COMMUNITY CARE HEALTH

Small Group - Employee Enrollment Form

Effective Date (mm/dd/yyyy) _____

Group no. _____

Please return completed form to your employer.

Purpose:

☐ New enrollment ☐ Re-hire ☐ Part-time to full-time ☐ Open enrollment ☐ Family addition ☐ Change ☐ COBRA ☐ Cal-COBRA

1: TYPE OF COVERAGE

Select from only the coverages offered by your employer.

MEDICAL HMO

☐ Bronze 60 HDHP HMO 7000/0	☐ Gold 80 HMO 250/35	☐ Platinum 90 HMO 0/10/500
☐ Bronze 60 HMO 6300/65	☐ Gold 80 HMO HRA 2150/35	☐ Platinum 90 HMO 0/25
	☐ Gold 80 HMO 500/35	☐ Platinum 90 HMO 0/10/250
☐ Silver 70 HMO 2250/50	☐ Gold 80 HMO 750/30	☐ Platinum 90 HMO 0/20
☐ Silver 70 HDHP HMO 2700/25	☐ Gold 80 HMO 1000/35	
☐ Silver 70 HMO HRA 2250/50		

MEDICAL EPO

☐ Silver 70 EPO 1500/50	☐ Gold 80 EPO 250/30	☐ Platinum 90 EPO 0/15
☐ Silver 70 HDHP EPO 2850/20	☐ Gold 80 EPO 500/30	☐ Platinum 90 EPO 0/25
	☐ Gold 80 EPO 750/30	
	☐ Gold 80 EPO 1500/35	

VISION

☐ Option 1: 12/12/12	☐ Option 2: 12/12/24	☐ Option 3: 12/24/24
Frame and Contact Lens Allowance	Frame and Contact Lens Allowance	Frame and Contact Lens Allowance
☐ $120 ☐ $130 ☐ $150	☐ $120 ☐ $130 ☐ $150	☐ $120 ☐ $130 ☐ $150

2: APPLICANT'S PERSONAL INFORMATION

Social Security no. required under CMS Regulations and by the IRS.

Language choice (optional) ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Other:_____

Last name _____ First name _____ M.I. ____

Social Security or ID no.[1] (required)_____ Home phone _____

Mailing address _____ City _____ State ____ Zip _____

Marital status: ☐ Single ☐ Married ☐ Domestic Partner (DP) Spouse/DP Social Security or ID no.[1] (required)_____

No. of dependents including spouse _____

Employer name _____ Job title _____ Class ____ Dept no. _____

Hire date/Rehire date/Part-time to Full-time date (mm/dd/yy)_____ Email address* _____

* To provide the best service and instant access to time-sensitive information, please include your email address.

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Social Security or ID no. (required) _____

3: EMPLOYEE AND FAMILY INFORMATION

Please list yourself and all eligible family members to be enrolled.

Sex	Last name	First name	M.I.	DOB (mm/dd/yy)	Social Security or ID no. (required)	Same address as employee	Primary Care Physician (PCP) name	Current MD?
☐ M ☐ F	Employee						☐ I would like a PCP assigned	☐ Yes ☐ No
☐ M ☐ F	Spouse					☐ Yes ☐ No	☐ I would like a PCP assigned	☐ Yes ☐ No
☐ M ☐ F						☐ Yes ☐ No	☐ I would like a PCP assigned	☐ Yes ☐ No
☐ M ☐ F						☐ Yes ☐ No	☐ I would like a PCP assigned	☐ Yes ☐ No
☐ M ☐ F						☐ Yes ☐ No	☐ I would like a PCP assigned	☐ Yes ☐ No
☐ M ☐ F						☐ Yes ☐ No	☐ I would like a PCP assigned	☐ Yes ☐ No
☐ M ☐ F						☐ Yes ☐ No	☐ I would like a PCP assigned	☐ Yes ☐ No

Address (if different from employee): _____ Street _____ City, State Zip _____

Dependent name: _____ Phone no. _____

4: DECLINATION

Please complete if any coverage is declined or refused by an eligible employee and/or their eligible dependents.

A. Medical coverage declined for:

☐ Myself ☐ Spouse/DP ☐ Child(ren)

B. Vision coverage declined for:

☐ Myself ☐ Spouse/DP ☐ Child(ren)

Reason for declining coverage — check one.

☐ Covered by spouse's group coverage
Insurer name and ID no. _____

☐ Covered by Individual policy

☐ Spouse covered by employer's group medical coverage
Insurer name: _____

☐ Enrolled in Tricare

☐ Enrolled in any other insurance plan
Insurer name: _____

☐ Medicare
Other (explain): _____

I acknowledge that the available coverages have been explained to me by my employer and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage. **BY DECLINING THIS GROUP MEDICAL COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UNTIL THE NEXT OPEN ENROLLMENT PERIOD TO BE ENROLLED IN THIS GROUP MEDICAL AND/OR GROUP LIFE INSURANCE PLAN.**

Signature if declining coverage for employee/dependent(s) Date

X _____ _____

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Social Security or ID no. (required) _____

5: COBRA/CAL-COBRA COVERAGE INFORMATION

Please complete only if enrolling in COBRA/Cal-COBRA.

Reason for COBRA/Cal-COBRA coverage _____

Federal COBRA qualifying event date (mm/dd/yy) _____ Cal-COBRA qualifying event date (mm/dd/yy) _____

Federal COBRA coverage begin date (mm/dd/yy) _____ Cal-COBRA coverage begin date (mm/dd/yy) _____

Federal COBRA coverage end date (mm/dd/yy) _____ Cal-COBRA coverage end date (mm/dd/yy) _____

6: OTHER COVERAGE FOR ALL ENROLLING EMPLOYEES AND DEPENDENTS

All questions must be answered.

A. Do any persons on this application intend to continue other group coverage if this application is accepted? ☐ Yes ☐ No

If yes, name of person(s): _____

Insurance company: _____ Policy no. _____ Phone no. _____

B. Does any person applying for coverage currently have **health** insurance coverage? ☐ Yes ☐ No

If yes, applicant/family member name(s): _____

Type of continuous coverage: ☐ Group ☐ Individual ☐ Other: _____

Insurance company: _____ Policy no. _____ Phone no. _____

Date coverage began (mm/dd/yy) _____ Date ended (mm/dd/yy) _____

C. Does any person applying for coverage currently have **vision** insurance coverage? ☐ Yes ☐ No

If yes, applicant/family member name(s): _____

Type of continuous coverage: ☐ Group ☐ Individual ☐ Other: _____

Insurance company: _____ Policy no. _____ Phone no. _____

Date coverage began (mm/dd/yy) _____ Date ended (mm/dd/yy) _____

7: MEDICARE

Complete if you, your spouse or dependent child(ren) have Medicare coverage. Attach additional sheets if necessary.

Name (last, first, M.I.)	Part A effective date (mm/dd/yy)	Part B effective date (mm/dd/yy)	Medicare claim no.

8: PLEASE READ CAREFULLY — SIGNATURE REQUIRED.

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

Deduction Authorization: If applicable, I authorize my employer to deduct from my wages the required subscription charges/premiums.

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

Effective Date: The effective date of coverage is subject to Community Care Health approval.

COBRA/Cal-COBRA Continuation Coverage

You may continue your health care coverage by: 1) completing the remainder of this form; 2) signing your name in the blank space below; 3) paying your Total Monthly Continuation Payment; and 4) mailing this form to Community Care Health, no later than sixty (60) days after the date you receive this notice. If you fail to choose COBRA Continuation Coverage within sixty (60) days after the date you receive this notice, your qualification for coverage will end. If you do choose COBRA Continuation Coverage, your current coverage will be continued until the earliest of the following dates:

1 The date eligibility for COBRA Continuation Coverage ends, or

2 The date you fail to make timely payments of your premium for COBRA Continuation Coverage, or

3 The date your employer discontinues coverage with Community Care Health, or

4 The date you become entitled to Medicare on the basis of age (65 years), or the date thirty (30) months after you become entitled to Medicare on the basis of end stage renal disease, or

5 The date you become covered under another group health plan as a result of employment, re-employment, remarriage, or otherwise.

If, at any time during the first sixty (60) days of your COBRA Continuation Coverage, you are determined under Title II or XVI of the United States Social Security Act to be disabled, you may be entitled to continue coverage while you are disabled for up to 29 months from the date you first qualified for Continuation Coverage under COBRA. Contact the Health Plan Administrator at your previous employer for full information.

The Monthly Continuation Payment is the cost of continued coverage for the month beginning on the date after the Date of Loss of Coverage. If you do not pay your initial monthly premium within 45 days after your election of COBRA Continuation Coverage, or if payment of succeeding premiums are not received within the 30-day grace period thereafter, your coverage will end.

Note: If you do not elect available COBRA Continuation of Medical Coverage, you will lose certain rights under federal law (HIPAA) to guaranteed issue individual coverage.

I certify each Social Security number listed on this application is correct.

COMMUNITY CARE HEALTH ARBITRATION AGREEMENT

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Community Care Health, any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Community Care Health, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

Signature required Date

X _____ _____