

CONTINUATION COVERAGE ELIGIBILITY/ENROLLMENT FORM COBL



See instructions on back - Incomplete information can delay the enrollment process

Section One - To be completed by Employer

Group #	Date Form Distributed (MM-DD-YYYY)	Date Election Period Expires (MM-DD-YYYY)
---------	------------------------------------	---

Section Two - To be completed by Applicant

This form is to be completed whether or not you wish to apply for continuation coverage.
Return the completed form to your employer before the date election period expires (see section above).

Last Name	First Name	MI	Social Security #
Mailing Address	Apt #	City	State ZIP
Home Phone	Business Phone	County	
Name of Employer who provided group health benefits	Are you currently covered under any other employer group health plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you wish to continue coverage through PacifiCare? <input type="checkbox"/> Yes <input type="checkbox"/> No

If you are not the covered employee, please fill in the name and PacifiCare I.D. number of the employee under whom you were previously covered:

Last Name	First Name	MI	PacifiCare ID #
-----------	------------	----	-----------------

Section Three

Complete for applicant and those eligible family members electing to continue coverage with PacifiCare:

Name (Last, First, MI)	Social Security #	Relationship to Subscriber	Sex	Student over 19	Disabled	Eligible for Medicare	Date of Birth MM-DD-YY	Primary Care Physician (PCP) Full Name and Street Address	Current Patient of PCP?	Dental Code
Subscriber 01	N/A	Self	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N			<input type="checkbox"/> Y <input type="checkbox"/> N	
Spouse 02		Spouse	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N			<input type="checkbox"/> Y <input type="checkbox"/> N	

1. Name of Spouse's Employer:

2. If spouse is using a different last name: wife retaining maiden/professional name Common Law Marriage

Dependent 03			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N			<input type="checkbox"/> Y <input type="checkbox"/> N	
Dependent 04			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N			<input type="checkbox"/> Y <input type="checkbox"/> N	
Dependent 05			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N			<input type="checkbox"/> Y <input type="checkbox"/> N	

Section Four

I am eligible for continuation of health coverage due to (check one):

- Death of a covered employee
 No longer meet eligibility requirements as a covered Dependent

- Employment termination or reduction in hours
 Divorce or legal separation from a covered employee
 Covered employee elects Medicare coverage

Date of Occurrence (MM-DD-YYYY):

Section Five

Type of Coverage: Employee Employee/Spouse Employee/Child Employee/Children Employee/Spouse/Child(ren) Split

If Applicable, Continue: HMO Dental PPO Dental Indemnity Dental Waive Dental

Section Six

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 DISPUTES OVER BENEFIT DENIALS SUBJECT TO ERISA, BETWEEN ITSELF, MEMBERS (INCLUDING ANY HEIRS OR ASSIGNS) AND PACIFICARE OF COLORADO, INC., 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. RIGHTS AFFORDED UNDER THE INTERNAL APPEALS PROCESS AND INDEPENDENT EXTERNAL REVIEW ARE NOT AFFECTED BY THIS PROVISION. DISPUTES NOT FULLY RESOLVED THROUGH THE INDEPENDENT EXTERNAL REVIEW PROCESS ARE SUBJECT TO THIS PROVISION.

To Decline Coverage: I have read the membership conditions on the reverse side and understand my right to continue health coverage. I hereby decline continuation coverage(s) available to me as a result of the qualifying event indicated above.

To Elect Coverage: I have read the membership conditions on the reverse side. I hereby request continuation coverage(s) as indicated above. I understand that failure to make timely payments of required premiums will result in permanent loss of this coverage.

Signature	Date
-----------	------

Signature	Date
-----------	------

For PacifiCare Use Only

Group #	Tier	Effective Date (MM-DD-YYYY)
---------	------	-----------------------------

Membership Conditions

I am aware of and accept the following PacifiCare membership conditions:

1. I (we) have chosen a Participating Primary Care physician as have my (our) Dependents, if any.
2. I (we) understand that each Member (Subscriber or Dependent) will not receive an I.D. card or have access to any benefits except for Emergency Care until a Primary Care Physician has been selected.
3. I (we) will use the Primary Care Physician to provide or arrange for all necessary health care (except for out-of-area benefits). I (we) may change Primary Care Physicians only by notifying the PacifiCare office in advance of such a change; Primary Care Physician changes will become effective on the first day of the following month.
4. I (we) authorize the release of all of my (our) medical records to PacifiCare or its authorized agents for the performance of any one or more of the following: (a) the administration of this Agreement; (b) medical research and education sanctioned by PacifiCare; (c) peer review for quality assurance and utilization review of statistical utilization data to the subscribing group; (d) creation and provision of statistical utilization data to the subscribing group; (e) bona fide medical emergencies; and (f) any other exceptions provided by law. Where the release of names or identifying demographic information is not necessary to the function being performed, such information will not be released.
5. I (we) will abide by the master contract applicable to the plan in which I (we) enrolled.
6. I (we) understand that if, prior to making an election, the employee or Qualified Beneficiary utilizes services from the Health Plan during the election period, the use of such services shall be considered a “**constructive election**,” and the employee or Qualified Beneficiary is obligated to pay the applicable Premium for the period during which coverage was provided.
7. I (we) will be held responsible for any claims paid by PacifiCare on my (our) behalf if I (we) fail to pay my (our) Premium.
8. I (we) have received notification of my (our) rights to continue group health coverage.
9. I (we) will cooperate as required in the general Coordination of Benefits and the Subrogation provisions of the master contract.
10. I (we) understand that **PacifiCare coordinates benefits with no-fault automobile insurance in the manner prescribed by the State and as explained in conspicuous fashion in PacifiCare printed materials and contracts.**
11. I (we) understand that my (our) identification cards are for identification only. The dates which may appear on the card reflect the effective date of the plan contract for which I (we) have enrolled, not necessarily my (our) dates of eligibility.

12. I (we) understand that by choosing the coverage specified in the *Combined Evidence of Coverage and Disclosure Form* (EOC), paying the Premium, or accepting benefits in the EOC, I (we) or my (our) legal representative expressly agree to all terms, conditions and provisions of the EOC.

Instructions

1. Please use pen, print clearly and press hard.
2. Complete all the information requested.
3. Be sure to select a Primary Care Physician for each covered member of your family. If desired, each family member may have a different Primary Care Physician. (Participating Primary Care Physicians are listed in the PacifiCare *Provider Directory*.)
4. Sign and date the form, keep the goldenrod copy for your records, and forward the other copies to your personnel office.

Remember

- Notify your employer promptly of any change in the status of your family that affects your coverage.
- Call the PacifiCare Customer Service Department if your address changes or if you wish to change your Primary Care Physician. Primary Care Physician changes will become effective on the first day of the following month.
- If you or any covered member of your family becomes ineligible to continue coverage under this plan, please contact PacifiCare within 31 days if interested in converting to a nongroup plan.
- Important information on how to use PacifiCare will be sent to you with your PacifiCare I.D. card.

Your PCP

PacifiCare Members are most satisfied with their Primary Care Physician when...

- they ask their family and friends to make recommendations.
- they choose a Primary Care Physician who is close to their home or work so physician visits are convenient.
- they visit or phone the doctor's office and talk with a staff member about such things as the office, office hours and parking.
- they find out more about the doctor, especially if they have a preference in a particular area, like age, years in practice, specialized training or board certification.

The importance of having a PacifiCare Primary Care Physician:

- You have a personal healthcare manager, helping you get the most appropriate care at the most appropriate time.
- You can develop a mutually satisfying relationship with a physician built on trust; establishing a rapport can promote consistency in your medical treatment.
- You have no claim forms to fill out when using PacifiCare benefits because your physician deals directly with PacifiCare.
- You have a physician who is familiar with your complete health history.

Customer Service:

- **SignatureValueSM (HMO) and SignaturePOSSM**
1-800-877-9777
TDHI 1-800-360-1797
- **SignatureFreedomSM (SDHP)**
1-866-867-0700
TDHI 1-866-867-0701

- **SignatureOptionsSM (PPO) and SignatureIndependenceSM (Indemnity)**
1-866-316-9776
TDHI 1-866-816-2018

P.O. Box 6975
Englewood, CO
80155-6975

www.pacificare.com

©2003 by PacifiCare Health Systems, Inc.
CM-903-51056.20
PC01303-001 Rev. 9/03