PacAdvantage

PairedChoice

Medical / Dental / Vision / Acupuncture & Chiropractic
Employee Enrollment Application

1. PERSONAL INFORMATION

Employer Use Only	☐ New Group-employee ☐ New Hire ☐ Open Enrollment **Effective Date:** **Group Number:** ☐ COBRA / Cal-COBRA ☐ Change ☐ Add Dependent

Name of Company	Employer Phone #	Employee Job Title	Date of Hire

(Note: if you or any of your dependents are not enrolling, you must also complete and sign the Refusal of Coverage section on page three.)

Sex: ☐ M ☐ F Marital Status: ☐ Married ☐ Single ☐ Domestic Partnership PacAdvantage reserves the right to request documents that verify the validity of a non-registered domestic partnership. See Summary of Employee Rules and Procedures available at www.pacadvantage.org for details.

Employee First Name

Employee Social Security Number

___ ___ ___ - ___ ___ - ___ ___ ___ ___

Employee Last Name

Date of Birth
MO DAY YEAR
____/____/____

Residence Address	Apt #	City	State	Zip Code

Home Telephone	Mailing Address *(if different)*
( )	
Hours Worked Per Week	**Employee Classification (check all that apply)**
	Managerial _____ Exempt _____ Union _____ Full-time _____
	Non-Managerial _____ Non-Exempt _____ Non-Union _____ Part-time _____

2. MEDICAL BENEFIT SELECTION (Enter one plan only – refer to Benefits Summary for Plan Numbers)

If you choose not to enroll for medical coverage, go to "Refusal of Coverage" on page three.

Plan Name	Three digit Plan Number
_____	_____ _____ _____

3. OPTIONAL BENEFITS

Only complete this section if your employer offers optional benefits: Dental, Vision, Acupuncture/Chiropractic

DENTAL COVERAGE

☐ Waiving coverage for dependent under age 2 (Must be checked if enrolling a dependent under age 2, or coverage will be included for the dependent.)

☐ Prepaid Dental (HMO) - Plan ___ ___ ___

☐ PPO Dental - Plan ___ ___ ___

☐ Fee-For-Service Dental - Plan ___ ___ ___

If you choose the Prepaid Dental (HMO) plan, you must select a dentist:	**Dentist**	**ID#**

☐ Check if dentist chosen is current provider

☐ Check if you would like a dentist assigned

VISION COVERAGE

☐ Waiving coverage for dependent under age 2 (Must be checked if enrolling a dependent under age 2, or coverage will be included for the dependent.)

☐ Plus Vision Plan - Plan ___ ___ ___

☐ Preferred Vision Plan - Plan ___ ___ ___

Acupuncture/Chiropractic

☐ Waiving coverage for dependent under age 2 (Must be checked if enrolling a dependent under age 2, or coverage will be included for the dependent.)

☐ Standard Acupuncture / Chropractic Plan - Plan ___ ___ ___

☐ Plus Acupuncture / Chiropractic Plan - Plan ___ ___ ___

4. ENROLLMENT / FAMILY INFORMATION (Complete for MEDICAL, DENTAL, VISION AND/OR ACUPUNCTURE/CHIROPRACTIC)

MEDICAL: ☐ Employee Only ☐ Employee & Spouse ☐ Employee & State of CA Registered Domestic Partner
☐ Employee & Non-Registered Domestic Partner ☐ Employee & Children ☐ Employee & Family

Do NOT complete this section for your dependents unless you are electing medical, dental, vision benefits, and/ or Acu-Chiro

Relationship To Employee	M F	First Name	Last Name	Social Security Number	Date of Birth	Primary Care Physician²	Physician ID #	Current Patient?	Dis-abled
								Y/N	
Prior Medical Coverage Carrier Name: (if no prior coverage, write "none")						Coverage Start Date:	Coverage End Date:		
Prior Dental Coverage Carrier Name: (if no prior coverage, write "none")						Coverage Start Date:	Coverage End Date:		
☐ Spouse ☐ Registered Domestic Partner ☐ Non-Registered Domestic Partner	M F			– –	/ /			Y/N	
Prior Medical Coverage Carrier Name: (if no prior coverage, write "none")						Coverage Start Date:	Coverage End Date:		
Prior Dental Coverage Carrier Name: (if no prior coverage, write "none")						Coverage Start Date:	Coverage End Date:		
☐ Child	M F			– –	/ /			Y/N	Y/N
Prior Medical Coverage Carrier Name: (if no prior coverage, write "none")						Coverage Start Date:	Coverage End Date:		
Prior Dental Coverage Carrier Name: (if no prior coverage, write "none")						Coverage Start Date:	Coverage End Date:		
☐ Child	M F			– –	/ /			Y/N	Y/N
Prior Medical Coverage Carrier Name: (if no prior coverage, write "none")						Coverage Start Date:	Coverage End Date:		
Prior Dental Coverage Carrier Name: (if no prior coverage, write "none")						Coverage Start Date:	Coverage End Date:		
☐ Child	M F			– –	/ /			Y/N	Y/N
Prior Medical Coverage Carrier Name: (if no prior coverage, write "none")						Coverage Start Date:	Coverage End Date:		
Prior Dental Coverage Carrier Name: (if no prior coverage, write "none")						Coverage Start Date:	Coverage End Date:		
☐ Child	M F			– –	/ /			Y/N	Y/N
Prior Medical Coverage Carrier Name: (if no prior coverage, write "none")						Coverage Start Date:	Coverage End Date:		
Prior Dental Coverage Carrier Name: (if no prior coverage, write "none")						Coverage Start Date:	Coverage End Date:		

☐ Check here if you would like your Health Care Service Plan to assign you a Primary Care Physician (PCP)

[2]*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.***

5. REFUSAL OF COVERAGE

Refusal of Coverage

PacAdvantage

COMPLETE THIS SECTION ONLY IF YOU DO NOT WANT COVERAGE FOR YOURSELF AND/OR YOUR ELIGIBLE DEPENDENTS. YOU MUST ENROLL FOR OPTIONAL BENEFITS IF YOUR EMPLOYER OFFERS THEM AND IF YOU ARE ENROLLING FOR MEDICAL COVERAGE.

PERSONAL INFORMATION

Name of Company	Employer Phone #
Employee Name	

I have been offered coverage by my employer, but at this time I wish to REFUSE coverage as follows:

1) Medical for:

- ☐ Myself and all dependents
- ☐ Spouse
- ☐ Domestic Partner
- ☐ Child (ren)

2) Reason for refusing medical coverage:

- ☐ Covered by another employer's health plan (e.g. through your spouse)

  Carrier Name: _____

- ☐ Covered by an Individual Health Plan

  Carrier Name: _____

- ☐ Medicare ☐ Medi-Cal ☐ Covered by CHAMPUS (Active Duty)
- ☐ No other employer health coverage
- ☐ Other Reason: _____ (explanation required)

I understand that a) by failing to elect coverage now, I may have to wait until my group's next Annual Open Enrollment, which could be as long as 12 months, b) if I lose other employer - or group-sponsored coverage, I must enroll in PacAdvantage within 30 days or wait until my group's next Annual Open Enrollment, and c) PacAdvantage reserves the right to request proof of other group-sponsored, Medicare, Medi-Cal, or CHAMPUS coverage.

Employee Signature	Date

DECLARATIONS

Read each of the following statements carefully. Any untrue or inaccurate responses may be reason for loss of eligibility, disenrollment by PacAdvantage and other sanctions. By signing this application you are responsible for each statement.

1) I have reviewed the services, coverage offered, and rates of the participating plans.
2) I understand that I must meet the Program requirements to be an eligible employee.
3) I certify that I work or reside in the service area of the participating insurance plan(s) I have selected.
4) I understand that if I am an eligible employee and do not enroll my dependents at this time; they cannot enroll in the Program until the next Open Enrollment period unless otherwise authorized by Program Governing Rules.
5) I understand that there may be waiting periods for certain dental services.
6) I declare that I will abide by the rules of participation of any participating plan in which I am enrolled.
7) I agree to follow the laws and rules governing the Program
8) I understand that this contact may require disputes to be resolved through binding arbitration. (See disclosure below.)
9) As an employee applying for the Program, I understand my eligibility is based on my employer's continuing qualification to participate.
10) By signing this application, I certify under penalty of perjury that the information provided on this application is true and correct. I understand that any untrue or inaccurate responses on this application may cause loss of eligibility, disenrollment, and other sanctions.

COBRA/Cal-COBRA APPLICANT DECLARATIONS (Only complete this section if applicable)

I, the COBRA/Cal-COBRA applicant, declare as follows:

1) I understand that by signing the application, I am responsible for the Declarations set forth above and where the term "employee" is used, the Declarations apply to me as the COBRA/Cal-COBRA applicant.
2) I will abide by the Program premium requirements.
3) I must meet the Program requirements and the requirements of federal or state law for continuation of coverage under COBRA or Cal-COBRA.
4) If my former employer terminates its participation in the Program, my coverage under the Program will cease, although I may have continuation coverage through a successor plan with the former employer.

COBRA or Cal-COBRA start date

__ __ / __ __ / __ __

Check COBRA coverage type: ☐ COBRA ☐ Cal-COBRA

Date of Qualifying Event

__ __ / __ __ / __ __

Indicate Qualifying Event:

☐ Termination of employment ☐ Child no longer eligible ☐ Medicare coverage

☐ Reduction of hours ☐ Divorce/legal separation ☐ Death of covered employee

I, the COBRA/Cal-COBRA applicant, certify that the information provided on this application is true and correct.

Signature of Cobra applicant

_____

Date Signed

__ __ / __ __ / __ __

ARBITRATION NOTICE

PacAdvantage offers a variety of health / dental / vision / complementary medicine options. Enrollment in many of the plans constitutes an agreement to have certain disputes decided by binding arbitration and waiver of any right to jury or court trial. Refer to the plan's Evidence of Coverage or Certificate of Insurance to determine whether the plan(s) you have selected require binding arbitration. If you choose a medical, dental, vision, or complementary medicine plan which requires resolution of disputes through arbitration, you, your dependents, and the plan may be waiving any right to a jury or court trial.

Employee Signature	Date:
Print Name	