

C Medical Benefit - IMPORTANT: Please select ONE benefit plan from the metal tier(s) and plan options available to you on your CaliforniaChoice® Enrollment Worksheet.				
HEALTH PLAN	BRONZE	SILVER	GOLD	PLATINUM
ANTHEM BLUE CROSS	<input type="checkbox"/> PPO A* <input type="checkbox"/> PPO B* <input type="checkbox"/> PPO C <input type="checkbox"/> PPO D	<input type="checkbox"/> HMO A <input type="checkbox"/> PPO B <input type="checkbox"/> HMO B <input type="checkbox"/> PPO C <input type="checkbox"/> PPO D* <input type="checkbox"/> PPO E*	<input type="checkbox"/> HMO A <input type="checkbox"/> PPO B <input type="checkbox"/> HMO B <input type="checkbox"/> PPO C <input type="checkbox"/> HMO C <input type="checkbox"/> PPO D <input type="checkbox"/> PPO E	<input type="checkbox"/> HMO A <input type="checkbox"/> PPO A <input type="checkbox"/> HMO B
HEALTH NET		<input type="checkbox"/> HMO A	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO D <input type="checkbox"/> HMO H <input type="checkbox"/> HMO B <input type="checkbox"/> HMO E <input type="checkbox"/> HMO I <input type="checkbox"/> HMO C <input type="checkbox"/> HMO G	<input type="checkbox"/> HMO C <input type="checkbox"/> HMO G <input type="checkbox"/> HMO J <input type="checkbox"/> HMO E <input type="checkbox"/> HMO H <input type="checkbox"/> HMO F <input type="checkbox"/> HMO I
KAISER PERMANENTE	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO C*	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO D* <input type="checkbox"/> HMO B <input type="checkbox"/> HMO E <input type="checkbox"/> HMO C	<input type="checkbox"/> HMO B <input type="checkbox"/> HMO E* <input type="checkbox"/> HMO C <input type="checkbox"/> HMO D	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B <input type="checkbox"/> HMO C
SHARP	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B*	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO C <input type="checkbox"/> HMO B	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO D <input type="checkbox"/> HMO B	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO C <input type="checkbox"/> HMO B
SUTTER HEALTH PLAN	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B*	<input type="checkbox"/> HMO B <input type="checkbox"/> HMO C*	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO C* <input type="checkbox"/> HMO B	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B
UNITED HEALTHCARE		<input type="checkbox"/> HMO A <input type="checkbox"/> HMO E <input type="checkbox"/> HMO F <input type="checkbox"/> HMO G	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO H <input type="checkbox"/> HMO N <input type="checkbox"/> HMO B <input type="checkbox"/> HMO J <input type="checkbox"/> HMO O <input type="checkbox"/> HMO F <input type="checkbox"/> HMO L <input type="checkbox"/> HMO P <input type="checkbox"/> HMO G <input type="checkbox"/> HMO M <input type="checkbox"/> HMO Q	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO G <input type="checkbox"/> HMO K <input type="checkbox"/> HMO B <input type="checkbox"/> HMO H <input type="checkbox"/> HMO L <input type="checkbox"/> HMO C <input type="checkbox"/> HMO I <input type="checkbox"/> HMO M <input type="checkbox"/> HMO E <input type="checkbox"/> HMO J <input type="checkbox"/> HMO N
WESTERN HEALTH ADVANTAGE	<input type="checkbox"/> HMO B <input type="checkbox"/> HMO C*	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO C* <input type="checkbox"/> HMO B	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO C <input type="checkbox"/> HMO B <input type="checkbox"/> HMO D*	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO C <input type="checkbox"/> HMO B

*HSA Qualified High Deductible Plan

	Employee	Spouse/Domestic Partner	Child 1	Child 2	Child 3
Primary Care Physician**					
Current Patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Provider ID#					
Provider City					
<input type="checkbox"/> 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 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)			Date of Birth	Relationship to You	***Percentage	***Type of Beneficiary
Last Name	First Name	M.I.	MM/DD/YYYY	(i.e. spouse, friend, child)		
						<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
						<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
						<input type="checkbox"/> Primary <input type="checkbox"/> 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

MetLife DHMO† <input type="checkbox"/> MET100 <input type="checkbox"/> MET185 <input type="checkbox"/> 1000 <input type="checkbox"/> 3000	SmileSaver DHMO† <input type="checkbox"/> 1000 <input type="checkbox"/> 3000	Ameritas PPO <input type="checkbox"/> 3000 <input type="checkbox"/> 3500 <input type="checkbox"/> 4000 <input type="checkbox"/> 5000	<input type="checkbox"/> Check if dentist chosen is current provider <input type="checkbox"/> Check if you would like a dentist assigned
† MetLife and SmileSaver DHMO plans require 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)*

*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*
 * Employer: please make note of this employee's election.

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 CaliforniaChoice® 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 CaliforniaChoice 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 CaliforniaChoice 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 CaliforniaChoice 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 CaliforniaChoice 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)



Grid for date entry: []/[]/[]

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.

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
<input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>
Employee Last Name	Employee Social Security #
<input type="text"/>	<input type="text"/>
Employee First Name	Group #
<input type="text"/>	<input type="text"/>

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
<input type="checkbox"/> Other Group Coverage	_____
<input type="checkbox"/> Medicare	
<input type="checkbox"/> Medi-cal	
<input type="checkbox"/> Individual Policy	
<input type="checkbox"/> Other Reason	_____ (explanation required)
2) Reason waiving Dental	Carrier Name
<input type="checkbox"/> Other Group Coverage	_____
<input type="checkbox"/> Medicare	
<input type="checkbox"/> Medi-cal	
<input type="checkbox"/> Individual Policy	
<input type="checkbox"/> 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)
		<input type="text"/> / <input type="text"/> / <input type="text"/>

Validate My Form