How to Apply for PacifiCare Individual Plans

You Are Now Ready to Apply

Here are the steps to follow to ensure your application is processed as quickly as possible.

1. Complete the Enrollment Application

Be sure to answer all questions completely and provide all the requested information. Incomplete information may result in a processing delay.

- ***Print clearly using black ink.*** Please don't type on your form. You, as the applicant, must complete the application in your own handwriting.
- ***Select the date you wish coverage to become effective.*** PacifiCare only allows first-of-the-month effective dates. Actual effective dates are determined by PacifiCare. **Do not cancel any existing coverage until you are notified by PacifiCare that you have been accepted.**
- ***Select your method of payment – monthly debit or monthly direct bill.*** Determine the amount of premium you need to submit with your application by referring to the *Monthly Premium for Individual Plans* enclosed with this brochure.
  - – If you and your Spouse/Domestic Partner are both applying, use the younger of your ages in determining your premium.
  - – Be sure to include your first premium payment with this application.
- ***Complete the Applicant Information section.*** Please list the younger Spouse/Domestic Partner (if applying) as the Primary Applicant. If the parent/guardian is applying for a child only, list the child's name as the Primary Applicant.
- ***Complete the Enrollment Information section and list each applicant applying.*** PacifiCare SignatureValue℠ (HMO) applicants must select a Primary Care Physician. Please visit our Web site at **www.pacificare.com** for assistance. When applying for the PacifiCare SignatureValue (HMO) plan, every applicant must choose a Primary Care Physician, along with the appropriate provider number, from this directory.
- ***Enrollment Information.*** Please answer all the questions in this section. These questions will be used to assess your eligibility for guaranteed coverage available under the Health Insurance Portability and Accountability Act (HIPAA). If you wish to apply under HIPAA, you do not need to answer the Health Questionnaire. Please call Individual Sales for rates of coverage under HIPAA. You should complete the entire application and apply for the standard individual product, in case you do not qualify under HIPAA.

2. Complete the Health Questionnaire

Answer every question in full. Otherwise, your application may be returned to you, resulting in a delay in processing.

- ***Be sure to disclose all health history on the Health Questionnaire for all applicants listed on the application.*** Even if your application is approved, any omissions or false statements may result in future claims being denied and/or termination of your coverage.
- ***Include all requested details and explanations.*** If you need to include additional information or explanations, simply attach an extra sheet.
- If you do not meet the standard PacifiCare underwriting requirements for the plan you have applied for, you may be offered a different option under one of the PacifiCare SignatureOptions℠ (Preferred Provider Organization PPO) plans. You are under no obligation to enroll.

3. Send Your Completed Enrollment Application to PacifiCare

- ***Review your application to be sure it is complete.***
- ***Sign and date your application.*** You, your Spouse/Domestic Partner (if applying) and any listed Dependent age 18 or over must sign and date the application.
- ***Mail your application to:***

  PacifiCare Individual Plans
  Individual Underwriting
  M/S # CY24-155
  P.O. Box 3069
  Cypress, CA 90630

  Before sealing the envelope be sure to enclose:

  – Your completed Enrollment Application

  – Your first premium payment (check or Credit Card Payment Authorization Form)

Please note: Coverage does not become effective under any circumstances until an application has been underwritten and approved by PacifiCare.

Your Individual Plan Enrollment Application

PacifiCare®

IMPORTANT: PLEASE *PRINT* IN BLACK INK. *Every* question must be answered completely by applicant or guardian. Application must be signed to be valid.

1. Application, Plan & Payment Information

A. Please check one: ☑ New Enrollment ☐ Adding Dependents to _____ (Subscriber Name) _____ (Subscriber ID Number)

☐ Plan Change ☐ HIPAA (Health Insurance Portability and Accountability Act) Attach Certificate of Creditable Coverage or other documentation showing prior coverage.

B. Requested Effective Date: 1st day of ____ (mm) – ____ (yy) *Note: Your requested effective date is not guaranteed. Actual effective date is determined by PacifiCare.*

C. Select ONE Plan:

PacifiCare SignatureValue℠ (HMO)
☐ 10-35/250d ☐ 20-35/80
☐ 35/70 ☐ 35/50

PacifiCare SignatureFreedom℠ (SDHP)
☐ 70-50/3000 ☐ 70-50/5000

PacifiCare SignatureOptions℠ (PPO)
☐ 70-50/1000 (with maternity) ☐ 70-50/500
☐ 70-50/1500 (with maternity) ☐ 70-50/1000
☐ 60-50/2500 ☐ 70-50/2000
☐ 70-50/5000 ☐ 70-50/3000

PacifiCare SignatureOptions℠ (HSA-Compatible)
☐ 100-50/5000 ☐ 35/80-50/2700

PacifiCare SignatureValue℠ (HMO) HIPAA
☐ 10-35/250d ☐ 35/70

PacifiCare SignatureOptions℠ (PPO) HIPAA
☐ 70-50/2000 ☐ 70-50/3000

D. Payment Options
Choose your payment method for:
1. First month payment; and
2. Recurring monthly
Payment will be deducted only if application is approved.

First Month Payment (please select one option)
☐ Check enclosed: amount of $_____
☐ Credit card (for this payment method you must enclose your completed Credit Card Payment Authorization Form)

Recurring Monthly Payment (please select one option. Credit card payment is not available for monthly option)
☐ Monthly Bill
☐ Monthly Easy Pay (For this payment method, you must enclose your completed Easy Pay form and a voided check)

2. Applicant Information

Important: If married and both Spouses/Domestic Partners are applying for coverage, indicate younger Spouse's/Domestic Partner's name as the Primary Applicant

Primary Applicant's Name _____ (Last) _____ (First) _____ (MI)

Home Address (P.O. Box not acceptable) _____ (Street) _____ (Apt #) _____ (City) _____ (State) _____ (ZIP)

Mailing Address (If different from home address) _____ (Street) _____ (Apt #) _____ (City) _____ (State) _____ (ZIP)

Billing Address (If different from mailing address) _____ (Street) _____ (Apt #) _____ (City) _____ (State) _____ (ZIP)

Phone No. (____) _____ (Home) (____) _____ (Work) **Marital Status** ☐ Single ☐ Married ☐ Domestic Partner

Applicant's Occupation _____ **Spouse's/Domestic Partner's Occupation** _____

3. Enrollment Information

List yourself and all eligible Dependents applying for coverage. **Each applicant applying for a PacifiCare SignatureValue (HMO) plan must select a Primary Care Physician.** You may choose the same or a different Primary Care Physician for each applicant. *Please refer to the* PacifiCare SignatureValue (HMO) Provider Directory *to make your choice and find the Primary Care Physician Code Number.*

Relation	Last Name	First Name	MI	Social Security #	Height	Weight	Birth Date Mo/Day/Yr	PacifiCare SignatureValue only Primary Care Physician (PCP) Name	PacifiCare SignatureValue Provider # (10-digits)	Current Patient of PCP? Y = Yes N = No
☐ Male ☐ Female	Applicant									
☐ Male ☐ Female	Spouse/Domestic Partner									
☐ Son ☐ Daughter										
☐ Son ☐ Daughter										
☐ Son ☐ Daughter										

Do all applicants reside with primary applicant? ☐ Yes ☐ No If no, please indicate name and mailing address of Dependent(s) below.

3. Enrollment Information (continued)

Has any applicant ever been a PacifiCare Member? ❑ Yes ❑ No

If yes, please provide the name used and the PacifiCare ID #, if known. _____

1. Do you have other coverage available to you, such as through your spouse/domestic partner, current employer, Medicare, or Medicaid? ❑ Yes ❑ No
2. Have you had 18 months of prior coverage, with no greater than a 62-day gap in coverage? ❑ Yes ❑ No
3. Was the last coverage you had a GROUP (employer-sponsored), Government or Church Plan? ❑ Yes ❑ No
4. Was the last coverage you had terminated due to non-payment of premium or fraud? ❑ Yes ❑ No

5a. Was COBRA or Cal-COBRA available to you when your last coverage was terminated? ❑ Yes ❑ No

5b. If yes, did you elect and exhaust your COBRA or Cal-COBRA coverage? ❑ Yes ❑ No

4. Health Questionnaire

A. Have any applicants listed on this application ever had or been treated for any of the following conditions? Please indicate either "yes" or "no." If yes, provide more details in Section B below. **Incomplete information will result in a processing delay.**

All questions must be answered

	YES	NO	CONDITION
1	❑	❑	Acquired Immune Deficiency (AIDS)/AIDS Related Complex (ARC)
2	❑	❑	ADD (Attention Deficit Disorder)/ADHD
3	❑	❑	Alcoholism and/or Drug Abuse
4	❑	❑	Allergies and/or Asthma
5	❑	❑	Anemia
6	❑	❑	Arthritis or Rheumatism
7	❑	❑	Back/Spinal Condition
8	❑	❑	Bacterial Infections, Multiple or Reoccurring
9	❑	❑	Birth Defect
10	❑	❑	Bladder Condition
11	❑	❑	Blood Condition – Past 10 Years
12	❑	❑	Bone Infection or Disorder
13	❑	❑	Breast Conditions/Implants
14	❑	❑	Cancer
15	❑	❑	Chronic Fatigue
16	❑	❑	Colon, Rectal, Bowel Condition
17	❑	❑	Cysts, Tumors, Growths or Fibroids
18	❑	❑	Depression/Anxiety/ Emotional Condition(s)
19	❑	❑	Diabetes
20	❑	❑	Disability/Disabled
21	❑	❑	Ear Condition
22	❑	❑	Emphysema

Incomplete information will result in a processing delay

	YES	NO	CONDITION
23	❑	❑	Epilepsy, Convulsions, Seizures
24	❑	❑	Eye Condition
25	❑	❑	Fibromyalgia
26	❑	❑	Gallbladder Condition
27	❑	❑	Headaches or Migraines
28	❑	❑	Heartburn/Gastroesophageal Reflux Disease (GERD)
29	❑	❑	Heart Problems or Disorders
30	❑	❑	Hemorrhoids
31	❑	❑	Hepatitis
32	❑	❑	Hernia
33	❑	❑	High Blood Cholesterol and/or Triglycerides If yes, Last Reading _____ **(Please explain below.)**
34	❑	❑	High Blood Pressure If yes, Last Reading _____ **(Please explain below.)**
35	❑	❑	Impotence
36	❑	❑	Jaw Condition or TMJ
37	❑	❑	Joint Condition
38	❑	❑	Kaposi's Sarcoma
39	❑	❑	Kidney Condition
40	❑	❑	Liver Condition
41	❑	❑	Lung or Respiratory Condition
42	❑	❑	Lupus
43			Mental Health Conditions
	❑	❑	Schizophrenia
	❑	❑	Schizoaffective Disorder
	❑	❑	Bipolar Disorder
	❑	❑	Major Depressive Disorder
	❑	❑	Panic Disorder
	❑	❑	Obsessive-Compulsive Disorder
	❑	❑	Autism and other pervasive developmental disorders
	❑	❑	Anorexia
	❑	❑	Bulimia Nervosa
	❑	❑	Any other mental or nervous conditions? (If yes, please explain below.)
44	❑	❑	Muscle Disorder
45	❑	❑	Neurological Condition
46	❑	❑	Non-Hodgkin's Lymphoma
47	❑	❑	Paralysis
48	❑	❑	Phlebitis or Blood Clot
49	❑	❑	Prostate Disorder
50	❑	❑	Sexually Transmitted Diseases
51	❑	❑	Skin Condition
52	❑	❑	Stomach or Abdominal Condition
53	❑	❑	Stroke
54	❑	❑	Thyroid Condition
55	❑	❑	**Does any applicant listed on this application have any other conditions not described above?** (If yes, please explain below.)

B. Give details for ALL "YES" ANSWERS indicated above in Section A. If you need more space for explanation, please attach a separate piece of paper.

Condition #	Applicant Name	Condition Description	Date First Diagnosed and/or Treated	Date of Most Recent Dr. Visit	Duration of Condition	Treatment/Medication		Name, Address & Phone # of Physician
						Type/Name	Date Discontinued	

C. Has any applicant listed on this application seen a Medical Practitioner, for any reason, in the past two years? ◯ Yes ◯ No
If yes, please provide details below:

Applicant(s) Name	Medical Practitioner Name	Complete Address/Telephone	Date	Reason/Result and Treatment/Recommendation

D. Please complete the following for ALL applicants listed on this application.
If you need more space for explanation, please attach a separate piece of paper.

Incomplete information will result in a processing delay

1. In the event one or more applicant(s) listed on this application is denied coverage, should PacifiCare continue the underwriting and enrollment process for the remaining eligible applicants? ◯ Yes ◯ No

2. Has any applicant listed on this application ever been advised to have an operation or treatment (including dental work) **that has not yet been performed?** ◯ Yes ◯ No
If yes, state individual's name(s) and explain (include date):

3. Has any applicant listed on this application been refused or restricted life or health insurance coverage within the last five years? ◯ Yes ◯ No If yes, state applicant's name(s) and give details:

4. Has any applicant listed on this application used tobacco products in the past 12 months? ◯ Yes ◯ No
If yes, please provide the following information:

NAME START DATE STOP DATE DAILY AMOUNT

NAME START DATE STOP DATE DAILY AMOUNT

5. Does any applicant listed on this application presently consume alcoholic beverages? ◯ Yes ◯ No
If yes, please provide the following information:

NAME ❑ 0 – 1 drinks per day ❑ 2 – 3 drinks per day ❑ 4+ drinks per day

NAME ❑ 0 – 1 drinks per day ❑ 2 – 3 drinks per day ❑ 4+ drinks per day

6. Does any applicant listed on this application use narcotics, hallucinogenics, amphetamines, barbiturates, or other illegal drugs, or has used drugs other than in accordance with the instructions or prescription for use? ◯ Yes ◯ No
If yes, state applicant's name(s) and explain **(include date and duration):**

7. Does any applicant listed on this application currently take prescription drugs? ◯ Yes ◯ No If yes, list applicant's name(s), drug name(s), dosage and date started:

NAME DRUG DOSAGE/DATE STARTED

NAME DRUG DOSAGE/DATE STARTED

NAME DRUG DOSAGE/DATE STARTED

8. Has any applicant listed on this application been hospitalized, been seen in an emergency room or been in therapy/counseling (mental, physical or emotional) within the last five years? ◯ Yes ◯ No If yes, state applicant's name(s) and explain **(include date and duration):**

9. Is any applicant listed on this application currently covered by medical insurance or a health care plan? ◯ Yes ◯ No ◯ Group or ◯ Individual If yes, provide the name of the insurance company or health care plan and effective date of coverage:

FEMALES ONLY (including Spouse/Domestic Partner and Dependents)

10. Has any female applicant listed on this application been treated in the last five years for infertility or any other female disorder? ◯ Yes ◯ No If yes, state applicant's name(s) and explain **(include date and duration):**

11. Please provide the date of last Pap smear: _____

Results:

12. Has every female applying for coverage had, during the last 6 months, a menstrual period every month, including in the last 30 days? If no, state name and reason.

NAME MONTH DAY YEAR

NAME MONTH DAY YEAR

13. Are any females applying for coverage currently pregnant? ◯ Yes ◯ No

MALES ONLY (including Spouse/Domestic Partner and Dependents)

14. Is any male applicant listed on this application an expectant father, even if the mother is not listed on this application? ◯ Yes ◯ No If yes, state applicant's name:

5. Terms & Conditions

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 PacifiCare is not liable for bills incurred before the effective date.
3. I agree that if this application is approved, PacifiCare will notify the applicant in writing of the effective date of coverage.
4. 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.
5. 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.
6. I agree that failure to provide full, complete, true and accurate information may result in the denial of benefits, termination and/or rescission of membership in PacifiCare for myself and/or my Dependents.
7. 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.
8. 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, 5701 Katella Avenue, Cypress CA 90630. 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.
9. 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.

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

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), EXCEPT FOR CLAIMS SUBJECT TO ERISA, 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.

6. Signatures

SIGNATURE OF APPLICANT/PARENT OR LEGAL GUARDIAN *(Required)*	**TODAY'S DATE** *(Required)*
X	

SIGNATURE OF APPLICANT'S SPOUSE/DOMESTIC PARTNER *(Required if applying)*	**TODAY'S DATE** *(Required)*
X	

SIGNATURE OF APPLICANT'S DEPENDENT AGE 18 OR OVER *(Required)*	**TODAY'S DATE** *(Required)*
X	

SIGNATURE OF APPLICANT'S DEPENDENT AGE 18 OR OVER *(Required)*	**TODAY'S DATE** *(Required)*
X	

■ **CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH CARE SERVICE PLANS AND INSURANCE COMPANIES AS A CONDITION OF OBTAINING COVERAGE.** ■

For Agent's Use Only

Agent Name	Firm Name	License No.	Tax I.D. No.
Oleg Skurskiy	No Firm	0E50389	

Payee ☐ AGENT ☐ FIRM — Is payee currently contracted with PacifiCare? ☐ Yes ☐ No If no, please submit a copy of payee's license — GA Name/Number _____

Street Address	City	State	ZIP
18440 Hatteras st 210	Tarzana	CA	91356

Agent's Signature	Date	Phone Number	Fax Number	E-mail Address
		(818) 987-5000	( ) -	oleg@askoleg.com

Is this the payee's first individual application with PacifiCare? ☐ Yes ☐ No Best way to contact: _____

Are you aware of any information not disclosed in this Health Questionnaire which may have a bearing on this risk? ☐ Yes ☐ No If yes, explain: _____

Did you see the applicant and did you ask each question on the Health Questionnaire exactly as set forth? ☐ Yes ☐ No If no, explain: _____

Was this Health Questionnaire completed by the applicant? ☐ Yes ☐ No

PacifiCare Individual Plans
Individual Underwriting
M/S CY24-155
5701 Katella Avenue
Cypress, CA 90630

Individual Sales:
800-577-0001
800-442-8833 (TDHI)
www.pacificare.com

PCA077845-002

Ref No.

Additional Dependents

Relationship	Last Name	First Name	MI	Social Security Number	Height	Weight	Birth Date Mo/Day/Yr	Primary Care Physician (PCP) Name **HMO Only**	PacifiCare Provider # **HMO Only**	Network (PMG)
☐ Male ☐ Female										
☐ Male ☐ Female										
☐ Male ☐ Female										
☐ Male ☐ Female										
☐ Male ☐ Female										

If you answered "Yes" to any of the General Health Questions (Section 4.A), provide details below:

Cond. #	Family Member Name	Condition Description	Date First Diagnosed and/or Treated	Date of Most Recent Drs. Visit	Duration of Condition	Treatment/Medication		Name, Address, & Phone # of Physician
						Type/Name	Date Discont'd	

Ref No.

If you answered "Yes" to any of the General Health Questions (Section 4.A), provide details below:

Cond. #	Family Member Name	Condition Description	Date First Diagnosed and/or Treated	Date of Most Recent Drs. Visit	Duration of Condition	Treatment/Medication		Name, Address, & Phone # of Physician
						Type/Name	Date Discont'd	

Ref No.

Details for Question 11 (Section D):

Family Member Name	Date of Last Pap Smear Exam	Exam Results

PacifiCare®

Medical Records Release Authorization Statement

Reference Number:
Plan Name:
Coverage Type:
Primary Applicant:
Monthly Premium:
Date Submitted:

I hereby authorize any physician, health care practitioner, hospital or other health care facility, clinic, medical group, health care service plan, or any other person or entity to release to PacifiCare Life or its designee my medical records and the medical records of my dependents, including mental health medical records from drug and alcohol abuse treatment or prevention, for the following purposes: diagnosis or treatment; payment of health care services rendered; billing, claims management, medical data processing, or other administrative functions of PacifiCare; peer review, including reviewing the competence or qualifications of health care professionals; utilization review and quality assurance, including reviewing health care services with respect to medical necessity, level of care, or justification of charges; handling of member grievances or appeals, external independent review, or other health dispute resolution; coordination of care with providers of health care or other health care service plans; administering the PacifiCare health benefit plan; chronic disease management programs, to monitor or administer care of a member for a covered benefit, other uses specifically authorized by law. This authorization is effective immediately and remains in effect for the duration of coverage under my PacifiCare health plan. I understand that I have a right to receive a copy of this authorization upon request.

I have read, understand and agree to the above Medical Records Release Authorization Statement.

	Date (required)
Spouse (if applicable)	Dependent over 18 (if applicable)
Dependent over 18 (if applicable)	Dependent over 18 (if applicable)
Dependent over 18 (if applicable)	Dependent over 18 (if applicable)

Please mail application to:
PacifiCare Individual Plans
Individual Underwriting
M/S # CY24-155
5701 Katella Avenue
Cypress, CA 90630