

Continuation Coverage Eligibility/Enrollment Form

- 1. This form is to be completed whether or not you wish to apply for continuation coverage.
2. Name of employer who provided group health benefits

FOR PacifiCare USE ONLY: GROUP NO., TIER, EFFECTIVE DATE
FOR EMPLOYER USE ONLY: MO, DAY, YR (Date form distributed), MO, DAY, YR (Date election period expires)

- 3. Are you currently covered under any other employer group health plan? No Yes
4. Do you wish to continue coverage through PacifiCare? No Yes
5. Return the completed form to your employer before the date election period expires.

Section One - To be Completed by Applicant See Instructions on Back • Incomplete Information Can Delay the Enrollment Process

Form fields for Section One: Social Security Number, Last Name, First Name, Initial, Bus. Phone, Mailing Address, Apt. No., City, State, Zip Code, Home Phone, County

Section Two - Complete for applicant and those eligible family members electing to continue coverage with PacifiCare:

Check here if currently a patient of the chosen primary care physician.

Table with columns: Last Name, First Name, Initial, Dependent's Social Security #, Relationship to Subscriber, Sex M/F, Check If Student over 19, Disabled, Date of Birth Mo./Day/Yr., Age, Primary Care Physician Full Name and Street Address, Dental Code

Name of spouse's employer
Is anyone listed on this application eligible for Medicare? Yes No If yes, who?

Section Three

I am eligible for continuation of health coverage due to (check one and indicate date of occurrence):

- 1. Employment termination or reduction in hours. Date
2. Death of a covered employee. Date
3. Divorce or legal separation from a covered employee. Date
4. No longer meet eligibility requirements as a covered dependent. Date
5. Covered employee elects Medicare coverage. Date

Section Four

Form fields for Section Four: Type of Coverage (Employee, Employee/Spouse, etc.), Employee Name (Last Name, First Name, Initial), PacifiCare I.D. No.

Section Five

To Decline Coverage: I have read the membership conditions on the reverse side and understand my right to continue health coverage. I hereby decline continuation coverage(s) available to me as a result of the qualifying event indicated above.

To Elect Coverage: I have read the membership conditions on the reverse side. I hereby request continuation coverage(s) as indicated above. I understand that failure to make timely payments of required premiums will result in permanent loss of this coverage.

X Date / / X Date / /

Membership Conditions

I am aware of and accept the following PacifiCare membership conditions:

1. I (we) have chosen a participating primary care physician (as have my (our) dependents, if any).
2. I (we) understand that each member (subscriber or dependent) will not receive an I.D. card or have access to any benefits except for emergency care until a primary care physician has been selected.
3. I (we) will use the primary care physician to provide or arrange for all necessary health care (except for out-of-area benefits). I (we) may change primary care physicians only by notifying the PacifiCare office in advance of such a change; PCP changes will become effective on the first day of the following month.
4. I (we) authorize the release of all of my (our) medical records to PacifiCare or its authorized agents for the performance of any one or more of the following: (a) the administration of this Agreement; (b) medical research and education sanctioned by PacifiCare; (c) peer review for quality assurance and utilization review of statistical utilization data to the subscribing group; (d) creation and provision of statistical utilization data to the subscribing group; (e) bona fide medical emergencies; and (f) any other exceptions provided by law. Where the release of names or identifying demographic information is not necessary to the function being performed, such information will not be released.
5. I (we) will abide by the master contract applicable to the plan in which I (we) enrolled.
6. I (we) understand that if, prior to making an election, the employee or qualified beneficiary utilizes services from the health plan during the election period, the use of such services shall be considered a **“constructive election,”** and the employee or qualified beneficiary is obligated to pay the applicable premium for the period during which coverage was provided.
7. I (we) will be held responsible for any claims paid by PacifiCare on my (our) behalf if I (we) fail to pay my (our) premium.
8. I (we) have received notification of my (our) rights to continue group health coverage.
9. I (we) will cooperate as required in the general Coordination of Benefits and the Subrogation provisions of the master contract .
10. I (we) understand that **PacifiCare coordinates benefits with no-fault automobile insurance in the manner prescribed by the State and as explained in conspicuous fashion in PacifiCare printed materials and contracts.**
11. I (we) understand that my (our) identification cards are for identification only. The dates which may appear on the card reflect the effective date of the plan contract for which I (we) have enrolled, not necessarily my (our) dates of eligibility.
12. I (we) understand that by choosing the coverage specified in the EOC, paying the premium, or accepting benefits in the EOC, I (we) or my (our) legal representa-

tive expressly agree to all terms, conditions and provisions of the EOC.

Instructions

1. Please use pen, print clearly and press hard.
2. Complete all the information requested.
3. Be sure to select a primary care physician (PCP) for each covered member of your family. If desired, each family member may have a different PCP. (Participating PCPs are listed in the PacifiCare Provider Directory.)
4. Sign and date the form, keep the goldenrod copy for your records, and forward the other copies to your personnel office.

Remember

- Notify your employer promptly of any change in the status of your family that affects your coverage.
- Call the PacifiCare Customer Service Department if your address changes or if you wish to change your primary care physician. Primary care physician changes will become effective on the first day of the following month.
- If you or any covered member of your family becomes ineligible to continue coverage under this plan, please contact PacifiCare within 31 days if interested in converting to a nongroup plan.
- Important information on how to use PacifiCare will be sent to you with your PacifiCare I.D. card.

Your PCP

PacifiCare members are most satisfied with their primary care physician (PCP) when . . .

- they ask their family and friends to make recommendations.
- they choose a primary care physician who is close to their home or work so physician visits are convenient.
- they visit or phone the doctor’s office and talk with a staff member about such things as the office, office hours and parking.
- they find out more about the doctor, especially if they have a preference in a particular area, like age, years in practice, specialized training or board certification.

The importance of having a PacifiCare primary care physician:

- You have a personal healthcare manager, helping you get the most appropriate care at the most appropriate time.
- You can develop a mutually satisfying relationship with a physician built on trust; establishing a rapport can promote consistency in your medical treatment.
- You have no claim forms to fill out when using PacifiCare benefits, because your physician deals directly with PacifiCare.
- You have a physician who is familiar with your complete health history.

PacifiCare®

Customer Service 1-800-877-9777

P.O. Box 6975

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