

California Southwest Carpenters Employee Enrollment Form (Please Print)



1. Personal Information (Please print on all sections of form)					
Company Name			Date of Hire		
Last Name	First Name	M.I.	Suffix	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Residence Mailing Address					
City			State	ZIP	
Home Telephone		Work Telephone		Date of Birth (mm-dd-yy)	
Social Security #		Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Widow <input type="checkbox"/> Single <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			
Preferred Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Other _____					
Census Information					
NOTE: Data collected in this section will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being. This information will not be used in the eligibility process.					
Race, check all that apply: <input type="checkbox"/> Black, African-American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other Race, please specify <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaskan Native _____					

Employer Required to Complete This Section
Group #/Plan Code
Source of Enrollment: <input type="checkbox"/> Open Enrollment <input type="checkbox"/> QMCSO <input type="checkbox"/> New Hire <input type="checkbox"/> Employee Status Change <input type="checkbox"/> Rehire
Requested Effective Date
Employer Verification/Signature
Employee Class

2. Selected Coverage (Select only the plans offered by your Employer)		
Medical Plan Options: <input type="checkbox"/> PacifiCare SignatureValue (HMO)	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 (Complete Waiver Form)

3. Employee and Dependent Information (List yourself and family members to be covered – attach additional sheets if necessary)					
Self	Primary Care Physician (PCP) Name			Provider #	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 from Employee's		
Preferred Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Other _____					
Primary Care Physician (PCP) Name			Provider #	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 from Employee's		
Preferred Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Other _____					
Primary Care Physician (PCP) Name			Provider #	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 from Employee's		
Preferred Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Other _____					
Primary Care Physician (PCP) Name			Provider #	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 from Employee's		
Preferred Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Other _____					
Primary Care Physician (PCP) Name			Provider #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

4. Benefit Coordination/Other Insurance Carrier InformationDoes anyone listed have other health insurance? Yes No If yes, complete section boxes a–e

a. Name	b. Insurance Company Name	c. Policy #	d. Effective Date	e. Other Employer Name and Address
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Is anyone listed eligible for Medicare? Yes No If yes, complete section boxes f–g

f. Name	g. Medicare ID#
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5. Authorization to Release Medical Information and Signature

I authorize United HealthCare Insurance Company and its affiliates (“UnitedHealthcare and Affiliates”) to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, who may be in possession of my confidential health information, to disclose my information to UnitedHealthcare and Affiliates. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my ability to enroll in the health plan or receive benefits, if permitted by law. I understand I may revoke this authorization at any time by notifying my UnitedHealthcare and Affiliates representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, UnitedHealthcare and Affiliates also request that I acknowledge the following, which I do: I understand that information I authorize a person or entity to obtain and use may be re-disclosed (with the exception of HIV/AIDS health information) and no longer protected by federal privacy regulations except as prohibited by state law. This authorization, unless revoked earlier, expires 30 months after the date it is signed.

I understand that I am completing a joint life and health application and that each response must be complete and accurate. I (we) request the indicated group medical coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contributions to be deducted from earnings. I (we) have not given the agent or any other persons any health information not included on the Request for Coverage. I (we) understand that the HMO/insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this Request for Coverage and any attachments.

Please maintain a copy of this authorization for your records.

Signature (Required) X	Employee Name (Please Print) (Required)	Date (Required)
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6. Signature Required on Binding Arbitration – Read Carefully**By signing below, I acknowledge that I have read, understand and agree to the Binding Arbitration. 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 MYSELF AND MY DEPENDENTS ENROLLED IN THE PLAN (INCLUDING ANY HEIRS OR ASSIGNS) AND PACIFICARE OF CALIFORNIA, UNITEDHEALTHCARE 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.

Signature (Required) X	Employee Name (Please Print) (Required)	Date (Required)
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CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH CARE SERVICE PLANS AS A CONDITION OF OBTAINING COVERAGE.

Health plan coverage provided by or through PacifiCare of California. Administrative services provided by PacifiCare Health Plan Administrators, Inc., Prescription Solutions, Ingenix, Inc. or ACN Group of California, Inc.. Behavioral health products are provided by PacifiCare Behavioral Health of California (PBHC), PacifiCare Behavioral Health, Inc. (PBHI) or United Behavioral Health (UBH).