



Arizona All Plans Enrollment Form

FOR PACIFICARE OFFICE USE ONLY

Tier Code	Process Date	Processor	Approval
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Type or print with ballpoint pen. Do not write in shaded areas. Incomplete information will delay the enrollment process.

A. Employer Information (To be completed by Employer)

Employer Name	Location	HMO Group No.	Life Group No.	Subgroup/Location No.	Effective Date of Coverage
Date of Full-time Hire	Hours worked per week	Status (retired, full, part time, etc.)	Job Title	Employer Initials	(If applicable) <input type="checkbox"/> High option <input type="checkbox"/> Low option

B. Employee/Dependent Information

Name (Last, First, Middle)	Social Security #	Home Phone	Work Phone	County
Street Address (No P.O. Boxes)	City, State, Zip	Mailing Address (If Different)		

C. Coverage Information

Medical <input type="checkbox"/> Yes <input type="checkbox"/> No Which type? <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> INDEMNITY <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents	Individual(s) Covered: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents	Dental <input type="checkbox"/> Yes <input type="checkbox"/> No Which type? <input type="checkbox"/> HMO <input type="checkbox"/> INDEMNITY <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents	Retiree: <input type="checkbox"/> Basic <input type="checkbox"/> Silver <input type="checkbox"/> Gold	If selecting HMO dental, list dentist's full name
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List all Members to be covered

Check here if currently a patient of chosen PCP

Relationship	Last Name	First Name	MI	Sex	Social Security #	Birth Date (MM/DD/YYYY)	Network Code	If electing HMO, list Primary Care Physician**			<input checked="" type="checkbox"/>	
								Last Name	First Name	MI		
Self (00)												
Spouse (02)												
Dependents (03)												
Dependents (04)												
Dependents (05)												
Dependents (06)												
Dependents (07)												

D. Coordination of Benefits

Will you or any dependent be covered by other Group Health in addition to PacifiCare? No Yes Name of Carrier _____

If you or any of your dependents are eligible for Medicare, are you: Retired Active Part A only Part B only Part A & B

Has anyone listed above been advised by a physician of any surgery or hospital confinement required within the next 60 days? Yes No If Yes, who? _____

E. Waivers

Waive Medical Dental Coverage for myself and dependents (if any) My dependents only

Reason for waiver of coverage: Covered by spouse's insurance Other (explain)

F. Life Insurance Information (If your employer has chosen PacifiCare Life Insurance complete this section)

Basic Life Insurance <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents	(If applicable)		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated	Annual earnings		
Beneficiary's Name (Last, First, Middle)	Social Security Number	Relationship	Supplemental Life Insurance 1x Salary <input type="checkbox"/> 2x Salary <input type="checkbox"/>
Street Address	City, State, Zip	Home Phone	

I hereby authorize any health care facility, physician or surgeon, or any other health care professional to disclose to PacifiCare of Arizona, Inc. or PacifiCare Life Assurance Company, its agents or employees, all information from my medical records pertaining to any past or future examination or treatment including treatment for substance abuse and mental and emotional disorders furnished to me or my dependents who are also applying for this coverage, and to any illness, injury or condition that I or these dependents have had at any time in the past or in the future until the expiration of this authorization. I understand that this information is collected in connection with the evaluation and processing of an application for coverage, to determine continuing eligibility for benefits and to process claims, and may in certain circumstances be disclosed to third parties without authorization. This authorization also includes PacifiCare of Arizona, Inc. or PacifiCare Life Assurance Company disclosing any medical information they may have in their files to the same entities in connection with the advance consideration of providing services or subsequent payment for such services. I understand that upon written request and within 30 business days of receipt by PacifiCare of Arizona, Inc. of that request, I have a right of access and correction with respect to all personal information collected. My authorized representative or I am entitled to receive a copy of this form as well as a separate notice that explains my right of access to recorded personal information and disclosure limitations and conditions. This authorization is valid until the termination of this policy. A photocopy or other reproduction of this authorization is as valid as the original. HMO product is offered/underwritten by PacifiCare of Arizona, Inc. PPO, Indemnity and Life Products are offered/underwritten by PacifiCare Life Assurance Company.

**If you elected HMO Plan and did not select primary care physician (PCP) and/or a HMO primary care dentist, PacifiCare will select one for you. You may select a new provider by contacting PacifiCare Customer Service (1-800-347-8600).

Applicant Signature _____ Date _____