Enrollment/Change of Status Form

IMPORTANT: See other side for instructions. Please print neatly and complete all sections.

PacifiCare®
Dental & Vision Administrators

1. Purpose of Form

Check One:
- ☐ Open Enrollment
- ☐ New Hire
- ☐ Re-Hire
- ☐ Change of Status

Important: *For Change of Status, this form will supersede all previous enrollment forms; please indicate all coverage you wish to begin or continue.*

For Change of Status, Check One:
- ☐ Name Change
- ☐ Provider Change
- ☐ Address Change
- ☐ Telephone Change
- ☐ Plan Change
- ☐ Dependent Change (Add or Remove)

For Dependent Change,
Group Administrator must submit form to PDVA within 31 days of Qualifying Event.
Date of event: ☐☐/☐☐/☐☐

Check One:
- ☐ Marriage
- ☐ Newborn
- ☐ Divorce
- ☐ Other
- ☐ Legal Guardianship
- ☐ Loss of Coverage
- ☐ Adoption/Placement

Employer Use Only

Company Name _____

Group Number ☐☐☐☐☐☐ Enrollee's Effective Date ☐☐/☐☐/☐☐

Plan Name (Dental/Vision) ☐☐☐☐/☐☐☐☐

Employer Verification Signature _____

2. Enrollee

Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Date of Hire ☐☐/☐☐/☐☐

First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ MI ☐

Date of Birth ☐☐/☐☐/☐☐ Sex ☐ M ☐ F Social Security Number ☐☐☐-☐☐-☐☐☐☐

Mailing Address ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Apt # (or secondary address information) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

City ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ State ☐☐ Zip ☐☐☐☐☐

Home Phone # (☐☐☐)-☐☐☐-☐☐☐☐ Work Phone # (☐☐☐)-☐☐☐-☐☐☐☐

Spouse's Insurance Carrier (if applicable) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Effective Date of Spouse's Insurance ☐☐/☐☐/☐☐

Have you had any dental coverage within the last 60 days? ☐ Yes ☐ No

For PacifiCare SignatureValue Provider Group Number ☐☐☐☐☐☐ Dentist's Name/City ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Existing Patient? ☐ Yes ☐ No

3. Selected Coverage

Select only plans offered by your employer.
Important: *For Change of Status, this form will supersede all previous enrollment forms; please indicate all coverage you wish to begin or continue.*

Dental Plan Options:
- ☐ PacifiCare SignatureValue*
- ☐ PacifiCare SignatureOptions*
- ☐ PacifiCare SignatureIndependence*

Individual(s) to be covered:
- ☐ Self
- ☐ Self + Spouse
- ☐ Self + Child(ren)
- ☐ Self + Family

Family means spouse and child(ren).

Vision Plan Options:
PacifiCare SignatureOptions*
- ☐ Full Service
- ☐ Eyewear Only
- ☐ Exam Only

Individual(s) to be covered:
- ☐ Self
- ☐ Self + Spouse
- ☐ Self + Child(ren)
- ☐ Self + Family

Family means spouse and child(ren).

For a list of PacifiCare SignatureValue dental Provider Groups in your area, visit www.pacificare-dental.com or check with your group administrator.

4. Dependents ■ For Additional Dependents, check here and attach additional sheet.

1
Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ MI ☐
Relationship: ☐ Spouse/Domestic Partner ☐ Daughter ☐ Son
Date of Birth ☐☐/☐☐/☐☐ Sex ☐ M ☐ F Social Security Number ☐☐☐-☐☐-☐☐☐☐
For PacifiCare SignatureValue Provider Group Number ☐☐☐☐☐☐ Dentist's Name/City ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Existing Patient? ☐ Yes ☐ No

2
Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ MI ☐
Relationship: ☐ Spouse/Domestic Partner ☐ Daughter ☐ Son
Date of Birth ☐☐/☐☐/☐☐ Sex ☐ M ☐ F Social Security Number ☐☐☐-☐☐-☐☐☐☐
For PacifiCare SignatureValue Provider Group Number ☐☐☐☐☐☐ Dentist's Name/City ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Existing Patient? ☐ Yes ☐ No

3
Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ MI ☐
Relationship: ☐ Spouse/Domestic Partner ☐ Daughter ☐ Son
Date of Birth ☐☐/☐☐/☐☐ Sex ☐ M ☐ F Social Security Number ☐☐☐-☐☐-☐☐☐☐
For PacifiCare SignatureValue Provider Group Number ☐☐☐☐☐☐ Dentist's Name/City ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Existing Patient? ☐ Yes ☐ No

X I understand and agree to the terms and conditions on the reverse side of this sheet.
Enrollee Signature _____ Date _____

Return completed form to your Group Administrator.

* PacifiCare SignatureOptions and PacifiCare SignatureIndependence plans underwritten by PacifiCare Life Assurance Company, except in California where underwritten by PacifiCare Life and Health Insurance Company. PacifiCare SignatureValue plans offered by PacifiCare Dental in California and by PacifiCare Dental of Colorado in Colorado.

Instructions for completing this 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 or changing your information.

2) **Enrollee:** This section must always be filled out completely. If you are on a PacifiCare SignatureValue dental plan, remember to indicate the **PacifiCare SignatureValue dental Provider Group number/dentist/city** you have selected. **For a list of Provider Groups in your area, visit www.pacificare-dental.com or check with your Group Administrator.**

3) **Selected Coverage:** Please indicate the plan(s) in which you are enrolling or continuing. Not all plans are available to all groups or in all states. Your Group Administrator will know which plans are available to you. Select only plans offered by your employer.

4) **Dependents:** All dependents you wish to be covered should be listed in this section. If your dependents are on a PacifiCare SignatureValue dental plan, remember to indicate their **PacifiCare SignatureValue dental Provider Group number/dentist/city** selections.

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** (available from your Group Administrator).

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 "**For 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.**

8) **Return completed form to your Group Administrator. This form cannot be processed if information is incomplete.**

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.

Enrollee:

- ☐ Signature
- ☐ Social security number
- ☐ Address
- ☐ Date of birth
- ☐ Provider Group selection
  (for PacifiCare SignatureValue dental plans)

Group Administrator:

- ☐ Company name
- ☐ Group number
- ☐ Enrollee's effective date of coverage
- ☐ Plan name (for example: V142, E450, I810)
- ☐ Employer verification signature

Terms and Conditions

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

I agree and understand that any and all disputes, including claims of dental or vision malpractice (that is as to whether any dental or vision services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for claims to ERISA, between myself and PacifiCare Dental and Vision Administrators, 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 state law provides for judicial review of arbitration proceedings. Both 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.

Group Administrator, please mail completed form to:

Attn: Employer Groups, MAS, LC05-342
PacifiCare Dental and Vision Administrators
P.O. Box 25187
Santa Ana, CA 92799-5187

Phone (714) 513-6494
or 1-800-622-6388, option #4