)	Date	Spouse's Signature (if applying)	Date
Dependent's Signature if 18 or older	Date	Dependent's Signature if 18 or older	Date

Note: Until you have received written approval of this application, **do not cancel** any insurance you may have.

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Determination of Self-Employed Business Group of One Form

1. Are you either a self-employed person with no employees, or a sole proprietor who is not offering or sponsoring health care coverage to your employees? . . . . . . ☐ Yes ☐ No
2. Have you carried on significant business activity as a self-employed person or sole proprietor for a period of at least one year prior to application for coverage? . . . . . . ☐ Yes ☐ No
3. Do you have gross income from your self-employment or sole proprietorship as indicated on Federal Internal Revenue forms 1040, Schedule C, F, or SE, or other forms recognized by the Federal Internal Revenue Service for income reporting purposes from which you have derived a substantial part of your income from your business as a self-employed person or sole proprietor for one year out of the past three years? Note: "Substantial part of your income" means income derived from business activities of the business group of one that are sufficient to pay for annual health insurance premiums for the business group of one. . . . . . . ☐ Yes ☐ No
4. Do you work a minimum of 24 hours a week on a permanent basis? . . . . . . ☐ Yes ☐ No

I, ____________________________________ , attest that the answers to the questions contained in this form are true and correct.

Signature of Applicant	Applicant's Business	Date

Confirmation of Intent of Coverage

Please complete and sign the following as required by Colorado State law:

☐ I **do not** meet the definition of a self-employed business group of one as attested by answering **"NO"** to any of the questions above on the "Determination of Self-Employed Business Group of One" form, and **I am requesting Individual Plan coverage.**

☐ I **do** meet the definition of a self-employed business group of one as attested by answering "YES" to all of the questions above on the "Determination of Self-Employed Business Group of One" form, and **I am requesting Individual Plan coverage.** **I understand that by purchasing an individual policy instead of a small group policy I waive my right to purchase, during open enrollment periods as specified by law, a business group of one Standard, Basic, or other small group health benefit plan from a small employer carrier for a period of three (3) years after the effective date of the individual health benefit plan in which I am applying.** I understand this will be the case unless a small employer carrier voluntarily permits me to purchase a small group policy within such a three (3)-year period. **Please sign attached Waiver of Coverage Form.**

☐ I **do** meet the definition of a self-employed business group of one as attested by answering "YES" to all the questions on the "Determination of Self-Employed Business Group of One" form above, and **I wish to apply for group coverage.** I have enclosed my completed group application, my group enrollment form, and a check for my first month's premium. I understand that I may be required to provide additional information to certify my self-employed business group of one status, such as tax forms or other materials.

I have read the enclosed information and completed the "Determination of Self-Employed Business Group of One" form. I have read and understand the options listed above and the actions associated with the option I have chosen. Further, I understand that the factors used to set new and renewal rates for the individual policy I want to purchase consist of overall cost and utilization trends ("index rate"), plan design, my age, gender, claims experience, health status and tobacco use and the age, gender, claims experience, health status and tobacco use of each of my dependents and a factor that reflects the cost of care where I live. By comparison the rating factors that would apply if I purchased a small group business group of one policy consist of overall cost and utilization trends ("index rate"), plan design, my age, my family size and a factor that reflects the cost of care where I live. After September 1, 2003, the additional rating factors that would apply if I purchased a small group business group of one policy consist of my claims experience, health status, and the claims experience, health status of each of my dependents, and the industry in which I work. I have been given a health plan description form showing the benefits under Colorado's Small Group Standard Health Benefit Plans; I have also been given a Colorado Health Benefit Plan Description Form for the plan for which I am applying.

Signed	Print Name	Date

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Individual Plan Waiver of Coverage Form

For self-employed Business Groups of One who elect Individual Plan Coverage

Office Use Only	IP WAIV
Effective Date	

Applicant Information (Please print)

Last Name	First Name	MI	Social Security #

Waiver of Benefits

I have been informed of an Individual Plan that provides benefits to me for medical coverage, and after considering it I wish to elect the following coverage for myself and/or my Dependents:

☐ I wish to enroll myself in an individual plan and do not have any Dependents. **I understand that by purchasing an individual policy instead of a small group policy (if applicable) I waive my right to purchase, during open enrollment periods as specified by law, a Business Group of One Standard, Basic, or other small group health benefit plan from a small employer carrier for a period of three (3) years after the effective date of the individual health plan in which I am applying.** I understand this will be the case unless a small employer carrier voluntarily permits me to purchase a small group policy within such a three (3)-year period.

☐ I wish to enroll my Dependents and myself in an individual plan.

☐ I wish to enroll myself in an individual plan and do not wish to enroll my Dependents. I wish to waive coverage for my Dependent(s) as they have other coverage in effect as follows (please print):

1. Dependent Name		Relationship to Subscriber:	☐ Spouse ☐ Child ☐ Other (please explain):
Name of other insurance carrier	Policy #		Effective Date of Coverage
2. Dependent Name		Relationship to Subscriber:	☐ Spouse ☐ Child ☐ Other (please explain):
Name of other insurance carrier	Policy #		Effective Date of Coverage
3. Dependent Name		Relationship to Subscriber:	☐ Spouse ☐ Child ☐ Other (please explain):
Name of other insurance carrier	Policy #		Effective Date of Coverage
4. Dependent Name		Relationship to Subscriber:	☐ Spouse ☐ Child ☐ Other (please explain):
Name of other insurance carrier	Policy #		Effective Date of Coverage

Please feel free to attach additional pages for more Dependents. ALL waived Dependent coverage must be disclosed. If you have declined enrollment for your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll your Dependents in this plan, provided that you request enrollment within thirty (30) days after the other health insurance ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your Dependents, provided that you request enrollment within thirty (30) days after the marriage, birth, adoption, or placement for adoption.

Validation

Print Name	Signature	Date

Company Name	Group Number

Company Address	City	State	ZIP

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Authorization for Eligibility Determination

Please print all information

Names of all individuals for which eligibility determination will be made	
Last Name	First Name
Last Name	First Name
Last Name	First Name
Last Name	First Name
Last Name	First Name

If additional individuals are to be included, please use another form and check here □

Information to Be Used or Disclosed

PacifiCare will use medical information provided by you and your medical claims history to make an eligibility determination for you and those listed above.

Purpose

PacifiCare requests this information to conduct underwriting and risk-rating activities so PacifiCare can determine your eligibility and, if applicable, determine the rates offered to you for coverage.

Expiration

PacifiCare lawfully will use and disclose this information until an eligibility determination is made. In addition, if the individual(s) enroll(s) in a PacifiCare plan, PacifiCare lawfully will use and disclose this information until the Member(s) disenroll(s) from the Plan, or as required by law.

Revocation of Authorization

You may revoke this authorization at any time before you become a PacifiCare Member, except for instances that PacifiCare has already taken action based on the authorization. Your revocation must be mailed to:

PacifiCare Individual Plans
Individual Underwriting M/S # CY24-155
P.O. Box 3069
Cypress, CA 90630-9962

Once you become a PacifiCare Member, **YOU MAY NOT REVOKE THIS AUTHORIZATION.**

Refusal to Authorize

If you refuse to provide this authorization, PACIFICARE WILL NOT MAKE AN ELIGIBILITY DETERMINATION, and you will not be considered for membership of a PacifiCare plan.

Copy of Authorization

You are entitled to a copy of the signed authorization.

Name(s) and Signature(s)

PacifiCare requires the signature of every individual to be considered for eligibility or, if applicable, the signature of the custodian of any minors listed, or the signature of the personal representative of any individual who elects to authorize a personal representative. Please note an additional valid authorization or Power of Attorney is required for personal representatives.

By signing below, you authorize PacifiCare employees and their agents designated to process eligibility information to use and disclose your protected health information for the purpose described above. A valid signature of each individual (or the individual's custodian or legitimate personal representative) listed above is required.

Name of Individual	Name of Custodian or Representative (if applicable)	Signature	Date
Name of Individual	Name of Custodian or Representative (if applicable)	Signature	Date
Name of Individual	Name of Custodian or Representative (if applicable)	Signature	Date
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PCO131545-000
4916-012805-CO-PLAC