

Member Enrollment/ Change of Status



Attn: Membership Accounting LC05-232
PacifiCare Dental & Vision Administrators
Post Office Box 25187
Santa Ana, CA 92799
Tel 800-228-3384
Fax 714-513-6507 or 714-513-6397

IMPORTANT: See other side for instructions. Please complete all sections. This form cannot be processed if information is incomplete.

New Enrollment <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire <hr/> <input type="checkbox"/> Change of Status	Change of Status <input type="checkbox"/> Name Change <input type="checkbox"/> Provider Change <input type="checkbox"/> Address Change <input type="checkbox"/> Telephone Change <input type="checkbox"/> Plan Change <small>(from PacifiCare SignatureOptionsSM to PacifiCare SignatureValueSM)</small> <input type="checkbox"/> Dependent Change <small>(Add or Remove)</small>	Dependent Change <small>Must be submitted to PDVA within 31 days of event. Date of Qualifying Event ____ / ____ / ____</small> <input type="checkbox"/> Marriage <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption/Placement <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> Divorce <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Other _____
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SUBSCRIBER *Please complete all sections. This form cannot be processed if information is incomplete.*

<input type="checkbox"/> Add <input type="checkbox"/> Remove	Employee last name	First name	MI	Date of hire / /
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / /	Social security number		Home phone ()
Mailing address		City	State	Zip
PacifiCare SignatureValue Dental facility number Dentist's name/city			Have you received treatment from this dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No	

DEPENDENTS *Please complete all sections. This form cannot be processed if information is incomplete.*

1 <input type="checkbox"/> Add <input type="checkbox"/> Remove	Relationship (<i>spouse, daughter, son</i>)	Last name	First name	MI
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / /	Social security number		
PacifiCare SignatureValue Dental facility number Dentist's name/city			Have you received treatment from this dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No	
2 <input type="checkbox"/> Add <input type="checkbox"/> Remove	Relationship (<i>spouse, daughter, son</i>)	Last name	First name	MI
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / /	Social security number		
PacifiCare SignatureValue Dental facility number Dentist's name/city			Have you received treatment from this dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No	
3 <input type="checkbox"/> Add <input type="checkbox"/> Remove	Relationship (<i>spouse, daughter, son</i>)	Last name	First name	MI
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / /	Social security number		
PacifiCare SignatureValue Dental facility number Dentist's name/city			Have you received treatment from this dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4 <input type="checkbox"/> Add <input type="checkbox"/> Remove	Relationship (<i>spouse, daughter, son</i>)	Last name	First name	MI
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / /	Social security number		
PacifiCare SignatureValue Dental facility number Dentist's name/city			Have you received treatment from this dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No	

PLAN SELECTION *Please complete all sections. This form cannot be processed if information is incomplete.*

Please mark the plan in which you are enrolling:

PacifiCare SignatureValue (HMO) Dental
 PacifiCare SignatureIndependenceSM (Indemnity) Dental*
 PacifiCare SignatureOptions (PPO) Dental*
 PacifiCare SignatureOptions Vision - Full Service*
 PacifiCare SignatureOptions Vision - Eyewear Only*
 Ortho
 No Dental
 No Vision
 No Ortho
 Other

Spouse's insurance carrier (*if applicable*) _____

EMPLOYER USE ONLY

Company name	Group number
Plan name	Enrollee's effective date of coverage

I understand and agree to the terms and conditions on the reverse side of this sheet.

X _____
Employee Signature Date

INSTRUCTIONS FOR COMPLETING ENROLLMENT FORM

- 1) **Check all appropriate boxes and print all information clearly:** It is important that you check all appropriate boxes. Be sure to indicate whether you are enrolling for the first time (*marked "New Enrollment"*) or changing your information (*marked "Change of Status"*).
- 2) **Subscriber:** This section must always be filled out completely. If you are on a PacifiCare SignatureValue Dental plan, don't forget to indicate the **PacifiCare SignatureValue Dental facility number/dentist/city** you have selected.
- 3) **Dependents:** All dependents you wish to be covered should be listed in this section with their selected **provider offices**. If you are adding or removing a dependent from coverage, also remember to mark the appropriate "ADD" or "REMOVE" box for that dependent. If your dependents are on a PacifiCare SignatureValue Dental plan, don't forget to indicate their **PacifiCare SignatureValue Dental facility number/dentist/city** selections.
- 4) **Plan information:** Please indicate the plan for which you are enrolling and your spouse's insurance carrier (*if applicable*).
- 5) **Refusal of Employee and/or Dependent Coverage:** If you do NOT wish coverage for either yourself or dependents, please complete and sign the **Refusal of Employee and/or Dependent Coverage Insurance** (form # PDVCA49REFUSE).
- 6) **Changing information:** If you are changing information previously submitted, please enter the changed information in the appropriate section. Be sure to mark the reason you are changing information in the box labeled "Change of Status" at the top of the form.
- 7) **Terms and Conditions:** Read the **Terms and Conditions** below and sign in the box on the front at the "X." **This form must be signed for coverage to be effective.**

MEMBER ENROLLMENT/CHANGE OF STATUS – CHECKLIST

This form cannot be processed if information is incomplete and will be returned. Please use this checklist to include all necessary information to process your enrollment form.

Subscriber:

- Signature
- Social Security Number
- Address
- Date of birth
- Facility selection (*for PacifiCare SignatureValue Dental plans*)

Group Administrator:

- Company name
- Group number
- Plan name
- Enrollee's effective date of coverage

TERMS AND CONDITIONS

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

For PacifiCare SignatureValue Dental plan members: PacifiCare Dental uses binding arbitration to resolve any and all disputes between PacifiCare Dental and group or member, including, but not limited to, allegations against PacifiCare Dental of medical malpractice (that is as to whether any dental services rendered under the PacifiCare Dental plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) and other disputes relating to the delivery of services under the PacifiCare Dental plan. PacifiCare Dental, group and member each understand and expressly agree that by entering into the PacifiCare Dental services group subscriber agreement or enrolling in the PacifiCare Dental plan and agreeing to be bound by the PacifiCare subscriber agreement, PacifiCare, group and member are each voluntarily giving up their constitutional right to have all such disputes decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

Group and member further understand that any disputes between group and member and a PacifiCare Dental contracting provider, including, but not limited to, claims against a PacifiCare Dental contracting provider for medical malpractice, are not governed by the PacifiCare subscriber agreement. However, PacifiCare Dental, group and member each expressly agree that the existence of any disputes between group or member and a PacifiCare Dental contracting provider, including, but not limited to, claims by group or member against a PacifiCare Dental contracting provider for medical malpractice, shall in no way affect the obligation to submit to binding arbitration all disputes between group or member and PacifiCare Dental.

For PacifiCare SignatureIndependence Dental /PacifiCare SignatureOptions Dental plan participants: ARBITRATION. If any Insured Person has a dispute, disagreement or claim against the Company, or any employee or agent of the Company, which has not been resolved or settled after exhaustion of the Company's grievance procedures, then the dispute or disagreement shall be resolved by arbitration. The provision shall be applicable to claims or controversies arising under the Policy. Arbitration shall be conducted in accordance with the Commercial Rules of Arbitration of the American Arbitration Association. The decision of the arbitrator(s) shall be binding upon the parties for all purposes and judgment upon the award granted by the arbitrator(s) may be entered in any court having jurisdiction thereof.