Applying is Simple.
Just Follow These 3 Easy Steps…

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: **805-495-1122** fax: **805-371-8759**

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly.

Step 3

SEND THE COMPLETED APPLICATION TO:

Integrity First Insurance Services, Corp.
650 Hampshire Rd #108
Thousand Oaks, CA 91361

Please make your check payable to: PacifiCare

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

If you have questions please contact our office at: 805-495-1122

Thank you for choosing...

PacifiCare®
A UnitedHealthcare Company

UnitedHealthcare
PacifiCare

Important Information
For Applicants

Thank you for choosing PacifiCare of California Individual HMO!

To complete our underwriting process, we require the following for all applicants age 18 and over:

Completed Health History Questionnaire
Blood Draw
Urinalysis

To request these services, please call Examination Management Services Inc. (EMSI) at 1-800-USA-EMSI (1-800-872-3674). You will be asked to pay for the health exam and lab fees up front and can do so either by credit card or check. The total amount will be $143.00.

Once your request is processed and payment has been received, the order will be sent to a local Examination Management Services branch office who will contact you within 48 hours to schedule your appointment.

If you need to cancel or reschedule your appointment, please do so at least 24 hours in advance. If cancelled same day, you will be charged a rescheduling fee.

If you have any questions about this requirement, please call your PacifiCare sales representative.

PacifiCare®
UnitedHealthcare Company

Application *Packet*

California–HMO

Have you:

- ✓ *Signed all forms necessary for health insurance application?*
- ✓ *Answered all applicable questions?*
- ✓ *Selected a method of payment and enclosed a voided check, if you selected Automatic Bank Draft?*

PacifiCare
SignatureValue®
A select group of physicians

HOW TO APPLY FOR COVERAGE

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

1. Applicant and Dependent Information and Eligibility

Complete these sections of the application. If the parent or legal guardian is applying for child-only coverage, list the child as the applicant.

2. Coverage Information

a) Indicate who is applying for medical coverage and enter your requested effective date. We only allow first of the month effective dates. Actual effective dates are determined by PacifiCare. **Do not cancel any existing coverage until you are notified that your application has been approved.**

b) Enter the details of the plan you have selected:

Plan Name: PacifiCare SignatureValue®
Network Name: PacifiCare SignatureValue
PCP Copay/IP Hospital Copay:
Example: 10-35/250d or 35/50

c) To best answer the statement about your status as a HIPAA Eligible Individual, you may refer to questions 1–6, on page 4 of the application.

3. Medical History

Be sure to disclose all health history 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 or rescission of coverage.

Include all requested details and explanations. If you need to include additional information, attach an extra sheet of paper. Include your signature and date on the extra sheet.

4. Prior Coverage and Terms and Conditions of Coverage

Complete the questions on page 4 of the application.

Review all Terms and Conditions of the application and the Arbitration Disclosure.

SUBMITTING YOUR COMPLETED APPLICATION

- Review your application to be sure it is complete.
- Sign and date your application. Signatures are also required for your spouse and adult dependent child over the age of 18, if applying for coverage.
- Complete the Payment Authorization Form. Be sure to include your first premium payment payable to PacifiCare.
- Please submit your completed application to your agent/producer*. Agent signature is required on the application. FAX OR E-MAIL SUBMISSIONS MAY ALSO BE AVAILABLE. PLEASE CONTACT US TO REVIEW YOUR OPTIONS at 1-888-272-0389.

Note: Coverage does not become effective under any circumstances until an application has been approved.

** If no agent, please submit all applicable forms and payments to:*
PacifiCare Individual Plan
P.O. Box 3069
m/s CA120-0155
Cypress, CA 90630

California PacifiCare SignatureValue® HMO
Individual Plan Enrollment Application

PacifiCare SignatureValue®
A select group of physicians

❑ New Business ❑ Change in Benefits (specify requested date below in Coverage Information section) ❑ Dependent Add

This application is to be completed by the applicant applying for coverage. For child only, application is to be completed by the child's parent or legal guardian if child is not of legal age.

Applicant's Social Security Number ____________ **Group No.** (Home Office to assign) ____________

APPLICANT INFORMATION

Last Name ____________ First Name ____________ Initial ______

Home Address ____________ City ____________ State ______ Zip ______ County ____________
(PO Box, not acceptable)

Billing Address ____________ City ____________ State ______ Zip ______

Home Phone No. (   ) ____________ Best Time to Call ____________ Alternate Phone No. (if applicable) (   ) ____________

Gender ❑ M ❑ F Date of Birth ________ Height ________ Weight ________ ❑ Single ❑ Married ❑ Domestic Partner

Chosen Primary Care Physician's (PCP) Name & Provider # (10 digits) ____________ Network (PMG) ____________

Language (Optional) ❑ English ❑ Spanish ❑ Other ____________

Ethnicity (Optional) ❑ Caucasian or White ❑ Hispanic or Latino ❑ Black or African-American ❑ Not Provided ❑ American Indian or Alaskan Native ❑ Asian, Native Hawaiian, other Pacific Islander

Applicant's Occupation: ____________ **Spouse/Domestic Partner's Occupation:** ____________

❑ Yes ❑ No Are you a U.S. citizen? If no, list how long in the U.S.: ____________ **(Attach copy of valid permanent resident card)**

DEPENDENT ENROLLMENT INFORMATION

(If more space is needed, attach an additional sheet of paper, sign and date it.)

Spouse or Domestic Partner (First Name & M.I., last name if different): ____________ Soc. Sec. No. ____________ Date of Birth ____________
Gender ❑ M ❑ F Height ______ Weight ______ Chosen PCP Name & Provider # (10 digits) ____________ Network (PMG) ____________

Child (First Name & M.I., last name if different): ____________ Soc. Sec. No. ____________ Date of Birth ____________
Gender ❑ M ❑ F Height ______ Weight ______ Chosen PCP Name & Provider # (10 digits) ____________ Network (PMG) ____________

Child (First Name & M.I., last name if different): ____________ Soc. Sec. No. ____________ Date of Birth ____________
Gender ❑ M ❑ F Height ______ Weight ______ Chosen PCP Name & Provider # (10 digits) ____________ Network (PMG) ____________

Child (First Name & M.I., last name if different): ____________ Soc. Sec. No. ____________ Date of Birth ____________
Gender ❑ M ❑ F Height ______ Weight ______ Chosen PCP Name & Provider # (10 digits) ____________ Network (PMG) ____________

Dependents (age 19 through 23) attending school full-time, include name of dependent, name/address of school, and number of credits: ____________

❑ Yes ❑ No Do all dependents reside with the primary applicant? If no, please indicate name & mailing address of dependents: ____________

ELIGIBILITY

❑ Yes ❑ No Are you or any family members covered by or eligible for Medicare/Medicaid? If yes, list family members and their effective date: ____________

❑ Yes ❑ No Are you, any family member, or significant other pregnant or in the process of adoption or surrogacy (including those not applying for coverage)? ____________

❑ Yes ❑ No Are you or any eligible dependent disabled, receiving disability payments, or hospital confined? ____________

COVERAGE INFORMATION

Medical: ❑ Applicant ❑ Applicant/Family ❑ Applicant/Spouse or Domestic Partner ❑ Applicant/Child(ren) ❑ Child only

Plan Name ____________ Network Name (Optional) ____________

PCP Copay ________ IP Hosp Copay ________ **Requested effective date** ____________ (Actual effective date is determined by PacifiCare)

Upon signature of this application, I am indicating that I have selected the health plan within this Coverage Information section and that I fully understand the benefit levels of this plan.

❑ I am a HIPAA Eligible Individual as defined in the Prior Coverage section on page 3 of this application and I choose to apply for (HIPAA Eligible medical plan indicated): ____________

❑ I am a HIPAA Eligible Individual as defined in the Prior Coverage section on page 3 of this application but I choose to apply for the Non-HIPAA Eligible medical plan indicated. I understand there is no guarantee of coverage of the selected non-HIPAA plan regardless of my status as a HIPAA eligible individual.

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.

Home Office Use Only	Reviewed by: Date:	Effective date: Plan:	Approved/Denied: Premium:

Depending upon state law, this information may be used in determining whether your application is approved for coverage.

MEDICAL HISTORY

A. Within the past five years, has any person to be covered ever had any symptoms that would cause an ordinarily prudent person to seek medical care; had any conditions, diagnosis, consultation, routine follow-up, treatment, or therapy; been prescribed any medication; been monitored; or received counseling for any of following? (Provide details to "Yes" answers below.)

1) Digestive Disorder	**Yes**	**No**
a. Irritable Bowel, Spastic Colon	❑	❑
b. Colitis, Crohn's Disease	❑	❑
c. Gastric Reflux, Heartburn	❑	❑
d. Gallbladder Disease	❑	❑
e. Hepatitis, Other Liver Disorder	❑	❑
f. Other Digestive or Intestinal Disorder	❑	❑

2) Cardiovascular/Circulatory	**Yes**	**No**
a. High Blood Pressure, Hypertension	❑	❑
b. Mitral Valve Prolapse, Heart Murmur	❑	❑
c. Chest Pain, Heart Attack, Arrhythmia, Angina, Palpitations	❑	❑
d. Vascular Abnormality, Poor Circulation	❑	❑
e. Stroke, Transient Ischemic Attack	❑	❑
f. Other Heart Condition or Disease	❑	❑

3) Respiratory/Lung	**Yes**	**No**
a. Allergies, Asthma	❑	❑
b. Bronchitis, COPD, Emphysema	❑	❑
c. Sleep Apnea, Tuberculosis	❑	❑
d. Other Respiratory or Lung Disorder	❑	❑

4) Musculoskeletal/Nerve	**Yes**	**No**
a. Arthritis or Rheumatism, Carpal Tunnel	❑	❑
b. Neck, Back, Spinal Condition	❑	❑
c. Bone, Muscles, Joint Condition	❑	❑
d. Fracture, Dislocation, Internal Fixation	❑	❑
e. Lupus, Connective Tissue Disease	❑	❑
f. Osteoporosis, Osteopenia	❑	❑

5) Cyst/Tumor/Polyp/Malignancy	**Yes**	**No**
a. Cancer, Leukemia	❑	❑
b. Cyst, Growth, Lump, Tumor, Polyp	❑	❑
c. Hodgkin's or Non-Hodgkin's Lymphoma	❑	❑

6) Genitourinary	**Yes**	**No**
a. Fibrocystic Breast, Implants, Other Breast Condition	❑	❑
b. Ovarian Cyst, Uterine Fibroid	❑	❑
c. Infertility Testing or Treatment	❑	❑
d. Menstrual, Reproductive Organ Disorder	❑	❑
e. Abnormal Pap Smear	❑	❑
f. Prostate Gland Disorder, Abnormal PSA Test	❑	❑
g. Sexually Transmitted Disease	❑	❑
h. Urinary Tract, Bladder, Kidney Disorder	❑	❑

7) Eyes/Ears/Nose/Throat/Skin	**Yes**	**No**
a. Acne, Skin Disorder	❑	❑
b. Ear, Nose, Sinus, Throat, Mouth	❑	❑
c. Eye, Cataracts, Glaucoma, Other	❑	❑
d. Loss of Hearing, Deafness	❑	❑
e. Jaw Condition or TMJ	❑	❑
f. Vision Impairment, Blindness	❑	❑

8) Endocrine/Gland/Lymph/Blood	**Yes**	**No**
a. Blood Abnormality, Anemia	❑	❑
b. Elevated Cholesterol/Triglycerides	❑	❑
c. Diabetes, Pancreas, Elevated Glucose	❑	❑
d. Hormonal Disorder, Adrenal	❑	❑
e. Lymph Gland Disorder, Immune System	❑	❑
f. Thyroid, Goiter	❑	❑

9) Alcohol/Drug	**Yes**	**No**
a. Alcoholism, Alcohol Use (3+ drinks/day)	❑	❑
b. Drug or Substance Abuse, Illicit Use	❑	❑

10) Psychological	**Yes**	**No**
a. Anxiety, Panic Disorder	❑	❑
b. Depression, Major Depressive Disorder	❑	❑
c. Bipolar Disorder	❑	❑
d. Obsessive Compulsive Disorder	❑	❑
e. Schizophrenia, Schizoaffective Disorder	❑	❑
f. Anorexia, Bulimia Nervosa	❑	❑
g. Other Psychological Condition	❑	❑

11) Neurological	**Yes**	**No**
a. Cerebral Palsy, Muscular Dystrophy	❑	❑
b. Epilepsy, Seizures, Convulsions	❑	❑
c. Headaches, Migraines	❑	❑
d. Mental Retardation, Down Syndrome	❑	❑
e. Multiple Sclerosis, Paralysis	❑	❑
f. Other Neurological Disease or Disorder	❑	❑
g. Alzheimer's Disease, Dementia	❑	❑
h. Parkinson's Disease	❑	❑
i. Autism, Pervasive Develop. Disorder	❑	❑

12) General	**Yes**	**No**
a. Abnormal Test Results	❑	❑
b. Burns	❑	❑
c. Congenital Abnormality, Loss of Limb	❑	❑
d. Edema	❑	❑
e. Fibromyalgia, Chronic Fatigue	❑	❑
f. Hernia	❑	❑
g. Organ or Tissue Transplant	❑	❑
h. Pain Disorder	❑	❑
i. Surgical Implants	❑	❑
j. Chronic Infection	❑	❑
k. Ulcer	❑	❑

13) Other	**Yes**	**No**
a. Health disorders not listed above	❑	❑

B. ❑ Yes ❑ No Have you or any eligible dependent ever been declined, postponed, ridered, rescinded, or rated up for medical, disability, critical illness, or life insurance with another health plan or insurance carrier? If yes, explain: _____

C. ❑ Yes ❑ No In the past five years, have you or any person to be covered received treatment, received therapy, taken medication, or consulted a health care provider for any reason? If yes, explain: _____

D. ❑ Yes ❑ No Are you or any person to be covered currently taking any prescription medication, over-the-counter medication, vitamin therapy or alternative remedies? Please indicate the reason for use: _____

E. ❑ Yes ❑ No In the past five years, have you or any person to be covered been advised to have a test or treatment, been advised to obtain equipment or service or been advised of a condition that may require attention or treatment? If yes, was this prompted by complaints or symptoms? Explain: _____

F. ❑ Yes ❑ No Within the past five years, has any person to be covered been advised to seek treatment for or been advised to limit alcohol or drug use, been a member of any alcohol or drug abuse support group or used any controlled drug not prescribed by a doctor? If yes, explain: _____

G. ❑ Yes ❑ No Has any person to be covered ever been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex by a physician or member of the medical profession, or had a T-cell abnormality? If yes, list names: _____

H. ❑ Yes ❑ No Has anyone to be covered used tobacco products during the previous 12 months? If yes, list names: _____

Provide details to "YES" answers (If more space is needed, attach an additional sheet of paper, sign and date it.)

Question No./Letter	Name	Illness/Impairment	Dates Treated	Medications/Treatment/Surgery/Physician's Name & Address

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.

PRIOR COVERAGE

HIPAA Eligible Individual Determination - Please indicate yes or no to the following:

Yes	No	
❑	❑	1. As of the date on which you are applying for coverage, have you been covered under creditable coverage for at least 18 months with no more than a 63-day lapse in coverage?
❑	❑	2. Was your most recent period of coverage under a group health plan (employer-sponsored), a governmental plan, or a church plan?
❑	❑	3. If you were offered the option of continuation of coverage under COBRA, Cal-COBRA or a similar state continuation program, did you complete the allowable period of coverage?
❑	❑	4. Are you eligible for any of the following: a group health plan (employer-sponsored plan); Part A or Part B of Medicare; or a state plan under Medicaid, Medi-Cal, or any successor program?
❑	❑	5. Do you have other health insurance or coverage?
❑	❑	6. Was your most recent health insurance or coverage terminated for fraud, intentional misrepresentation of material fact, or individual nonpayment of premium?

If you answered YES to questions 1 through 3 and NO to questions 4 through 6, you or your dependents may qualify as a HIPAA Eligible Individual, and we may waive the pre-existing limitation for you and your dependents on selected plans. If qualifying as a HIPAA Eligible Individual, please attach a Certificate of Creditable Coverage from the prior plan, or any other documents to prove that you or your dependents had prior coverage.

❑ Yes ❑ No Are you or any dependents replacing coverage that was in effect within the last 63 days?

❑ Yes ❑ No Do you or any dependents to be covered have or intend to keep any health coverage, including COBRA and/or state continuation currently in force?

❑ Yes ❑ No Have you or any dependents ever been previously covered by PacifiCare?

If you answered "Yes" to any of the above questions, please complete the following section. If you answered "No" to all questions, please proceed to the Terms and Conditions of Coverage section.

Name(s) of covered individual	Insurance Company/Health Plan Name, Address and Phone	Policy or Group Number	Type of Coverage (individual, employer group, short term, COBRA, Medicare, other)	Effective Date	Termination Date

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TERMS AND CONDITIONS OF COVERAGE

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 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.

3) 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.

4) I agree that PacifiCare may terminate or rescind membership for any person covered under this plan, if I intentionally provided incomplete or incorrect material misstatements, omissions or false information or intentionally mispresent a material fact on this form, if I intentionally fail to provide PacifiCare with updated material changes to this form prior to enrollment.

5) 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.

6) 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 CA120-0155, P.O. Box 3069, Cypress CA 90630-9962. 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.

7) I understand that PacifiCare is not liable for bills incurred before the effective date.

8) 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.

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Arbitration Disclosure - By signing below, I acknowledge that I have read, understand and agree to the Arbitration Disclosure and the Terms and Conditions on all the pages of this application.

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), 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.

REQUIRED SIGNATURES

Applicant's Signature **X**_____ Date_____

Signature of applicant, authorized representative or if child only and not of legal age, signature of parent or legal guardian.

_____
(Print Name of Parent, Legal Guardian, or Authorized Representative)

If signed by a representative of Applicant, please indicate the representative's authority to act on behalf of Applicant. _____

Spouse/Domestic Partners Signature **X**_____ Date_____
(If spouse/domestic partner is to be covered)

Dependent's Signature (age 18 or older) **X**_____ Date_____
(If dependents are to be covered)

X_____ Date_____

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.

AGENT, BROKER, OR PRODUCER INFORMATION

PacifiCare compensates agents, brokers, or producers for the sale of certain products. Your premium is the same if you purchase coverage directly from PacifiCare or if you use a producer. Please contact your agent, broker, or producer, if applicable, regarding the amount of compensation. In addition, you may request information regarding agent, broker, or producer commissions attributable to your policy by contacting PacifiCare Membership Accounting.

Writing Agent, Broker, or Producer Name **Jason Mayling** (Please print) Carrier ID Number Assigned _____

Writing Agent, Broker, or Producer Address **650 Hampshire Rd #108** **Thousand Oaks, CA 91361** (Please include firm name if applicable)

Phone **805-495-1122** Fax **805-371-8759** E-mail **jmayling@integrityfirstins.c**

Best way to contact _____

General Agent Name (if applicable) _____ Carrier ID Number Assigned _____

General Agent Address _____

Writing Agent, Broker, or Producer Signature **X** _____ Date: _____

Payee Name and Address _____ (if other than the writing agent, broker, or producer)

If first individual application with PacifiCare: Dept. of Insurance License No. _____ State of License Issuance _____

❑ Yes ❑ No Are you aware of any information not disclosed in the Medical History Section of this Enrollment Application which may have a bearing on this risk? If yes, explain _____

❑ Yes ❑ No Did you see the applicant and did you ask each question on the Medical History Section of this Enrollment Application exactly as set forth? If no, explain _____

❑ Yes ❑ No Was the Medical History Section of this Enrollment Application completed by the applicant?

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.

Payment Authorization Form

(For use with HMO/MCO products only)

A. APPLICANT INFORMATION

Last Name_____ First Name _____ SS#_____

B. INITIAL METHOD OF PAYMENT

❑ Check Enclosed ❑ Credit Card (Complete Credit Card Authorization below)

CREDIT CARD AUTHORIZATION (AVAILABLE FOR FIRST MONTH PAYMENT ONLY)

❑ VISA ❑ MasterCard

Cardholder's First Name _____ Middle Initial _____ Last Name _____
(As it appears on credit card)

Cardholder's Address _____ Cardholder's Phone Number_____

Credit Card Number:_____ Verification Code_____ Expiration Date: _____
(16 digits required) (3 digits required from back of credit card) (MM/YYYY)

As a convenience, I request and authorize PacifiCare to charge my credit card account, identified above, for the payment of my health plan premium and any fees for the payment option(s) designated. In submitting this payment authorization with my application, I understand that the initial premium for my coverage may be adjusted based on my medical history (or that of any dependent to be covered) and agree that the additional amount(s) required may be charged to this account. I further agree that should this card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, PacifiCare will attempt to contact me, but shall be under no liability whatsoever, including any fees imposed by the card issuer, even though such dishonor may ultimately result in forfeiture of coverage.

Signature of Credit Cardholder **X** _____Date_____
(As it appears on credit card)

If the VISA/Mastercard request for payment is declined, a $25 nonrefundable service fee may be applied when allowed by state law.

C. ONGOING METHOD OF PAYMENT

❑ Automatic Monthly Bank Draft (Complete Bank Draft Authorization below)

❑ Monthly Direct Bill

BANK DRAFT AUTHORIZATION

Type of Account: ❑ Checking ❑ Savings

Account Holder Name _____ Financial Institution _____
(As it appears on financial institution records)

Routing/Transit # (9 digits required) _____ Account Number (9 digits required) _____

I (we) hereby authorize PacifiCare to initiate debit entries to my (our) account and the financial institution named above. PacifiCare will not be held responsible for coverage lapse or cancellation due to nonpayment of premium if the withdrawal is presented and not honored for any reason and the amount due is not paid. PacifiCare is not responsible for charges I (we) may incur from my (our) bank due to late notification of a termination or change. This authorization is to remain in full force and effect until PacifiCare has received written notice of my (our) intention to terminate this authorization. I (we) understand that I (we) must give at least 30 days advance notice to terminate or change this authorization. I (we) understand that PacifiCare retains the right to revoke or change my (our) authorization at any time.

If the automatic bank draft or direct payment by check transaction is returned for any reason, a $25 nonrefundable service fee may be applied when allowed by state law.

I understand that PacifiCare retains the right to revoke or change my authorization at anytime.

Signature of Primary Applicant/Parent or Legal Guardian **X** _____Date_____

Signature of Account Holder **X** _____Date_____
(If other than Primary Applicant/Parent or Legal Guardian)

Home Office Use Only

Authorization Date:_____ Transaction #: _____ ID #: _____

PacifiCare®

A UnitedHealthcare Company

Important Notice from PacifiCare of California About Prescription Drug Coverage and Medicare

Creditable Plans
HMO 35/70 (Standard, Conversion and HIPAA)
HMO 35/50
HMO 20-35/80 (Standard and HIPAA)
HMO 10-35/250d (Standard and HIPAA)
FHP Conversion

Please read this notice carefully. It has information about prescription drug coverage with the PacifiCare Individual Plans.

Creditable Plans

Individuals with Medicare may enroll in a standard Part D Medicare prescription drug plan starting November 15, 2005 through May 15, 2006. If after May 15, 2006, you go 63 days or longer without the standard Part D Medicare prescription drug coverage, or coverage that is at least as good as the standard Part D Medicare prescription drug coverage, your Part D monthly premium will go up at least 1% per month for every month after May 15, 2006. For example, if you go 19 months without coverage, your premium will always include a 19% penalty. You will have to pay this higher premium as long as you have Medicare Part D coverage. In addition, you may have to wait until next November to enroll.

The PacifiCare Plan's listed under Creditable Plans have coverage that is at least as good as the standard Part D Medicare prescription drug coverage. Therefore, you will NOT incur a late enrollment penalty if you later decide to enroll in a standard Part D Medicare prescription drug coverage plan.

Non-Creditable Plans

Prescription drug coverage that is *not creditable* means that the amount PacifiCare expects to pay on average for prescription drugs for members covered by your PacifiCare Plan in 2006 is less than what standard Medicare prescription drug coverage would be expected to pay on average.

This is important, because if you do not get Medicare prescription drug coverage (or *creditable* coverage) before May 15, 2006, you may have to pay a higher premium if you join later. If, after May 15, 2006, you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your Part D premium will go up at least 1% per month for every month after May 15, 2006 that you did not have that coverage. You will pay this higher premium for as long as you have the Medicare prescription drug coverage.

For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare coverage.

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You 2006" handbook. You can also get more information about Medicare prescription drug plans from these places:

- Visit www.medicare.gov for personalized help,
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number)
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Original Medicare customer service is available, 24 hours a day, including weekends.

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage after May 15, 2006, you may need to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

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PacifiCare®

Member/Enrollee Rights and Responsibilities

As a Member/Enrollee you have the right to receive information about, and make recommendations regarding, your rights and responsibilities.

You Have the Right to:

- Receive information about PacifiCare and the covered services under your plan/policy.
- Submit complaints regarding PacifiCare or contracting providers or request appeals for denied service.
- Be treated with dignity and respect and have your right to privacy recognized in accordance with state and federal laws.
- Discuss and actively participate in decision-making with your contracting provider regarding the full range of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
- Refuse any treatment or leave a medical facility, even against the advice of a contracting provider. Your refusal in no way limits or otherwise precludes you from receiving other medically necessary covered services for which you consent.
- Complete an Advance Directive, living will or other directive and provide it to your contracting provider to include in your medical record. Treatment decisions are not based on whether or not an individual has executed an advance directive.
- Exercise these rights regardless of your race, physical or mental disability, ethnicity, gender, sexual orientation, creed, age, religion, national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for your health care.

Your Responsibilities Are to:

- Review information regarding your benefits, covered services, any exclusions, limitations, deductibles or copayments and the rules you need to follow as stated in your *Evidence of Coverage*.
- Provide PacifiCare and contracting providers, to the degree possible, the information needed to provide care to you.
- Follow treatment plans and care instructions as agreed upon with your contracting provider. Actively participate, to the degree possible, in understanding and improving your own medical and behavioral health condition and in developing mutually agreed upon treatment goals.
- Accept your financial responsibility for health plan premiums, any other charges owed and any copayment or coinsurance associated with services received while under the care of a contracting provider or while a patient in a facility.

If you have questions or concerns about your rights, please call Customer Service at the phone number listed on the back of your membership card. If you need help with communication, such as help from a language interpreter, Customer Service representatives can assist you.

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
NO ACTION IS REQUIRED ON YOUR PART.

At PacifiCare the protection of our members' privacy and the confidentiality of medical information has always been a priority. We recognize that you depend upon us to safeguard your personal information and uphold your privacy rights. This document — which is based on state and federal law, as well as our own company code of ethics — offers a declaration of our commitment to preserving member confidentiality and privacy.

OUR PRIVACY PRACTICES

This notice describes PacifiCare's privacy practices for both current and former members. It explains how we use health information about you and when we may share that health information with others. It also informs you about your rights with respect to your health information and how you may exercise these rights. We are required by law to maintain the privacy of your health information and to send you a copy of this notice so that you are aware of how we maintain the privacy of your health information.

PacifiCare employees are required to comply with our policies and procedures to protect the confidentiality of health information. Any employee who violates our privacy policy is subject to a disciplinary process.
Employee access to health information is limited on a business "need-to-know" basis, such as: to make benefit determinations, pay claims, manage care, underwrite coverage, perform quality assessment measurements, administer a plan or provide customer service.

PacifiCare maintains physical, electronic and process safeguards that restrict unauthorized access to your health information. Such safeguards include secured office facilities, locked file cabinets, and controlled computer network systems and password accounts.

This notice applies to all applicable companies within the PacifiCare family of companies, which includes businesses owned or controlled by PacifiCare Health Systems, Inc. (PacifiCare).

Please share this notice with everyone covered by your policy or contract. You have a right to receive a copy of this notice upon request at any time. If you would like additional copies of the notice or have questions related to the information contained within the notice, please call Member/Customer Services at the toll-free number on your health plan identification card. You may also view a copy of this notice on our Web sites at **www.pacificare.com** and **www.securehorizons.com**.
Form #: PEW7275-004
Should any of our privacy practices change, we reserve the right to change the terms of this notice and to make the new notice effective for all health information that we maintain. We will provide you a copy of the revised notice and post the revised notice on our Web sites.

HEALTH CARE INFORMATION MAINTAINED AT PACIFICARE

When we refer to "information" or "health information" in this notice, we mean information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health and related health care services. Health information may be transmitted or shared in any form or medium (oral, written or electronic).

The health information we receive may vary by product; therefore, the examples that follow may not apply to all members, but are designed to represent the general categories of information that may be received and maintained by PacifiCare:

- Information provided by you on applications, forms, surveys and our Web sites, such as your name, address and date of birth;
- Information from physicians, hospitals or other health care providers, clinics, medical groups, or health care service plans;
- Information provided by your employer, benefits plan sponsor or association, regarding any group product that you may have;
- Information about your transactions and experiences with our affiliates, others and us, such as products or services purchased, account balances, payment history, claims history, policy coverage and premiums;
- Information from consumer or medical reporting agencies or other third parties, including medical and demographic information.

HOW WE MAY USE OR SHARE YOUR INFORMATION
The following categories describe how we may use and share your health information. For each category we provide examples that help illustrate each type of use or disclosure. Not every use or disclosure in a category will be listed. However, the ways in which we are permitted to use and share health information will fall into one of these categories.

For Treatment
We may share health information with your doctors or hospitals to help them provide medical care for you. For example, if you are hospitalized, we may allow the hospital staff access to any medical records sent to us by your doctor.

We may also use or share your health information with others to help coordinate and manage your health care. For example, we may talk to your doctor to suggest a disease management or wellness program that can help improve your health.

For Payment
We may use your health information when paying your medical bills submitted to us by you or your health care providers, such as doctors and hospitals. Examples of payment activities include billing, claims management and other related administrative functions.

For Health Care Operations
We may use or share certain health information for necessary health care operations. Examples of health care operations include the following:

- Performing quality assessment and improvement activities;
- Evaluating provider and health plan performance;
- Providing underwriting coverage;
- Conducting or arranging medical reviews to determine medical necessity, level of care or justification of services;
- Performing auditing functions;
- Resolving internal grievances, such as addressing problems or complaints about your access to care or satisfaction with services;
- Making benefit determinations, administering a benefit plan and providing customer service; and
- Other uses specifically authorized by law.

We may also share your health information with other individuals or entities —also known as business associates — that perform payment or health care operations on behalf of PacifiCare. However, we will not share your health information with these business associates unless they agree in writing to protect the privacy of that information.

To Make Certain Communications to You
We may use or share your health information with a third party acting on behalf of PacifiCare in order to inform you about alternative medical treatments and programs or about health-related products and services that may be of value to you. We may also inform you about enhancements, replacements or substitutions to your health plan coverage.

(For members who reside in Oregon and Nevada, if you do not want PacifiCare to share health information as described above, you may "opt-out" by calling the Member/Customer Service toll-free number on your health plan identification card during normal business hours.)

Information Not Personally Identifiable
We may use or share your health information when it has been "de-identified." Health information is considered to be de-identified when it does not personally identify you.

We may also use a "limited data set" that does not contain any information that can directly identify you. This limited data set may only be used for the purposes of research, public health matters or health care operations. For example, a limited data set may include your city, county and ZIP code, but not your name or street address.

To the Employee Benefit Plan
Under certain circumstances, we may share limited health information about you with the employee benefit plan through which you receive health benefits. For example, we may share summary health information with the employee benefit plan so that they may obtain bids from other health plans, or modify, amend or terminate coverage with PacifiCare. We may also share health information related to your enrollment, disenrollment and/or participation in a PacifiCare health plan. We will not share detailed health information with your benefit plan unless they agree to maintain the privacy of your information.

(For members who reside in California, PacifiCare may not share your health information with your employer or benefit plan unless you provide written permission for us to do so.)

SPECIAL CIRCUMSTANCES AND STATE AND FEDERAL LAWS
Special situations and certain state and federal laws may require us to use or release your health information. For example, we may be obligated to release your health information for the following reasons:

- To comply with state and federal laws that require us to release your health information to others;
- To report information to state and federal agencies that regulate our business, such as the U.S. Department of Health and Human Services and your state's regulatory agencies;
- To assist with public health activities; for example, we may report health information to the Food and Drug Administration for the purpose of investigating or tracking a prescription drug and medical device malfunctions;
- To report information to public health agencies if we believe there is a serious threat to your health and safety or that of the public or another person; this includes disaster relief efforts;
- To report certain activities to health oversight agencies; for example, we may report activities involving audits, inspections, licensure and peer-review activities;
- To assist court or administrative agencies; for example, we may provide information pursuant to a court order, search warrant or subpoena;
- To support law enforcement activities; for example, we may provide health information to law enforcement agents for the purpose of identifying or locating a fugitive, material witness or missing person;
- To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official;
- To report information to a government authority regarding child abuse, neglect or domestic violence;
- To share information with a coroner or medical examiner as authorized by law (we may also share information with funeral directors, as necessary to carry out their duties);
- To use or share information for procurement, banking or transplantation of organs, eyes or tissues;
- To report information regarding job-related injuries as required by your state workers' compensation laws;
- To share information related to specialized government functions, such as military and veteran activities, national security and intelligence activities and protective services for the President and others;
- To researchers when their research has been approved by an institutional review board that has approved the research proposal and established protocols to ensure the privacy of your health information;
- To a family member or friend under any of the following circumstances: (1) if you provide a verbal agreement to allow such a disclosure;
  (2) if you are given an opportunity to object to such a disclosure and you do not raise an objection; or (3) if it can be inferred from the circumstances, based on PacifiCare's professional judgment, that you would not object.

WRITTEN PERMISSION TO USE OR SHARE YOUR INFORMATION
For any other activity or purpose not listed above or as otherwise permitted by law we must obtain your written permission — known as an authorization — prior to using or sharing your health information. If you provide a written authorization and you change your mind, you may revoke your authorization in writing at any time.

Once an authorization has been revoked, we will no longer use or share the health information as outlined in the authorization form; however, you should be aware that we may not be able to retract a use or disclosure that was previously made based on a valid authorization.

OTHER RESTRICTIONS REGARDING USE AND DISCLOSURE OF YOUR INFORMATION
Depending on the state in which you reside, there may be additional laws related to the use and disclosure of health information related to HIV status, communicable diseases, reproductive health, genetic test results, substance abuse, mental health and mental retardation.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION
The following are your rights with respect to your health information. If you would like to exercise the following rights, please call Member/Customer Service at the toll-free number on your health plan identification card.

You have the right to ask us to restrict how we use or share your health information for treatment, payment or health care operations. You also have the right to ask us to restrict health information that we have been asked to give to family members or to others who are involved in your health care or payment for your health care.

Please note that while we will try to honor your requests, we are not required by law to agree to the type of restrictions described above.

You have the right to request confidential communications of health information. For example, if you believe that sending your information to your current mailing address would put your safety at risk (e.g. in situations involving domestic disputes or violence), you may ask us to send the information by alternative means (such as by fax) or to an alternate address. We will accommodate reasonable requests for confidential communication of your information.

You have the right to inspect and obtain a copy of the health information we maintain about you in a designated record set. A designated record set refers to a group of records that includes enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for PacifiCare. The types of health information included in a designated record set may vary depending on the state in which you reside.

This right does not obligate us to grant you access to certain types of health information. Please note that under most circumstances we will not provide you with copies of the following information:

- Psychotherapy notes;
- Information compiled in reasonable anticipation of, or for use in, a civil or criminal administrative action or proceeding;
- Information subject to certain federal laws governing biological products and clinical laboratories;
- Medical information compiled and used for quality assurance or peer-review purposes.

If you request a copy of your designated record set, a fee for the costs of copying, mailing or other associated supplies may be charged.

Additionally, under certain circumstances we may deny your request to inspect or obtain a copy of your health information. If we deny your request, we will notify you in writing and may provide you the option to have the denial reviewed.

If you would like to request access to review or copy your patient medical records, please directly contact your Primary Care Physician or the health care provider who created the records. Patient medical records include records in any form or medium maintained by, or in the custody or control of, a health care provider relating to health history, diagnosis or condition of a patient, or relating to treatment provided or proposed to be provided to the patient.

You have the right to ask us to make changes to the health information that we maintain about you in your designated record set. These changes are referred to as amendments. We may require that your request be in writing and that you provide a reason for your request.
If we make the amendment, we will notify you that it was made. If we deny your request to amend, we will notify you in writing of the reason for denial. This written notification will explain your right to file a written statement of disagreement. In return, we have a right to rebut your statement. Furthermore, you have the right to request that your initial written request, our written denial and your statement of disagreement be included with your health information for any future disclosures.

You have the right to receive an accounting of certain disclosures of your health information made by us during the six years prior to your request. We may require that your request for an accounting be in writing. Your first accounting is free. Subsequently, you are allowed one free accounting upon request every 12 months. If you request an additional accounting within 12 months of receiving your free accounting, we may charge you a fee. We will inform you in advance of the fee and provide you with an opportunity to withdraw or modify your request.

Please note that, under most circumstances, we are not required to provide you with an accounting of disclosures of the following information:

- Any information collected prior to April 14, 2003;
- Information shared for treatment, payment or health care operations;
- Information already disclosed to you;
- Information shared as part of an authorization request;
- Information that is incidental to a use or disclosure that is otherwise permitted;
- Information provided for use in a facility directory;
- Information that was provided to persons involved in your care or for other notification purposes;
- Information shared for national security or intelligence purposes;
- Information that was shared or used as part of a limited data set for research, public health or health care operation purposes;
- Information disclosed to correctional institutions, law enforcement officials or health oversight agencies.

QUESTIONS REGARDING USE AND DISCLOSURE AND YOUR PRIVACY RIGHTS

How to File a Privacy Complaint

If you believe that your privacy rights have been violated, you may file a complaint with us by calling PacifiCare's Privacy Line at 1-800-481-6982. You may also direct your complaints to the Secretary of the U.S. Department of Health and Human Services.

PacifiCare will not penalize you or take any action against you for filing a complaint.

How to Obtain More Information Regarding Your Rights as well as the Use and Disclosure of Your Health Information

If you have any questions about how we use or share your health information or your rights regarding your health information, you may call Member/Customer Service at the toll-free number on your health plan identification card during normal business hours.

The PacifiCare Family of Companies includes:

PacifiCare Health Systems, Inc.
PacifiCare eHoldings
PacifiCare Health Systems Foundation
PacifiCare Health Plan Administrators, Inc.
PacifiCare Insurance Company
SeniorCo, Inc.
RxSolutions, Inc.
PacifiCare Behavioral Health, Inc.
PacifiCare Behavioral Health of California, Inc.
PacifiCare Behavioral Health of New Jersey, Inc.
PacifiCare Behavorial Health NY IPA, Inc.
Secure Horizons USA, Inc.
PacifiCare International Ltd.
PacifiCare Dental
PacifiCare Dental of Colorado, Inc.
PacifiCare Asia Pacific Insurance Brokers, Inc.
PacifiCare Health Insurance Company of Micronesia, Inc.
PacifiCare Life and Health Insurance Company
PacifiCare Life Assurance Company
American Medical Security Group, Inc.
American Medical Security Life Insurance Company
Continental Plan Services, Inc.
FHP Reinsurance Limite
PacifiCare Advantage, Inc.
PacifiCare of Arizona, Inc.
PacifiCare of Oregon, Inc.
PacifiCare of California
PacifiCare of Texas, Inc.
PacifiCare of Washington, Inc.
PacifiCare of Oklahoma, Inc.
PacifiCare of Nevada, Inc.
PacifiCare of Colorado, Inc.
PacifiCare Southwest Operations, Inc.
Antero Health Plans, Inc.
Union Health Solutions, Inc.
Covantage, LLC

Alere Medical Incorporated
Salveo Holding, LLC
Salveo Insurance Company Ltd.

Close

PacifiCare®

A UnitedHealthcare Company

American Medical Security Life Insurance Company provides administrative services for insurance products underwritten by PacifiCare Life and Health Insurance Company.

UnitedHealthcare
PacifiCare

California HMO Attestation Form

A new law became effective January 1, 2009 (1389.8) which requires all agents/brokers to attest on each California HMO application submitted if that agent/broker assisted the applicant in completing the application.

___ ___ ___ ___ ___ ___ ___ ___ ___ _____

Applicant's Social Security or ID No. Type or Print Applicant's Name

Fax: (714) 226-4597

Mail: PacifiCare
c/o Individual Plan Underwriting
PO Box 3069
Mail Stop CA120-0155
Cypress, CA 90630

As the agent/broker, please check one of the following:

☐ I did not interact with this applicant either by phone, fax, email or in person and did not assist the applicant in providing answers or responses to any questions on the application.

☐ I assisted the applicant in submitting their application. To the best of my knowledge, the information on the application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate or incomplete information and the applicant understood the explanation.

Notice: If you state as an agent/broker any material fact that you know to be false, you are subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under California Health and Safety Code 1389.8(c).

_____ _____

Signature of Agent/Broker (required) Date

_____ _____

Type or Print Agent/Broker Name Carrier ID Number Assigned