

# ARIZONA ALL PLANS ENROLLMENT FORM



**For PacifiCare Office Use Only**

Tier Code	Process Date	Processor	Approval
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Type or print with ballpoint pen. Incomplete information will delay the enrollment process.

## Employer Information (To be completed by Employer)

Employer Name		Location		HMO Group #		Life Group #		Subgroup/Location #		PPO Group #	
Date of Full-Time Hire	Hours worked per week	Status (retired, full, part time, etc.)			Job Title		Employer Initials		Effective Date of Coverage		(If applicable) <input type="checkbox"/> High option <input type="checkbox"/> Low option

## Employee/Dependent Information

Name (Last, First, Middle)			Social Security #			Home Phone		Work Phone		County	
Street Address (No P.O. Boxes)				City, State, ZIP				Mailing Address (if different)			

## Coverage Information

**Medical**  Yes  No **Which Type?**  HMO  POS  Open Access  PPO  Indemnity  SDHP **Individual(s) Covered**  Self  Spouse  Dependents

**Dental**  Yes  No **Which Type?**  HMO  Indemnity **Individual(s) Covered**  Self  Spouse  Dependents **Dentist's Full Name:** \_\_\_\_\_

## List all Members to be covered

If electing HMO, list Primary Care Physician\*\*

Relationship	Last Name	First Name	MI	Sex	Social Security #	Birth Date (MM/DD/YYYY)	Network Code	Last Name	First Name	MI	Current Patient
Self											<input type="checkbox"/> Y <input type="checkbox"/> N
Spouse											<input type="checkbox"/> Y <input type="checkbox"/> N
Dependent											<input type="checkbox"/> Y <input type="checkbox"/> N
Dependent											<input type="checkbox"/> Y <input type="checkbox"/> N
Dependent											<input type="checkbox"/> Y <input type="checkbox"/> N
Dependent											<input type="checkbox"/> Y <input type="checkbox"/> N
Dependent											<input type="checkbox"/> Y <input type="checkbox"/> N

## Coordination of Benefits

Will you or any Dependent be covered by other Group Health in addition to PacifiCare?  Yes  No **Name of Carrier** \_\_\_\_\_

If you or any of your Dependents are eligible for Medicare, are you:  Retired  Active  Part A only  Part B only  Part A & B

Has anyone listed above been advised by a Physician of any surgery or hospital confinement required within the next 60 days?  Yes  No **If Yes, who?** \_\_\_\_\_

## Waivers

**Waive**  Medical  Dental  
 Coverage for myself and Dependents (if any)  My Dependents only

**Reason for waiver of coverage**  Covered by Spouse's Insurance  Other (explain): \_\_\_\_\_

## Life Insurance Information

Basic Life Insurance <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated		(If applicable) Annual Earnings:		Supplemental Life Insurance <input type="checkbox"/> 1x Salary <input type="checkbox"/> 2x Salary	
Beneficiary's Name (Last, First, Middle)				Social Security #		Relationship	
Street Address				City, State, ZIP		Home Phone	

I hereby authorize any health care facility, physician or surgeon, or any other health professional to disclose to PacifiCare of Arizona, Inc. or PacifiCare Life Assurance company, its agents or employees, all information from my medical records pertaining to any past or future examination or treatment including treatment for substance abuse and mental and emotional disorders furnished to me or my Dependents who are also applying for this coverage, and to any illness, injury or condition that I or these Dependents have had at any time in the past or in the future until the expiration of this authorization. I understand that this information is collected in connection with the evaluation and processing of an application for coverage, to determine continuing eligibility for benefits and to process claims, and may in certain circumstances be disclosed to third parties without authorization. This authorization also includes PacifiCare of Arizona, Inc. or PacifiCare Life Assurance Company disclosing any medical information they may have in their files to the same entities in connection with the advance consideration of providing services or subsequent payment for such services. I understand upon written request and within 30 business days of receipt by PacifiCare of Arizona, Inc. of that request, I have a right of access and correction with respect to all personal information collected. My authorized representative or I am entitled to receive a copy of this form as well as a separate notice that explains my right of access to recorded personal information and disclosure limitations and conditions. This authorization, for the purpose of collecting information in connection with application of insurance, is valid for thirty (30) months from the date signed and is valid until the termination of this policy for collecting information in connection with a claim for benefits. A photocopy or other reproduction of this authorization is as valid as the original. HMO product is offered/underwritten by PacifiCare of Arizona, Inc. PPO, SDHP, Indemnity and Life Products are offered/underwritten by PacifiCare Life Assurance Company. Member shall complete and submit to PacifiCare or Group an enrollment application or other forms or statements as PacifiCare may reasonably require. Member agrees to promptly notify PacifiCare or Group of any changes in the information contained in the enrollment application packet. Member warrants that to the best of his or her knowledge, all information contained in such application, forms and statements is true and complete, and agrees that all rights to benefits under this Agreement are subject to the condition that all such information is true and complete.

\*If you elected HMO or POS Plan and did not select a primary care physician (PCP) and/or an HMO primary care dentist, PacifiCare will select one for you. You may select a new PCP by contacting PacifiCare Customer Service (1-800-347-8600).

Applicant Signature	Date
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