



ENROLLMENT FORM (OKLAHOMA)

■ Instructions

You can either:

Accept the health care services coverage provided through your Employer by signing the space provided on the enrollment form. Your signature indicates that you have read, understand and agree to the terms and conditions below. Affixing your signature also indicates your acceptance of payroll deductions (if necessary) to pay your share of the cost.

OR

You can waive the health care services coverage provided through your Employer for yourself, your spouse or your Dependents by signing the DECLINATION OF COVERAGE FORM. We strongly recommend that you read through the entire form carefully before signing your name in ink and dating it. Please request the Declination of Coverage Form from your Employer.

■ Terms and Conditions –

Please read carefully before signing

On behalf of myself and my eligible Dependents, I hereby apply for health care services coverage indicated in PacifiCare's Group Health Plan offered through my Employer, and agree to and understand the following:

1. To be bound by the PacifiCare group health plan documents ("Agreement" or "Policy") if I have chosen the PacifiCare SignatureValueSM (HMO), PacifiCare SignatureOptionsSM (PPO), PacifiCare SignatureIndependenceSM (Indemnity) or PacifiCare SignatureFreedomSM (SDHP) plan.
2. My Employer may deduct from my earnings the employee contribution required to cover my share of the premium, if any.
3. Differences between myself and/or my Dependents and any health care providers, including claims of medical malpractice are not governed by the Agreement or Policy.
4. PacifiCare or a designee may access and/or use my medical records and the medical records of my enrolled Dependents, including mental health medical records and medical records from drug and alcohol abuse treatment or prevention, for purposes of Utilization Review, Quality Assurance, Surveys, Processing of Claims, Financial Audit or other purposes reasonably related to the performance of treatment, payment, or health care operations of the Agreement or Policy.
5. Any material omission or misrepresentation in answering the questions on this application may result in the denial of benefits and the termination of my and/or my Dependents' membership or grounds for rescission of the policy with PacifiCare.
6. Coverage shall not begin until acceptance of this enrollment by PacifiCare. Upon acceptance of this application, PacifiCare shall be bound by the terms of the Agreement or Policy, and any Amendments thereto.
7. I have received, read and understand the PacifiCare Disclosure Form, Directory of Contracting Medical Groups and a copy of this Enrollment Form.
8. My Dependents and I must live or work in PacifiCare's service area if enrolling in the PacifiCare SignatureValue plan.

PacifiCare products and services are offered by one or more of the following PacifiCare family of companies: Health plan products and services are offered by PacifiCare of Arizona, Inc., PacifiCare of California, PacifiCare of Colorado, Inc., PacifiCare of Nevada, Inc., PacifiCare of Oklahoma, Inc., PacifiCare of Oregon, Inc., PacifiCare of Texas, Inc., PacifiCare of Washington, Inc., PacifiCare Dental of Colorado, Inc., PacifiCare Behavioral Health of California, Inc., PacifiCare Health Insurance Company of Micronesia, Inc., and PacifiCare Dental (in California). Indemnity insurance products (including PPO products) offered in California are underwritten by PacifiCare Life and Health Insurance Company. Indemnity insurance products (including PPO products) offered in Arizona, Colorado, Nevada, Washington, Oregon, Texas and Oklahoma are underwritten by PacifiCare Life Assurance Company. Other products and services are offered by PacifiCare Health Plan Administrators, Inc., RxSolutions, Inc., SeniorCo, Inc., and PacifiCare Behavioral Health, Inc. PacifiCare[®] is a federally registered trademark of PacifiCare Life and Health Insurance Company.

EMPLOYEE ENROLLMENT FORM (Please Print)



Personal Information						
Last Name		First Name		MI	Suffix	<input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security #		Company Name		Date of (Re)Hire	Job Title	
Number of hours worked per week		Salary/Wages <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Annual \$ _____		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner		
Are you currently on COBRA? <input type="checkbox"/> Yes <input type="checkbox"/> No				COBRA Qualifying Event		
If yes, qualifying event:				Effective Date		
Residence Mailing Address						
City			State	ZIP	Date of Birth (mm-dd-yy)	
Home Telephone () () ()			Work Telephone () () ()			

Your Employer Completes This Section
Group #/Plan Code
Dental/Vision Group #
Life/STD/LTD Group and Policy #s
Source of Enrollment: <input type="checkbox"/> QMCSO <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Employee Status Change <input type="checkbox"/> New Hire <input type="checkbox"/> Rchire
Employee Class
Requested Effective Date
Employer Verification

Selected Coverage (Select only the plans offered by your Employer)	
Medical	Individual(s) to be covered: <input type="checkbox"/> Self <input type="checkbox"/> Self + Spouse <input type="checkbox"/> Self + Dependent(s) <input type="checkbox"/> Self + Family <input type="checkbox"/> Waive Medical Plan Options: <input type="checkbox"/> PacifiCare SignatureValue (HMO) – High <input type="checkbox"/> PacifiCare SignatureOptions (PPO) – High <input type="checkbox"/> PacifiCare SignatureIndependence (Indemnity) <input type="checkbox"/> PacifiCare SignatureValue (HMO) – Low <input type="checkbox"/> PacifiCare SignatureOptions (PPO) – Low <input type="checkbox"/> PacifiCare SignatureFreedom (SDHP)
Dental	Individual(s) to be covered: <input type="checkbox"/> Self <input type="checkbox"/> Self + Spouse <input type="checkbox"/> Self + Dependent(s) <input type="checkbox"/> Self + Family <input type="checkbox"/> Waive Dental Plan Options: <input type="checkbox"/> PacifiCare SignatureOptions (Dental PPO) <input type="checkbox"/> PacifiCare SignatureIndependence (Dental Indemnity)
Vision	Individual(s) to be covered: <input type="checkbox"/> Self <input type="checkbox"/> Self + Spouse <input type="checkbox"/> Self + Dependent(s) <input type="checkbox"/> Self + Family <input type="checkbox"/> Waive Vision Plan Options: <input type="checkbox"/> PacifiCare SignatureOptions (Vision PPO)
Life/Disability	<input type="checkbox"/> Life/AD&D <input type="checkbox"/> Short Term Disability <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Waive STD <input type="checkbox"/> Waive LTD <input type="checkbox"/> Waive Life

I desire to participate in the coverages selected above and hereby authorize my Employer to make the necessary deduction(s) from my wage/salary to pay my portion of the premium.
Initials: _____

- Primary Care Physician (PCP) selection is only required if a PacifiCare SignatureValue plan is selected (if you do not select a PCP, one will be assigned).
- Please select a PCP from the Provider Directory for you and each of your family members by writing the PCP name and number below.
- You may choose a different PCP for each member of your family.

Employee & Dependent Information (List yourself and family members to be covered – attach additional sheets if necessary)

Self	Primary Care Physician (PCP) Name & # (for PacifiCare SignatureValue only)	Medical Group # (if applicable)	Existing Patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Dentist Name & City (for PacifiCare SignatureValue only)	Dental Facility #	Existing Patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse/Domestic Partner*	<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name	First Name	M.I.
	Date of Birth (mm-dd-yy)	Social Security #	Address, if different than Employee's	
	Primary Care Physician (PCP) Name & # (for PacifiCare SignatureValue only)	Medical Group # (if applicable)	Existing Patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Dentist Name & City (for PacifiCare SignatureValue only)	Dental Facility #	Existing Patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent 1	<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name	First Name	M.I.
	Date of Birth (mm-dd-yy)**	Relationship		
	Social Security #	Address, if different than Employee's		
	Primary Care Physician (PCP) Name & # (for PacifiCare SignatureValue only)	Medical Group # (if applicable)	Existing Patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Dentist Name & City (for PacifiCare SignatureValue only)	Dental Facility #	Existing Patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent 2	<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name	First Name	M.I.
	Date of Birth (mm-dd-yy)**	Relationship		
	Social Security #	Address, if different than Employee's		
	Primary Care Physician (PCP) Name & # (for PacifiCare SignatureValue only)	Medical Group # (if applicable)	Existing Patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Dentist Name & City (for PacifiCare SignatureValue only)	Dental Facility #	Existing Patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent 3	<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name	First Name	M.I.
	Date of Birth (mm-dd-yy)**	Relationship		
	Social Security #	Address, if different than Employee's		
	Primary Care Physician (PCP) Name & # (for PacifiCare SignatureValue only)	Medical Group # (if applicable)	Existing Patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Dentist Name & City (for PacifiCare SignatureValue only)	Dental Facility #	Existing Patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No

* Please verify that domestic partner coverage is available through your Employer.

** Over age Dependents require proof of full-time student status or permanent disability status within 31 days of enrollment.

Employee Name	Social Security #
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Benefit Coordination/Other Insurance Carrier Information

1. Does anyone listed have other health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete section below ↓		2. Is anyone listed permanently disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the following: 2a. Name _____ 2b. Date disability began _____		3. Is anyone listed eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the following: 3a. Name _____ 3b. Medicare ID# _____	
1a. Name	1b. Insurance Company Name	1c. Policy #	1d. Effective Date	1e. Other Employer Name and Address	

*** Group Life Insurance [Complete only if your Employer is offering this benefit]**

I apply for coverage for:	<input type="checkbox"/> Self Only <input type="checkbox"/> Self and Eligible Dependents	Employee's Benefits – Life: \$	AD&D: \$	Supp. Life:** \$
Spouse – Date of Birth (mm-dd-yy)	Amount: \$	Children – <input type="checkbox"/> One child <input type="checkbox"/> Two or more	Per child amount: \$	

As a covered employee, you have the right to select and/or change your beneficiary(ies) in accordance with the provisions of your policy.

Life Insurance Primary Beneficiary (full name)***	Phone Number ()	Relationship***
Contingent Beneficiary (full name)	Phone Number ()	Relationship

** Evidence of Insurability may be required.

*** Your spouse MUST sign this form if: (a) you are a resident of AZ, CA, ID, LA, NV, NM, TX, WA or WI **and** (b) you designate someone other than your spouse as beneficiary

Spouse Signature	Date
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*** Group Long Term Disability (LTD) & Group Short Term Disability (STD) Insurance [Complete only if your Employer is offering this benefit]**

Job Duties

I understand that a medical examination, at my own expense, may be required if I want to participate at a later date.

Employee Signature X	Date
LTD/STD Insurance Beneficiary (full name)	Relationship

* Life coverage is underwritten by Continental Assurance Company or CNA Group Life Assurance Company. Long Term Disability and Short Term Disability are underwritten by Continental Casualty Company or CNA Group Life Assurance Company. The issuing company is identified on the group policy.

Signature

By signing below, I acknowledge that I have read, understand and agree to the Terms and Conditions on all pages of this form. A reproduction of this authorization shall be as valid as the original.

Signature (Required) X	Date (Required)
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PacifiCare SignatureValue

P.O. Box 400046
San Antonio, TX 78229
1-800-825-9355
1-800-557-7595 (TDHI)

**PacifiCare SignatureOptions and
PacifiCare SignatureIndependence**

P.O. Box 6098
Cypress, CA 90630
1-866-316-9776
1-866-816-2018 (TDHI)

PacifiCare SignatureFreedom

P.O. Box 69312
Harrisburg, PA 17106-9312
1-866-867-0700
1-866-866-0701 (TDHI)

**PacifiCare Dental & Vision
Administrators**

P.O. Box 25187
Santa Ana, CA 92799
1-800-228-3384

CNA Group Life and Disability

1-866-262-7316 (CNA benefits)
1-888-726-3449 (CNA claims)

Visit our Web site @ www.pacificare.com