CaliforniaChoice®
Your Health. Your Choice.®

721 South Parker, Suite 200, Orange, CA 92868
(800) 558-8003 • www.calchoice.com

Medical / Dental / Life / Vision Enrollment Application

COMPLETE WAIVER SECTION ON PAGE 4 IF YOU OR ANY OF YOUR DEPENDENTS ARE NOT ENROLLING.
COMPLETE AN EMPLOYEE CHANGE REQUEST FORM IF YOU ARE AN EXISTING MEMBER AND NEED TO MAKE CHANGES.
FOR PRIMARY CARE PHYSICIAN CHANGE ONLY, PLEASE CONTACT YOUR HEALTH PLAN DIRECTLY.

Select one ☐ New Business ☐ New Hire ☐ New Renewal ☐ New COBRA ☐ Qualifying/Triggering Event

A Personal Information

Company Name

Group #

Employee Job Title

Full-Time Employment Date (MM/DD/YYYY)

Gender ☐ M ☐ F **Status** ☐ Married ☐ Single ☐ Domestic Partner

(exclude any orientation periods, if applicable)

Employee Last Name

Employee Social Security #

Employee First Name **M.I.** **Date of Birth (MM/DD/YYYY)**

Home Phone # (XXX) XXX-XXXX **E-mail Address**

Physical Address (Do not use P.O. Box) **Apt. #** **City**

State **ZIP Code** **County**

Mailing Address ***(if different from above)*** **Apt. #** **City**

State **ZIP Code** **County**

B Enrollment Information

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

	Employee	Spouse/Domestic Partner	Child 1	Child 2	Child 3
	☐ Life only				
Enrolling For?	☐ Medical ☐ Dental ☐ Vision	☐ Medical ☐ Dental ☐ Vision	☐ Medical ☐ Dental ☐ Vision	☐ Medical ☐ Dental ☐ Vision	☐ Medical ☐ Dental ☐ Vision
Last Name					
First Name					
Relationship to Employee		☐ Spouse ☐ Domestic Partner			
Social Security #		Social Security # required!	Social Security # required!	Social Security # required!	Social Security # required!
Gender		☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Date of Birth		MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
Disabled? *(Complete only if over age 26)*			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

➡ To enroll more dependents, complete sections A & B on an additional application.

COBRA Applicants

Please check COBRA type
☐ COBRA
☐ Cal-COBRA

Indicate Qualifying/Triggering Event
☐ Termination of employment ☐ Child no longer eligible ☐ Medicare entitlement
☐ Reduction of hours ☐ Divorce/legal separation ☐ Death of employee

Date of Qualifying/Triggering Event (MM/DD/YYYY)

PLEASE SIGN AND DATE APPLICABLE SECTIONS INSIDE APPLICATION

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CC 0310 6/2018 Eff. 10/1/2018

Print Employee Name _____ Group # _____

C Medical Benefit - IMPORTANT: Please select ONE benefit plan from the metal tier(s) shown on your Enrollment Worksheet.

HEALTH PLAN	BRONZE	SILVER	GOLD	PLATINUM
ANTHEM BLUE CROSS	☐ EPO A	☐ HMO A ☐ PPO A ☐ PPO B ☐ EPO A ☐ EPO B*	☐ HMO A ☐ PPO A ☐ PPO B ☐ PPO C ☐ PPO D	☐ HMO A
HEALTH NET	☐ HSP A	☐ HMO A ☐ HSP A ☐ HMO B	☐ HMO A ☐ HMO D ☐ HMO B ☐ HMO E ☐ HMO C	☐ HMO C ☐ HMO D ☐ HMO E
KAISER PERMANENTE	☐ HMO A ☐ HMO C*	☐ HMO B ☐ HMO D* ☐ HMO C	☐ HMO A ☐ HMO B	☐ HMO A ☐ HMO B
SHARP	☐ HMO A ☐ HMO D* ☐ HMO B*	☐ HMO A ☐ HMO C ☐ HMO B	☐ HMO A ☐ HMO D ☐ HMO B	☐ HMO A ☐ HMO C ☐ HMO B
SUTTER HEALTH PLUS	☐ HMO A ☐ HMO B*	☐ HMO B ☐ HMO C*	☐ HMO A ☐ HMO B	☐ HMO A ☐ HMO B
UNITEDHEALTHCARE	☐ HMO B* ☐ HMO C	☐ HMO A ☐ HMO C ☐ HMO B ☐ HMO D	☐ HMO A ☐ HMO C ☐ HMO B	☐ HMO A ☐ HMO C ☐ HMO B
WESTERN HEALTH ADVANTAGE	☐ HMO B ☐ HMO D* ☐ HMO C*	☐ HMO A ☐ HMO C* ☐ HMO B	☐ HMO A ☐ HMO C ☐ HMO B ☐ HMO D*	☐ HMO A ☐ HMO B

*HSA Qualified High Deductible Plan

	Employee	Spouse/Domestic Partner	Child 1	Child 2	Child 3
Primary Care Physician**					
Current Patient?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Provider ID#					
Provider City					

☐ Check here if you would like your Health Plan to assign you a Primary Care Physician.

** *A Primary Care Physician (PCP) is not required for Kaiser Permanente, EPO and PPO benefit plans. If a PCP is not contracted with your selected Health Plan prior to enrolling or if a PCP is not listed, one will automatically be assigned to you.*

D Optional Benefits - Ask your health plan administrator if any of the optional benefits below are being offered by your employer.

Sections A, B & E of this application must be completed for all Optional Benefits.

Life Insurance

Beneficiary Name(s)						
Last Name	First Name	M.I.	Date of Birth	Relationship to You (i.e. spouse, friend, child)	***Percentage	***Type of Beneficiary
			MM/DD/YYYY			☐ Primary ☐ Secondary
			MM/DD/YYYY			☐ Primary ☐ Secondary
			MM/DD/YYYY			☐ Primary ☐ Secondary

*** If you are listing more than one primary beneficiary or more than one secondary beneficiary, please enter the percentage of the insurance proceeds that each individual should receive. The percentage of insurance proceeds must equal 100% for each type of beneficiary (primary or secondary). No secondary beneficiaries will be entitled to any part of the insurance proceeds if any primary beneficiary is living at the time of death of the insured.

Dental Coverage

☐ Prepaid 1000† ☐ Voluntary Prepaid 1000† ☐ PPO 3000 ☐ PPO 4000 ☐ Check if dentist chosen is current provider

☐ Prepaid 3000† ☐ Voluntary Prepaid 3000† ☐ PPO 3500 ☐ PPO 5000 ☐ Check if you would like a dentist assigned

† Plan 1000/3000 requires selection of a family dentist. Upon receipt of dental ID cards, you may elect other dentists for dependents.

Dentist Name / Office (If left blank or dentist is unavailable, one will be assigned) _____ **ID#** _____

Vision Coverage – IMPORTANT: Please select ONE benefit plan below

☐ Voluntary EyeMed (provided by Ameritas)* ☐ Voluntary VSP (provided by Ameritas)* ☐ Vision One Discount Plan (No Charge)

*Employee is responsible for 100% of this cost if selected for coverage

Premium Only Plan (P.O.P.)

☐ I want my portion of eligible insurance premiums paid on a pre-tax basis

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Print Employee Name _____ Group # _____

E Your Legal Acknowledgement and Mandatory Binding Arbitration Agreement (Read, sign and date where indicated)

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, 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 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 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 either 20+ or 30+ hours per week, or I am an eligible COBRA/Cal-COBRA participant.
- I am not a temporary, seasonal, per diem, 1099 or substitute 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, or a nontemporary legal ward, and/or have an established parent-child relationship with me or my spouse/domestic partner. **I understand** that I am required to notify California*Choice* when an established parent-child relationship ceases to exist.

I understand that the preceding 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.

All statements and answers I have given are true and complete. I **understand** it is a crime to knowingly perform an act or practice constituting fraud or make an intentional misrepresentation of material fact to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. I understand all benefits are subject to conditions stated in the Group Contract and coverage documents. If my plan is rescinded or canceled, I will receive from my insurer a notice at least 30 days prior to the effective date of the rescission explaining the reasons for the intended rescission and my right to appeal that decision to the Commissioner of Insurance pursuant to subdivision (b) of Section 10273.4 of the California Insurance Code. Notwithstanding subdivision (a) of Section 10273.4 or any other provision of the law, I understand that after 24 months following the issuance of my health plan or insurance policy, my insurer may not rescind my health plan or insurance policy for any reason, and shall not cancel my health plan or insurance policy, limit any provisions of the health plan or policy, or raise premiums due to any omissions, misrepresentations, or inaccuracies in the application for, whether willful or not.

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.
- The coverage may be cancelled or the employer's contract rescinded because of the performance of an act or practice constituting fraud or making of an intentional misrepresentation of a material fact to an insurance company for the purposes of defrauding the company.
- 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 as a condition of obtaining coverage.

MANDATORY BINDING ARBITRATION

I understand that, if I select a Health Plan that uses mandatory binding arbitration to resolve disputes, I am agreeing to arbitrate claims that relate to my or a dependent's membership in the Health Plan (except for Small Claims Court cases and claims that cannot be subject to binding arbitration under governing law). I understand that any dispute between myself, my heirs, relatives, or other associated parties on the one hand and the Health Plan, 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 the Health Plan, 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 in the Health Plan's coverage document, which is available for my review.

Employee SIGN HERE FOR MEDICAL, DENTAL, LIFE OR VISION COVERAGE ➡ _____ Print Name _____ Today's Date (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

My signature acknowledges that I have read Section E, the applicable mandatory binding arbitration of the plan I selected in Section C and my decision to enroll in the medical, dental, life or vision coverage that I selected in Sections C and D.

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MEDICAL / DENTAL WAIVER

IMPORTANT!

Complete this page 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

Company Name

Company Phone # (XXX) XXX-XXXX

Employee Last Name

Employee Social Security #

Employee First Name

Group #

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** **Carrier Name** **Group #**

- ☐ Other Group Coverage
- ☐ Medicare
- ☐ Medi-cal
- ☐ Individual Policy
- ☐ Other Reason _____ (explanation required)

2) **Reason waiving Dental** **Carrier Name** **Group #**

- ☐ Other Group Coverage
- ☐ 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. will require me to wait to enroll until my employer group's next open enrollment period, unless I experience a qualifying/triggering event that would allow me to enroll for coverage prior to open enrollment.**

☒ **I understand that by failing to elect DENTAL coverage now, *CHOICE* Administrators Insurance Services, Inc. can also impose a 6 month pre-existing condition exclusion, both of which would begin at the time of my later decision to elect DENTAL 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 60 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) Has added a new dependent as a result of marriage, domestic partnership, birth, adoption, or placement for adoption or has assumed a parent-child relationship and if enrollment is requested within 60 days after the marriage, domestic partnership, birth, adoption or placement for adoption or has assumed a parent-child relationship OR employee or eligible dependents loses minimum health care coverage, for any reason other than due to failure to pay premiums, fraud, or intentional misrepresentation of material fact; C) Requests enrollment within 60 days of loss of coverage.

Employee **SIGN HERE TO WAIVE COVERAGE** ➡

Print Name

Today's Date (MM/DD/YYYY) / /

Validate My 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 all required documentation is received before the 16th day of the month of marriage, premiums are charged for the full month and coverage begins on the date of marriage. If all required documentation is received on or after the 16th day of the month of marriage, coverage begins on the 1st of the month following the date of receipt.	■ New spouse must be legally married to the employee ■ New stepchild must also meet the dependent children requirements listed below
Birth/Adoption/ Legal Guardianship/ Eligible Dependent Child	If birth/date of placement occurred before the 16th of the month, coverage begins on the first day of the month of the date of 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. Coverage for the dependent begins on the first of the month following the birth/date of placement.	MEDICAL, CHIRO, VISION and **SMILESAVER** DENTAL Dependent eligibility: ■ Born to, a stepchild or legal ward of, adopted by, or have an established parent-child relationship with the eligible employee, employee spouse or domestic partner ■ Under age 26 (unless disabled, disability diagnosed prior to age 26) **AMERITAS** DENTAL Dependent eligibility: ■ Born to, a stepchild or legal ward of, adopted by, or have an established parent-child relationship with the eligible employee, employee spouse or domestic partner ■ Financially dependent upon the employee per IRS guidelines ■ Unmarried or not involved in a domestic partnership ■ Under age 26 (unless disabled, disability diagnosed prior to age 26) **Disabled Dependents:** Dependents who are incapable of self-support because of continuous mental or physical disability that existed before the age limit are eligible for coverage until the incapacity ends. Documentation of disability will be requested. Once the child reaches the age limit for coverage, verification of eligibility will occur annually at the child's birthday. **Dependents must meet all requirements listed in order to be eligible for enrollment**
Domestic Partner/ Child of Domestic Partner	During Initial Enrollment or Group's Annual Renewal: Coverage begins on group's effective date. Involuntary Loss of Other Coverage: Domestic Partner can be added outside of Renewal 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 Registration of Domestic Partnership from a state or local government agency authorized to perform such registrations within 60 days of issue or a signed affidavit for opposite sex and over age 62 domestic partnerships. If all required documentation is received before the 16th day of the month in which the domestic partnership was established, premiums are charged for the full month and coverage begins on the date of the event. If all required documentation is received on or after the 16th day of the month in which the domestic partnership was established, coverage begins on the 1st of the month following the date of receipt.	For a Domestic Partner to qualify, Employee and Domestic Partner must: ■ Neither is married under either statutory, common law or part of another domestic partnership ■ Both be 18 years of age or older; or, if under 18, have a valid court order allowing partnership ■ Share an intimate and committed relationship ■ Agree to be jointly responsible for each other's basic living expenses incurred during the domestic relationship ■ Both be mentally competent ■ Not related by blood to a degree of closeness that would prohibit marriage in this state ■ Agree to notify California*Choice*® immediately upon termination of domestic partnership Children of Domestic Partner must also meet the dependent children requirements listed above Members who are in a same sex partnership, or the opposite sex and are over the age of 62, are required to submit a state-stamped Certificate of Registration of Domestic Partnership from a state or local government agency authorized to perform such registrations within 60 days of issue; all others must submit a signed Affidavit of Domestic Partnership. **Employee and Domestic Partner must meet all requirements listed in order to be eligible for enrollment**