

# Enrolling is Simple. Just Follow These 3 Easy Steps...

## **Step 1**

**COMPLETE THE APPLICATION IN BLUE OR BLACK INK.** Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department  
at: \_\_\_\_\_ fax: \_\_\_\_\_

## **Step 2**

**SELECT THE TYPE OF BILLING YOU WANT** – monthly.

## **Step 3**

**SEND THE COMPLETED APPLICATION TO:**

**Please make your check payable to: PacifiCare**

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

**If you have questions please contact our office at:**

Thank you for choosing...

***PacifiCare***<sup>®</sup>  
A UnitedHealthcare Company

California PacifiCare SignatureValue® HMO  
Individual Plan Enrollment Application



New Business     Change in Benefits (specify requested date below in Coverage Information section)     Dependent Add

This application is to be completed by the applicant applying for coverage. For child only, application is to be completed by the child's parent or legal guardian if child is not of legal age.

Applicant's Social Security Number \_\_\_\_\_ Group No. (Home Office to assign) \_\_\_\_\_

APPLICANT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_  
(PO Box, not acceptable)

Billing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone No. ( ) \_\_\_\_\_ Best time to Call \_\_\_\_\_ Alternate Phone No. (if applicable) ( ) \_\_\_\_\_

Gender  M  F Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  Single  Married  Domestic Partner

Chosen Primary Care Physician's (PCP) Name & Provider # (10 digits) \_\_\_\_\_ Network (PMG) \_\_\_\_\_

Language (Optional)  English  Spanish  Other \_\_\_\_\_ Ethnicity (Optional)  Caucasian or White  Hispanic or Latino  Black or African-American  Not Provided  
 American Indian or Alaskan Native  Asian, Native Hawaiian, other Pacific Islander

Applicant's Occupation: \_\_\_\_\_ Spouse/Domestic Partner's Occupation: \_\_\_\_\_

Yes  No Are you a U.S. citizen? If no, list how long in the U.S.: \_\_\_\_\_ (Attach copy of valid permanent resident card)

DEPENDENT ENROLLMENT INFORMATION

(If more space is needed, attach an additional sheet of paper, sign and date it.)

Spouse or

Domestic Partner (First Name & M.I., last name if different): \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_ Date of Birth \_\_\_\_\_

Gender  M  F Height \_\_\_\_\_ Weight \_\_\_\_\_ Chosen PCP Name & Provider # (10 digits) \_\_\_\_\_ Network (PMG) \_\_\_\_\_

Child (First Name & M.I., last name if different): \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_ Date of Birth \_\_\_\_\_

Gender  M  F Height \_\_\_\_\_ Weight \_\_\_\_\_ Chosen PCP Name & Provider # (10 digits) \_\_\_\_\_ Network (PMG) \_\_\_\_\_

Child (First Name & M.I., last name if different): \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_ Date of Birth \_\_\_\_\_

Gender  M  F Height \_\_\_\_\_ Weight \_\_\_\_\_ Chosen PCP Name & Provider # (10 digits) \_\_\_\_\_ Network (PMG) \_\_\_\_\_

Child (First Name & M.I., last name if different): \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_ Date of Birth \_\_\_\_\_

Gender  M  F Height \_\_\_\_\_ Weight \_\_\_\_\_ Chosen PCP Name & Provider # (10 digits) \_\_\_\_\_ Network (PMG) \_\_\_\_\_

Dependents (age 19 through 23) attending school full-time, include name of dependent, name/address of school, and number of credits: \_\_\_\_\_

Yes  No Do all dependents reside with the primary applicant? If no, please indicate name & mailing address of dependents: \_\_\_\_\_

ELIGIBILITY

Yes  No Are you or any family members covered by or eligible for Medicare/Medicaid? If yes, list family members and their effective date: \_\_\_\_\_

Yes  No Are you, any family member, or significant other pregnant or in the process of adoption or surrogacy (including those not applying for coverage)? \_\_\_\_\_

Yes  No Are you or any eligible dependent disabled, receiving disability payments, or hospital confined? \_\_\_\_\_

COVERAGE INFORMATION

Medical:  Applicant  Applicant/Family  Applicant/Spouse or Domestic Partner  Applicant/Child(ren)  Child only

Plan Name \_\_\_\_\_ Network Name (Optional) \_\_\_\_\_

PCP Copay \_\_\_\_\_ IP Hosp Copay \_\_\_\_\_ Requested effective date \_\_\_\_\_ (Actual effective date is determined by PacifiCare)

Upon signature of this application, I am indicating that I have selected the health plan within this Coverage Information section and that I fully understand the benefit levels of this plan.

I am a HIPAA Eligible Individual as defined in the Prior Coverage section on page 3 of this application and I choose to apply for (HIPAA Eligible medical plan indicated): \_\_\_\_\_

I am a HIPAA Eligible Individual as defined in the Prior Coverage section on page 3 of this application but I choose to apply for the Non-HIPAA Eligible medical plan indicated. I understand there is no guarantee of coverage of the selected non-HIPAA plan regardless of my status as a HIPAA eligible individual.

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Home Office Use Only	Reviewed by:	Effective date:	Approved/Denied:
	Date:	Plan:	Premium:

Depending upon state law, this information may be used in determining whether your application is approved for coverage.

## MEDICAL HISTORY

A. Within the past five years, has any person to be covered ever had any symptoms that would cause an ordinarily prudent person to seek medical care; had any conditions, diagnosis, consultation, routine follow-up, treatment, or therapy; been prescribed any medication; been monitored; or received counseling for any of following?... (Provide details to "Yes" answers below.)

<p><b>1) Digestive Disorder</b>                    <b>Yes</b>   <b>No</b></p> <p>a. Irritable Bowel, Spastic Colon      <input type="checkbox"/>   <input type="checkbox"/></p> <p>b. Colitis, Crohn's Disease            <input type="checkbox"/>   <input type="checkbox"/></p> <p>c. Gastric Reflux, Heartburn           <input type="checkbox"/>   <input type="checkbox"/></p> <p>d. Gallbladder Disease                 <input type="checkbox"/>   <input type="checkbox"/></p> <p>e. Hepatitis, Other Liver Disorder     <input type="checkbox"/>   <input type="checkbox"/></p> <p>f. Other Digestive or Intestinal Disorder <input type="checkbox"/>   <input type="checkbox"/></p>	<p><b>6) Genitourinary</b>                        <b>Yes</b>   <b>No</b></p> <p>a. Fibrocystic Breast, Implants,      <input type="checkbox"/>   <input type="checkbox"/></p> <p>   Other Breast Condition               <input type="checkbox"/>   <input type="checkbox"/></p> <p>b. Ovarian Cyst, Uterine Fibroid       <input type="checkbox"/>   <input type="checkbox"/></p> <p>c. Infertility Testing or Treatment     <input type="checkbox"/>   <input type="checkbox"/></p> <p>d. Menstrual, Reproductive Organ Disorder <input type="checkbox"/>   <input type="checkbox"/></p> <p>e. Abnormal Pap Smear                 <input type="checkbox"/>   <input type="checkbox"/></p> <p>f. Prostate Gland Disorder,           <input type="checkbox"/>   <input type="checkbox"/></p> <p>   Abnormal PSA Test                     <input type="checkbox"/>   <input type="checkbox"/></p> <p>g. Sexually Transmitted Disease      <input type="checkbox"/>   <input type="checkbox"/></p> <p>h. Urinary Tract, Bladder,             <input type="checkbox"/>   <input type="checkbox"/></p> <p>   Kidney Disorder</p>	<p><b>10) Psychological</b>                       <b>Yes</b>   <b>No</b></p> <p>a. Anxiety, Panic Disorder            <input type="checkbox"/>   <input type="checkbox"/></p> <p>b. Depression, Major Depressive Disorder <input type="checkbox"/>   <input type="checkbox"/></p> <p>c. Bipolar Disorder                      <input type="checkbox"/>   <input type="checkbox"/></p> <p>d. Obsessive Compulsive Disorder    <input type="checkbox"/>   <input type="checkbox"/></p> <p>e. Schizophrenia, Schizoaffective Disorder <input type="checkbox"/>   <input type="checkbox"/></p> <p>f. Anorexia, Bulimia Nervosa         <input type="checkbox"/>   <input type="checkbox"/></p> <p>g. Other Psychological Condition     <input type="checkbox"/>   <input type="checkbox"/></p>	
<p><b>2) Cardiovascular/Circulatory</b>       <b>Yes</b>   <b>No</b></p> <p>a. High Blood Pressure, Hypertension <input type="checkbox"/>   <input type="checkbox"/></p> <p>b. Mitral Valve Prolapse, Heart Murmur <input type="checkbox"/>   <input type="checkbox"/></p> <p>c. Chest Pain, Heart Attack, Arrhythmia, Angina, Palpitations                     <input type="checkbox"/>   <input type="checkbox"/></p> <p>d. Vascular Abnormality, Poor Circulation <input type="checkbox"/>   <input type="checkbox"/></p> <p>e. Stroke, Transient Ischemic Attack   <input type="checkbox"/>   <input type="checkbox"/></p> <p>f. Other Heart Condition or Disease    <input type="checkbox"/>   <input type="checkbox"/></p>	<p><b>7) Eyes/Ears/Nose/Throat/Skin</b>       <b>Yes</b>   <b>No</b></p> <p>a. Acne, Skin Disorder                 <input type="checkbox"/>   <input type="checkbox"/></p> <p>b. Ear, Nose, Sinus, Throat, Mouth    <input type="checkbox"/>   <input type="checkbox"/></p> <p>c. Eye, Cataracts, Glaucoma, Other    <input type="checkbox"/>   <input type="checkbox"/></p> <p>d. Loss of Hearing, Deafness            <input type="checkbox"/>   <input type="checkbox"/></p> <p>e. Jaw Condition or TMJ                 <input type="checkbox"/>   <input type="checkbox"/></p> <p>f. Vision Impairment, Blindness       <input type="checkbox"/>   <input type="checkbox"/></p>	<p><b>11) Neurological</b>                         <b>Yes</b>   <b>No</b></p> <p>a. Cerebral Palsy, Muscular Dystrophy <input type="checkbox"/>   <input type="checkbox"/></p> <p>b. Epilepsy, Seizures, Convulsions    <input type="checkbox"/>   <input type="checkbox"/></p> <p>c. Headaches, Migraines               <input type="checkbox"/>   <input type="checkbox"/></p> <p>d. Mental Retardation, Down's Syndrome <input type="checkbox"/>   <input type="checkbox"/></p> <p>e. Multiple Sclerosis, Paralysis       <input type="checkbox"/>   <input type="checkbox"/></p> <p>f. Other Neurological Disease or Disorder <input type="checkbox"/>   <input type="checkbox"/></p> <p>g. Alzheimer's Disease, Dementia     <input type="checkbox"/>   <input type="checkbox"/></p> <p>h. Parkinson's Disease                 <input type="checkbox"/>   <input type="checkbox"/></p> <p>i. Autism, Pervasive Develop. Disorder <input type="checkbox"/>   <input type="checkbox"/></p>	
<p><b>3) Respiratory/Lung</b>                      <b>Yes</b>   <b>No</b></p> <p>a. Allergies, Asthma                     <input type="checkbox"/>   <input type="checkbox"/></p> <p>b. Bronchitis, COPD, Emphysema      <input type="checkbox"/>   <input type="checkbox"/></p> <p>c. Sleep Apnea, Tuberculosis          <input type="checkbox"/>   <input type="checkbox"/></p> <p>d. Other Respiratory or Lung Disorder <input type="checkbox"/>   <input type="checkbox"/></p>	<p><b>8) Endocrine/Gland/Lymph/Blood</b>      <b>Yes</b>   <b>No</b></p> <p>a. Blood Abnormality, Anemia         <input type="checkbox"/>   <input type="checkbox"/></p> <p>b. Elevated Cholesterol/Triglycerides <input type="checkbox"/>   <input type="checkbox"/></p> <p>c. Diabetes, Pancreas, Elevated Glucose <input type="checkbox"/>   <input type="checkbox"/></p> <p>d. Hormonal Disorder, Adrenal         <input type="checkbox"/>   <input type="checkbox"/></p> <p>e. Lymph Gland Disorder, Immune System <input type="checkbox"/>   <input type="checkbox"/></p> <p>f. Thyroid, Goiter                        <input type="checkbox"/>   <input type="checkbox"/></p>	<p><b>12) General</b>                                 <b>Yes</b>   <b>No</b></p> <p>a. Abnormal Test Results               <input type="checkbox"/>   <input type="checkbox"/></p> <p>b. Burns                                      <input type="checkbox"/>   <input type="checkbox"/></p> <p>c. Congenital Abnormality, Loss of Limb <input type="checkbox"/>   <input type="checkbox"/></p> <p>d. Edema                                     <input type="checkbox"/>   <input type="checkbox"/></p> <p>e. Fibromyalgia, Chronic Fatigue      <input type="checkbox"/>   <input type="checkbox"/></p> <p>f. Hernia                                     <input type="checkbox"/>   <input type="checkbox"/></p> <p>g. Organ or Tissue Transplant         <input type="checkbox"/>   <input type="checkbox"/></p> <p>h. Pain Disorder                          <input type="checkbox"/>   <input type="checkbox"/></p> <p>i. Surgical Implants                      <input type="checkbox"/>   <input type="checkbox"/></p> <p>j. Chronic Infection                      <input type="checkbox"/>   <input type="checkbox"/></p> <p>k. Ulcer                                      <input type="checkbox"/>   <input type="checkbox"/></p>	
<p><b>4) Musculoskeletal/Nerve</b>               <b>Yes</b>   <b>No</b></p> <p>a. Arthritis or Rheumatism, Carpal Tunnel <input type="checkbox"/>   <input type="checkbox"/></p> <p>b. Neck, Back, Spinal Condition       <input type="checkbox"/>   <input type="checkbox"/></p> <p>c. Bone, Muscles, Joint Condition      <input type="checkbox"/>   <input type="checkbox"/></p> <p>d. Fracture, Dislocation, Internal Fixation <input type="checkbox"/>   <input type="checkbox"/></p> <p>e. Lupus, Connective Tissue Disease   <input type="checkbox"/>   <input type="checkbox"/></p> <p>f. Osteoporosis, Osteopenia           <input type="checkbox"/>   <input type="checkbox"/></p>	<p><b>9) Alcohol/Drug</b>                         <b>Yes</b>   <b>No</b></p> <p>a. Alcoholism, Alcohol Use (3+ drinks/day) <input type="checkbox"/>   <input type="checkbox"/></p> <p>b. Drug or Substance Abuse, Illicit Use <input type="checkbox"/>   <input type="checkbox"/></p>	<p><b>13) Other</b>                                    <b>Yes</b>   <b>No</b></p> <p>a. Health disorders not listed above   <input type="checkbox"/>   <input type="checkbox"/></p>	
<p><b>5) Cyst/Tumor/Polyp/Malignancy</b>       <b>Yes</b>   <b>No</b></p> <p>a. Cancer, Leukemia                     <input type="checkbox"/>   <input type="checkbox"/></p> <p>b. Cyst, Growth, Lump, Tumor, Polyp   <input type="checkbox"/>   <input type="checkbox"/></p> <p>c. Hodgkin's or Non-Hodgkin's Lymphoma <input type="checkbox"/>   <input type="checkbox"/></p>			

- B.  Yes  No Have you or any eligible dependent ever been declined, postponed, ridered, rescinded, or rated up for medical, disability, critical illness, or life insurance with another health plan or insurance carrier? If yes, explain: \_\_\_\_\_
- C.  Yes  No In the past five years, have you or any person to be covered received treatment, received therapy, taken medication, or consulted a health care provider for any reason? If yes, explain: \_\_\_\_\_
- D.  Yes  No Are you or any person to be covered currently taking any prescription medication, over-the-counter medication, vitamin therapy or alternative remedies? Please indicate the reason for use: \_\_\_\_\_
- E.  Yes  No In the past five years, have you or any person to be covered been advised to have a test or treatment, been advised to obtain equipment or service or been advised of a condition that may require attention or treatment? If yes, was this prompted by complaints or symptoms? Explain: \_\_\_\_\_
- F.  Yes  No Within the past five years, has any person to be covered been advised to seek treatment for or been advised to limit alcohol or drug use, been a member of any alcohol or drug abuse support group or used any controlled drug not prescribed by a doctor? If yes, explain: \_\_\_\_\_
- G.  Yes  No Has any person to be covered ever been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex by a physician or member of the medical profession, or had a T-cell abnormality? If yes, list names: \_\_\_\_\_
- H.  Yes  No Has anyone to be covered used tobacco products during the previous 12 months? If yes, list names: \_\_\_\_\_

Provide details to "YES" answers (If more space is needed, attach an additional sheet of paper, sign and date it.)

Question No./Letter	Name	Illness/Impairment	Dates Treated	Medications/Treatment/Surgery/Physician's Name & Address

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**PRIOR COVERAGE**

**HIPAA Eligible Individual Determination - Please indicate yes or no to the following:**

**Yes    No**

- 1. As of the date on which you are applying for coverage, have you been covered under creditable coverage for at least 18 months with no more than a 63 day lapse in coverage?
- 2. Was your most recent period of coverage under a group health plan (employer-sponsored), a governmental plan, or a church plan?
- 3. If you were offered the option of continuation of coverage under COBRA, Cal-COBRA or a similar state continuation program, did you complete the allowable period of coverage?
- 4. Are you eligible for any of the following: a group health plan (employer-sponsored plan); Part A or Part B of Medicare; or a state plan under Medicaid, Medi-Cal, or any successor program?
- 5. Do you have other health insurance or coverage?
- 6. Was your most recent health insurance or coverage terminated for fraud, intentional misrepresentation of material fact, or individual nonpayment of premium?

If you answered YES to questions 1 through 3 and NO to questions 4 through 6, you or your dependents may qualify as a HIPAA Eligible Individual, and we may waive the pre-existing limitation for you and your dependents on selected plans. If qualifying as a HIPAA Eligible Individual, please attach a Certificate of Creditable Coverage from the prior plan, or any other documents to prove that you or your dependents had prior coverage.

- Yes  No Are you or any dependents replacing coverage that was in effect within the last 63 days?
- Yes  No Do you or any dependents to be covered have or intend to keep any health coverage, including COBRA and/or state continuation currently in force?
- Yes  No Have you or any dependents ever been previously covered by PacifiCare?

**If you answered "Yes" to any of the above questions, please complete the following section. If you answered "No" to all questions, please proceed to the Terms and Conditions of Coverage section.**

Name(s) of covered individual	Insurance Company/Health Plan Name, Address and Phone	Policy or Group Number	Type of Coverage (individual, employer group, short term, COBRA, Medicare, other)	Effective Date	Termination Date

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## TERMS AND CONDITIONS OF COVERAGE

- 1) I understand that all health care services under the PacifiCare SignatureValue (HMO) coverage options must be provided or arranged for by PacifiCare, except for Emergency or Urgently Needed Services.
- 2) I understand that this application is not a contract. The contract consists of the PacifiCare Health Plan Individual Subscriber Agreement or Policy, including but not limited to all applications, health questionnaires and information submitted by the Subscriber or Insured and his or her Dependents in applying for coverage, appropriate attachments and addenda, and any amendments hereto. Should my application be accepted, PacifiCare will send me a Subscriber Agreement or Policy which details the exact terms and conditions of coverage to which I will be legally bound.
- 3) I understand that any agent or broker or other producer selling PacifiCare coverage does not have the authority to approve my application, change any terms of the agreement or waive any PacifiCare requirements.
- 4) I agree that PacifiCare may terminate or rescind membership for any person covered under this plan, if I intentionally provided incomplete or incorrect material misstatements, omissions or false information or intentionally misrepresent a material fact on this form, if I intentionally fail to provide PacifiCare with updated material changes to this form prior to enrollment.
- 5) If the applicant is a minor, as the parent/legal guardian of the minor child (the "applicant") and on behalf of the applicant, I request PacifiCare to provide health care coverage under its Individual Plan to the applicant. I hereby assume responsibility for the applicant's compliance with the terms and conditions of the PacifiCare Individual Plan selected as set forth in the applicable Subscriber Agreement or Policy and agree to be responsible for making Health Plan Premium and Copayments, on behalf of the applicant.
- 6) I hereby authorize any "Provider of health care" to disclose or provide to PacifiCare, its agents or employees, all information and medical records pertaining to any examination or treatment, including treatment for alcohol abuse, substance abuse, psychiatric disorders and/or acquired immune deficiency syndrome (AIDS), regarding myself or any applying applicant. I understand this 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. I understand that I may revoke this authorization in writing at any time before I become a PacifiCare member, except for instances where PacifiCare has already taken action based on the authorization. I agree to send my revocation to PacifiCare Individual Underwriting, M/S CY24-155, P.O. Box 3069, Cypress CA 90630-9962. I understand that if my information is shared with someone who is not required to follow state or federal privacy laws, my information may no longer be protected. I understand that if I refuse to provide this authorization, PacifiCare will not make an eligibility determination, and I will not be considered for membership in a PacifiCare plan.
- 7) I understand that PacifiCare is not liable for bills incurred before the effective date.
- 8) By signing below, I attest and agree that all of the information is correct and that the submission of this application to PacifiCare constitutes an offer to obtain the PacifiCare individual coverage summarily described in the Subscriber Agreement or Policy. I have read the disclosure brochure outlining the benefits, limitations and exclusions and other elements of the disclosure, the above terms and conditions and the authorization to disclose personal information.

CONDITION OF OBTAINING COVERAGE.



this application.

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), BETWEEN ME AND MY DEPENDENTS ENROLLED IN THE PLAN (INCLUDING ANY HEIRS OR ASSIGNS) AND PACIFICARE OF CALIFORNIA 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.

Applicant's Signature  \_\_\_\_\_ Date \_\_\_\_\_

Signature of applicant, authorized representative or if child only and not of legal age, signature of parent or legal guardian.

\_\_\_\_\_  
(Print Name of Parent, Legal Guardian, or Authorized Representative)

If signed by a representative of Applicant, please indicate the representative's authority to act on behalf of Applicant. \_\_\_\_\_

Spouse/Domestic Partners Signature  \_\_\_\_\_ Date \_\_\_\_\_  
(If spouse/domestic partner is to be covered)

Dependent's Signature (age 18 or older)  \_\_\_\_\_ Date \_\_\_\_\_  
(If dependents are to be covered)

\_\_\_\_\_ Date \_\_\_\_\_

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PacifiCare compensates agents, brokers, or producers for the sale of certain products. Your premium is the same if you purchase coverage directly from PacifiCare or if you use a producer. Please contact your agent, broker, or producer, if applicable, regarding the amount of compensation. In addition, you may request information regarding agent, broker, or producer commissions attributable to your policy by contacting PacifiCare Membership Accounting.

Writing Agent, Broker, or Producer Name \_\_\_\_\_ Carrier ID Number Assigned \_\_\_\_\_  
(Please print)

Writing Agent, Broker, or Producer Address \_\_\_\_\_  
(Please include firm name if applicable)

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

Best way to contact \_\_\_\_\_

General Agent Name (if applicable) \_\_\_\_\_ Carrier ID Number Assigned \_\_\_\_\_

General Agent Address \_\_\_\_\_

Writing Agent, Broker, or Producer Signature **X** \_\_\_\_\_ Date: \_\_\_\_\_

Payee Name and Address \_\_\_\_\_  
(if other than the writing agent, broker, or producer)

***If first individual application with PacifiCare:*** Dept. of Insurance License No. \_\_\_\_\_ State of License Issuance \_\_\_\_\_

Yes  No Are you aware of any information not disclosed in the Medical History Section of this Enrollment Application which may have a bearing on this risk? If yes, explain \_\_\_\_\_

Yes  No Did you see the applicant and did you ask each question on the Medical History Section of this Enrollment Application exactly as set forth? If no, explain \_\_\_\_\_

Yes  No Was the Medical History Section of this Enrollment Application completed by the applicant?

Products and services are offered by PacifiCare of California, PacifiCare Behavioral Health of California, Inc., PacifiCare Dental (in California), PacifiCare Health Plan Administrators, Inc., RxSolutions, Inc., and SeniorCo, Inc. Indemnity insurance products underwritten by PacifiCare Life and Health Insurance Company, PacifiCare Life Assurance Company and American Medical Security Life Insurance Company. PacifiCare is a federally registered trademark of PacifiCare Life and Health Insurance Company.

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