



Enrollment Form

721 South Parker, Suite 200, Orange, CA 92868

Fax to (559) 733-3250.

Questions? Call 827-8308 or 260-5927.

Group Number

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Complete Personal Information

A. Subscriber Information						
First Name		MI	Last Name		Social Security Number	Date of Birth <small>MO DAY YEAR</small> / /
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partner		Phone ()		Email Address	
Home Address			Apt #	City	State	Zip Code
Mailing Address (if different from Home Address)						
Employer Name			Job Title	Work Phone ()	Full-Time Employment Date <small>MO DAY YEAR</small> / /	
COBRA Applicants Only	Indicate Qualifying Event:				Date of Qualifying Event <small>MO DAY YEAR</small> / /	
	<input type="checkbox"/> Termination of employment		<input type="checkbox"/> Child no longer eligible		<input type="checkbox"/> Medicare entitlement	
<input type="checkbox"/> Reduction of hours		<input type="checkbox"/> Divorce/legal separation		<input type="checkbox"/> Death of employee		
Employee Name (if not self)						

B. Dependent Information <small>Note: If you have more than 3 children please make additional copies and attach.</small>						
Print full legal name <small>(First, MI, Last name)</small>	Relationship to Subscriber	Social Security Number	Gender <small>(M/F)</small>	Date of Birth <small>(MM/DD/YYYY)</small>	Full-Time Student	Disabled
	<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner					
	Child				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Child				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Child				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

C. Full-Time Student Verification <small>Note: Please make additional copies of Full-Time Student Verification form as needed</small>			
<small>For student eligibility guidelines, please refer to the Employee Enrollment Guide.</small>			
Student's Name			
Name of School			
School Address		City	State Zip Code
Signature X		Date <small>MO DAY YEAR</small> / /	

Select Dental & Vision Benefits

Note: If you or any of your dependents are not enrolling in dental or vision coverage, you must complete and sign the dental/vision waiver form

Dental – DeltaCare USA (DHMO) or Ameritas Group (PPO)**Select Enrollees**

Myself Spouse Domestic Partner * Children

* See employer to verify non-registered domestic partner coverage availability

Select Plan - Please complete either the DHMO Plan (Option 1) section OR the PPO Plan (Option 2) Section

Option 1: DHMO Plan - Complete this section only if you are choosing to enroll in a DeltaCare USA DHMO plan.

Carrier: *DeltaCare USA*

Plan: Gold Silver

Select Provider or Have One Assigned (DHMO Only)

If you are selecting your own dental provider: Please be sure to verify that your Provider is contracted with DeltaCare USA prior to enrolling. New Hire forms added to existing groups will automatically be assigned a Provider if one is not chosen or Provider is not contracted with DeltaCare USA.

	Dentist Name	Dentist ID	Current Patient	Have a Dental Provider Assigned
Subscriber			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Spouse			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Domestic Partner			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Children			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>

Acknowledgment and Authorization

Signature

X

Date

MO / DAY / YEAR

Option 2: PPO Plan - Complete this section only if you are choosing to enroll in an Ameritas Group dental plan.

Carrier: *Ameritas Group**

*See employer regarding orthodontia availability

Plan: Platinum Gold Silver

Acknowledgment and Authorization

Signature

X

Date

MO / DAY / YEAR

Vision – VSP**Select Enrollees**

Myself Spouse Domestic Partner * Children

* See employer to verify non-registered domestic partner coverage availability

Select Plan

Plan: Platinum Gold Silver (only available as an Employer-Sponsored plan)

Acknowledgment and Authorization

Signature

X

Date

MO / DAY / YEAR

Chiropractic/Acupuncture* – Landmark Healthcare *See enrollment worksheet for plan availability

Select Enrollees

Myself Spouse Domestic Partner ** Children

** See employer to verify non-registered domestic partner coverage availability.

Legal Acknowledgment and Authorization

Landmark Healthcare Chiropractic Enrollees:

Terms and conditions of enrollment are described in your Landmark Healthplan of California, Inc. (the "Plan") Combined Evidence of Coverage and Disclosure Form, and the Group Agreement between the Plan and your Employer Group.

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In the event that this application for coverage is accepted, I authorize my health care practitioner, as permitted by law, to provide the Plan with information concerning the health condition or treatment of any enrollee named above, as required for the Plan to authorize or pay for covered services provided by such practitioner.

I further authorize the Plan and any other health care plan through which I and/or my dependents have coverage to release any information to one another that would be necessary to coordinate benefits between or among the plans.

With regard to the authorizations above, I agree that a copy of this form shall be valid as the original.

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 CLAIMS SUBJECT TO ERISA, BETWEEN MYSELF AND MY DEPENDENTS ENROLLED IN THE PLAN (INCLUDING ANY HEIRS OR ASSIGNS) AND LANDMARK HEALTHPLAN OF CALIFORNIA, 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 ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

Signature

X

Date

MO DAY YEAR
/ /

Legal Acknowledgment

I agree for myself and my dependents to be bound by the benefits, co-pays, deductibles, exclusions, limitations and other terms of the health plan's small group contract as administered by the state of California.

I declare under the penalty of perjury under the laws of the state of California that the following statements are true, correct and pertain to the employer named on this form, myself and my dependents named on this form.

- I am considered eligible by my employer because I am a full-time employee who works the required number of hours per week.
- If I am an eligible employee applying for coverage outside of a renewal period, I have had a change in family status or have experienced another qualifying event that qualifies either me or my dependent(s) as a "Late enrollee" pursuant to California law.
- I am not a part-time, substitute or temporary employee.
- My children's dates of birth are accurate. My children meet all eligibility requirements. I understand that the preceding statements are subject to audit at any time and agree to provide Choice Builder with any and all information necessary to prove the above statements.
- I understand that false statements made with the intent to deceive or that materially affects the insurer's acceptance of risk will cause the termination of all Choice Builder benefits 15 days following the date of the notice of termination and I will be held responsible for all services and charges incurred through Choice Builder program providers thereafter. Additionally, the coverage may be cancelled or the employer's contract rescinded.
- I understand that any persons, business or health plan that suffers a loss because of false-declarations contained in this statement may take legal action against me to recover their losses.
- I authorize any payroll deduction that may be required towards the cost of this coverage.
- The representations made are the basis upon which coverage may be issued.
- California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.
- A policy of group health insurance shall provide equal coverage to employers for the registered domestic partner of an employee, insured, or policyholder to the same extent, and subject to the same terms and conditions, as provided to a spouse of the employee, insured, or policyholder, and shall inform employers of this coverage.
- I have READ, UNDERSTAND and ATTEST that I myself and my dependents have met all of the eligibility requirements.

My signature acknowledges both my understanding of the information presented above as well as the decision to enroll in the coverage I have selected.

Signature

X

Print Name

Date

MO DAY YEAR

/ /

Dental/Vision Waiver (if applicable)

IMPORTANT

Complete this page only if you do not want dental and/or vision coverage being offered by your employer, for yourself and/or your eligible dependents.

Details of Waiver

I have been offered group dental and vision coverage, but at this time I wish to DECLINE coverage for:

<input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner * <input type="checkbox"/> Children	<u>Dental</u> coverage
<input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner * <input type="checkbox"/> Children	<u>Vision</u> coverage

Employee Information

First Name	Last Name	Social Security Number	Group Number
Company Name		Work Phone ()	

Reason

Only required if you are waiving coverage for yourself

Reason waiving Dental

Other group Dental Coverage Carrier Name: _____ Group # _____
 Individual Policy
 Other Reason: _____ (explanation required)

Reason waiving Vision

Other group Vision Coverage Carrier Name: _____ Group # _____
 Individual Policy
 Other Reason: _____ (explanation required)

Signature

I understand that by waiving coverage now, Choice Builder can impose up to a 12 month period of exclusion from enrollment should I request coverage at a later date.

I also understand that if my employer is sponsoring life coverage, chiropractic coverage, or chiropractic/acupuncture coverage, I CANNOT WAIVE ANY OF THESE COVERAGES.

This waiver provision will not apply if: 1) Court orders coverage of a spouse or child and the request for enrollment occurs within 30 days of the court order; or 2) Employee meets ALL of the following: A) Was covered under another employer-sponsored health plan at the time of initial eligibility; B) Lost coverage as a result of termination of employment, change in employment status, involuntary termination of other plan's coverage, cessation of employer's contribution, or death or divorce of spouse; C) Requests enrollment within 30 days of loss of coverage.

SIGN HERE TO WAIVE COVERAGE X	Date MO DAY YEAR / /
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*See employer to verify non-registered domestic partner availability