

Wait!

**Please call before
attempting to complete your application!**

Avoid headaches and delays by allowing our office to assist you. We can help you complete your application and answer any questions you may have. You'll be surprised at how simple completing an application can be.

1 800 721-2618

(6:30 a.m. to 6:30 p.m. PST. Monday through Friday)

Please mail your application to:

Health One Insurance Agency
1344 Disc Dr. #210
Sparks, NV 89436
Attn: APDT

Or you may fax your application to:

800 905-6750

HOW TO APPLY FOR PACIFICARE INDIVIDUAL PLANS

Terms and Conditions

1. I understand that all health care services under the HMO Coverage options must be provided or arranged for by PacifiCare, except for Emergency or Urgently Needed Services.
2. I certify that the answers in any part of this application are true and complete. I acknowledge that the discovery of facts known and not disclosed may result in the rescission of my PacifiCare Individual Plan Agreement. I alone am responsible for the accuracy and completeness of the application and related documents. I understand that neither I, nor my Dependents, will be eligible for benefits if any known material information is false or incomplete, and that coverage may be rescinded based on such a finding. If rescinded, the contract will be deemed to never have existed and I will be financially responsible for any cost incurred while under the plan.
3. I understand that if I choose to enroll in a PPO health plan there will be a twelve (12)-month waiting period before coverage for pre-existing medical conditions will begin, for either myself, and/or my dependents who have these medical conditions, even if I am or my Dependents are on another PacifiCare plan, unless Guaranteed Availability is applied for and approved.
4. I understand that monies collected at the time of this application submission in no way entitle the applicant to any medical coverage prior to the approved effective date as stated within your written acceptance letter from PacifiCare of Arizona, Inc. or PacifiCare Life Assurance Company.

I understand that there is no coverage unless an application is approved by either PacifiCare of Arizona, Inc. or PacifiCare Life Assurance Company Underwriting Department. PacifiCare and PacifiCare Life Assurance Company are not liable for bills incurred before the effective date of coverage. PacifiCare and PacifiCare Life Assurance Company are not liable for the cost in obtaining medical records or the cost of special tests such as, but not limited to, X-rays, EKGs, or mammograms that may be required to determine eligibility.
5. If this application is approved, the date coverage begins will be provided to me by the PacifiCare or PLAC Underwriting Department.
6. The agent selling PacifiCare health coverage does not have the authority to approve my application and cannot change any terms of the PacifiCare Individual Plan Agreement or waive any requirements.
7. I understand that I am responsible for reporting to PacifiCare or PacifiCare Life Assurance Company any changes in the health status, which occur before the effective date of the PacifiCare Individual Plan Agreement. This applies to every person listed on the application.
8. I understand that any applicant listed herein may be required to undergo a basic physical and/or basic laboratory testing as part of the application process.

Authorization for disclosure of personal information

9. I hereby authorize any health care facility, Physician or surgeon, or any other health care professional to disclose to PacifiCare of Arizona, Inc., or any of its parents, subsidiaries, or affiliates, their agent or employees, all information from my medical records pertaining to any past or future examination or treatment, including treatment for substance abuse and mental or 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, up 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. I understand that if I refuse to provide this authorization, PacifiCare will not make an eligibility determination, and I will not be considered for membership in a PacifiCare plan. This authorization also includes PacifiCare or PacifiCare Life Assurance Company disclosing any medical information that 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. This authorization is valid for eighteen (18) months from the date inserted below. A photocopy or other reproduction of this authorization is as valid as the original. My authorized representative or I am entitled to receive a copy of this form. I understand that I may revoke this authorization at any time before I become a PacifiCare Member, except for instances that PacifiCare has already taken action based on the authorization, by mailing my written revocation to:

**PacifiCare Individual Plans
Individual Underwriting
M/S # CY38-224
P.O. Box 3069
Cypress, CA 90630-9962**

PacifiCare compensates Agents/Brokers for the sale of certain products. Your premium is the same if you purchase coverage directly from PacifiCare or if you use an Agent/Broker. Please contact your Agent/Broker, if applicable, regarding the amount of compensation. In addition, you may request information regarding broker commissions attributable to your policy by contacting PacifiCare Membership Accounting.

**HMO Questions? Call the Customer Service Department at 1-800-347-8600.
PPO Questions? Call the Customer Service Department at 1-866-316-9776.
SDHP Questions? Call the Customer Service Department at 1-866-867-0700.**

You Are Now Ready to Apply

Here are the steps to follow to ensure your application is processed as quickly as possible.

1. Complete the Enrollment Application

Be sure to answer all questions completely and provide all the requested information. Incomplete information may result in a processing delay.

- **Print clearly using black ink.** Please don't type on your form. You, as the applicant, must complete the application in your own handwriting.
- **Select the date you wish coverage to become effective.** PacifiCare allows effective dates beginning on the 1st or the 15th of the month. Please submit your application by the 20th of the month to be considered for the 1st of the following month, or by the 5th to be considered for the 15th of the same month. Actual effective dates are determined by the Company. **Do not cancel any existing coverage until you are notified by PacifiCare or PacifiCare Life Assurance Company that you have been accepted.**
- **Select your method of payment for your first month and recurring monthly payments.** Determine the amount of your initial premium by referring to the Rate Card enclosed with this form.
 - If you and your Spouse are both applying, price yourselves individually and then add the two premiums together. Please add any Dependents, if applicable.
 - Select the premium payment option for your initial premium – either check or credit card.
 - Be sure to include your first premium payment check or credit card authorization with this application.
 - Determine your recurring payment option – either monthly bill or EZ Pay automatic deduction.
- **Complete the Primary Applicant Information section.** Please list yourself as the Primary Applicant and, if married, include your Spouse as a Dependent (if the Spouse is also applying). If the parent/guardian is applying for a child-only plan, list the child's name as the Primary Applicant. If applying for coverage of multiple children, list the youngest child as the Primary Applicant. Dependent children age 19 or older who are not full-time students must apply for their own policy.
- **Complete the Enrollment Information section and list each family Member applying.** All PacifiCare SignatureValue (HMO) applicants must select a Primary Care Physician from the *PacifiCare SignatureValue (HMO) Provider Directory* or www.pacificare.com.

2. Complete the Health Questionnaire

Answer every question in full. Otherwise, your application may be returned to you, resulting in a delay in processing.

- **Be sure to disclose all health history on the Health Questionnaire for all family members listed on the application.** Even if your application is approved, any omissions or false statements may result in future claims being denied and/or termination of your coverage.
- **Include all requested details and explanations.** If you need to include additional information or explanations, simply attach an extra sheet.
- If you do not meet the standard PacifiCare underwriting requirements for the plan you have applied for, you may be offered a different option. You are under no obligation to enroll.

3. Send Your Completed Enrollment Application to PacifiCare

- **Review your application to be sure it is complete.**
- **Sign and date your application.** You, your Spouse (if applying) and any listed dependent age 18 or over, must sign and date the application.

- **Mail your application to:**

**PacifiCare Individual Plans
Individual Underwriting
M/S # CY38-224
P.O. Box 3069
Cypress, CA 90630-9962**

Before sealing the envelope, be sure to enclose:

- Your completed Enrollment Application
- Your first premium check or credit card payment authorization form

Please note: Coverage does not become effective under any circumstances until an application has been underwritten and approved by PacifiCare of Arizona, Inc. for HMO plans, and PacifiCare Life Assurance Company for PPO and SDHP plans. All plan documents are available for inspection prior to enrollment upon request.

ARIZONA ENROLLMENT APPLICATION



Requested Effective Date:
Subject to Approval

For Office Use Only

Date _____
Group Number _____ Effective Date _____
Approved/Denied _____ Approved by _____

Type or print with a black ball-point pen. Incomplete information will delay processing.
Application must be signed to be valid.

1. Application, Plan & Payment Information

Application for:

- New Individual Plan Membership Existing PacifiCare Individual Plan Member – adding Dependent
 New Child(ren)-only Plan Current PacifiCare Member applying for Individual Plan or child(ren) only
 Guaranteed Availability (HIPAA)

Note: Applicants/Dependents who are eligible for Medicare Benefits (or over age 64) are not eligible for Individual Plan. Please submit Certificates of Creditable Coverage if available with application.

Plan Options: (choose one)

- PacifiCare SignatureValueSM (HMO) Plan 3B – \$15-\$30/\$250 per day
 PacifiCare SignatureValueSM (HMO) Plan 4B – \$20-\$40/\$350 per day
 PacifiCare SignatureValueSM (HMO) Plan 5B – \$25-\$45/\$500 per day
 PacifiCare SignatureOptionsSM (PPO) Plan 5 – \$25-\$45/80-60/\$500
 PacifiCare SignatureOptionsSM (PPO) Plan 6 – \$25-\$45/80-60/\$1,000
 PacifiCare SignatureOptionsSM (PPO) Plan 7 – \$25-\$45/80-60/\$1,500
 PacifiCare SignatureOptionsSM (PPO) Plan 8 – \$35-\$50/80-50/\$2,500
 PacifiCare SignatureOptionsSM (PPO) Plan 9 – \$35-\$50/80-50/\$5,000
 PacifiCare SignatureFreedomSM (SDHP) Plan 2 – 70-50/\$3,000

HIPAA Eligible:

- PacifiCare SignatureValueSM (HMO) Plan 5B – \$25-\$45/\$500 per day
 PacifiCare SignatureOptionsSM (PPO) Plan 7 – \$25-\$45/80-60/\$1,500
 PacifiCare SignatureOptionsSM (PPO) Plan 8 – \$35-\$50/80-50/\$2,500

Payment Options

Choose your payment method for:
1. First month payment; and
2. Recurring monthly

First Month Payment (please select one option)

- Check enclosed: amount of \$ _____
 Credit card (for this payment method you must enclose your completed Credit Card Payment Authorization Form – payment will be deducted only if application is approved)

Recurring Monthly Payment (please select one option. Credit card payment is not available for recurring monthly payments)

- Monthly Bill
 Monthly EZ Pay (For this payment method, you must enclose your completed EZ Pay form)

2. Primary Applicant Information

Important: Indicate yourself as the Primary Applicant and if married, include your Spouse as a Dependent (if the Spouse is also applying for coverage). If the parent/guardian is applying for a child-only plan, list the child's name as the Primary Applicant. If covering multiple children, list youngest child as Primary Applicant.

Primary Applicant's Name _____ Married Single
Last First MI

Home Address _____
P.O. Box not acceptable Street Apt./Suite # City County State ZIP

Mailing Address

for Premium for Medical Information for Both
If different from home address

_____ Street Apt./Suite # City State ZIP

Home Phone _____ Work Phone _____

Applicant's Occupation _____ Spouse's Occupation _____

3. Enrollment Information (Attach a separate piece of paper for additional information)

List yourself and all eligible family members applying for coverage. **Each applicant applying for HMO plan must select a Primary Care Physician.** You may choose the same or a different Primary Care Physician for each family member, using the number shown in the network pages of the *Provider Directory*. If covering multiple children, list youngest child as Primary Applicant.

Relationship	Last Name	First Name	MI	Gender	Social Security Number	Height	Weight	Birth Date Mo/Day/Yr	Primary Care Physician (PCP) Name HMO only	PacifiCare Provider # HMO only	Network (PMG)
Primary Applicant				<input type="checkbox"/> M <input type="checkbox"/> F							
Spouse				<input type="checkbox"/> M <input type="checkbox"/> F							
Child				<input type="checkbox"/> M <input type="checkbox"/> F							
Child				<input type="checkbox"/> M <input type="checkbox"/> F							
Child				<input type="checkbox"/> M <input type="checkbox"/> F							

Do all applying family members reside with applicant? Yes No If no, please indicate name and mailing address of Dependent(s) below.

Note: Until you have received written approval of this application, do not cancel any insurance you may have.

Please note: If the Subscriber is not applying for coverage for his or her eligible Dependents, all future applicants, including newborns who are not enrolled within 31 days of birth, will be required to submit Evidence of Insurability, which is subject to approval by PacifiCare.

Important Notice: PacifiCare or PacifiCare Life Assurance Company will use the information provided in this application to make its determination about coverage for all persons named on the application. Read the application and the instructions very carefully. **If any material information about any applicant's medical background is misstated or omitted, it may result in rescission of the contract. If your contract is rescinded, it will be deemed never to have been in effect. A rescinded application will result in the applicant being billed for any expenses incurred while under the Plan.**

4. Health Questionnaire

You must disclose any and all medical information regarding any of the general categories listed below. If you are not sure whether the information is relevant, include it so PacifiCare or PacifiCare Life Assurance Company can make a determination. The information you provide will not necessarily cause a denial, but underwriting may depend on the items noted and medical information submitted by your doctor(s). **Note: Any illness, condition or change in health status of any applicant that may occur or be discovered between the date of this application and the effective date of coverage must be reported. Please notify any changes in writing to the PacifiCare Individual Plans Individual Underwriting, Mail Stop CY38-224, P.O. Box 3069, Cypress, CA 90630-9962. An unreported illness, condition or change will be treated as a nondisclosure and may result in rescission of coverage.**

Check "Yes" or "No" for each category below. Do not write N/A or leave any blanks. You must check "Yes" if any person named on this application has been aware of or has been evaluated, diagnosed, treated or received advice related to the following categories from any type of health care professional within the last ten (10) years prior to this application.

A. General Health Questions

- | | |
|--|--|
| <p>1. Alcoholism, Alcohol Abuse, DUI/DWI <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Allergies, Asthma, Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Arthritis, Gout, Bone/Joint Condition, TMJ, Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Anorexia, Bulimia, Eating Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Attention Deficit Disorder (ADD)/ADHD <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Autism and other pervasive developmental disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Back, Neck, Spine, Disc Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Birth/Physical Defect, Deformity, Congenital Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Blood Disease, Blood Condition (past 10 years), Leukemia, Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Blood Vessel/Circulation Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Breast Disease, Implants (Silicone or Saline) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Broken Bones, Bone Disease or Infections <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Colon, Rectal or Bowel Condition <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15. Concussion, Head Injury <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>17. Ear, Nose, Throat (Diseases, Infections) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>18. Epilepsy, Seizure Disorder, Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>19. Eyes (Cataracts, Glaucoma, Strabismus, Crossed Eyes) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>20. Female Organs, Abnormal Pap, Menstrual Disorder, Hysterectomy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>21. Fibromyalgia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>22. Gallbladder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>23. Heartburn/Gastroesophageal Reflux Disease (GERD) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>24. Heart Conditions of Any Kind <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>25. Hemorrhoids <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>26. Hepatitis (A, B, C or other), Liver Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>27. Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>28. High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, last reading _____</p> | <p>29. High Blood Cholesterol and/or Triglycerides <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, last reading _____</p> <p>30. Hormonal/Endocrine (Thyroid, Pituitary) Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>31. Illicit Drug Use/Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>32. Immune System Disorder, AIDS/HIV+, AIDS Related Complex (ARC), Lupus <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>33. Intestinal/Stomach, Colitis, Crohn's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>34. Kaposi's Sarcoma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>35. Kidney/Urinary Tract/Bladder (Stones/Infections) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>36. Liver Conditions <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>37. Lung Conditions, Chronic Obstructive Pulmonary Disease, Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>38. Male Sex Organs, Prostate, Impotence <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>39. Nervous System Conditions, Multiple Sclerosis, Paralysis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>40. Mental/Nervous, Anxiety, Depression, Psychiatric Counseling <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>41. Schizoaffective Disorder, Bipolar Disorder, Major Depressive Disorder, Panic Disorder, Obsessive-Compulsive Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>42. Migraines/Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>43. Muscle/Tendon Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>44. Non-Hodgkin's Lymphoma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>45. Phlebitis or Blood Clot <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>46. Prosthetic Implants, Artificial Limb <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>47. Reconstructive/Cosmetic Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>48. Sexually Transmitted Diseases <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>49. Skin Disorders, Lesions, Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>50. Steroid Use (Anabolic, Prednisone) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>51. Stroke/Transient Ischemic Attacks (TIA) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>52. Stomach or Abdominal Condition <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>53. Thyroid Condition <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>54. Tumors, Cysts, Polyps, Growths <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>55. Ulcers, Digestive Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>56. Weight Problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|--|--|

B. Give details for ALL "YES" ANSWERS indicated above in Section A. If you need more space for explanation, please attach a separate piece of paper.

Condition #	Family Member Name	Condition Description	Date First Diagnosed and/or Treated	Date of Most Recent Dr. Visit	Duration of Condition	Treatment/Medication		Name, Address & Phone # of Physician
						Type/Name	Date Discontinued	

Note: Until you have received written approval of this application, do not cancel any insurance you may have.

C. Has any applicant listed on this application seen a Physician, for any reason, in the past two (2) years? Yes No

If yes, please provide details below:

Applicant(s) Name	Physician Name	Address/Telephone	Date	Reason/Result and Treatment/Recommendation

D. Has any applicant received any alternative, complementary, holistic or natural therapies within the last twelve (12) months? Examples include acupuncture, ayurveda, biofeedback, chelation therapy, chiropractic, herbal medicines, homeopathy, imagery, reiki, shiatsu and visualization. Yes No If yes, please explain:

Applicant(s) Name	Physician Name	Address/Telephone	Date	Reason/Result and Treatment/Recommendation

E. Please complete the following for ALL applicants listed on this application.

Incomplete information will result in a processing delay

If you need more space for explanation, please attach a separate piece of paper.

1. In the event one or more applicant(s) listed on this application is denied coverage, should PacifiCare or PacifiCare Life Assurance Company continue the underwriting and enrollment process for the remaining eligible family members? . . . Yes No

2. Has surgery (major/minor, inpatient/outpatient) been performed for any applicant within the last ten (10) years? . . . Yes No
If yes, please explain:

3. Has surgery (major/minor, inpatient/outpatient) been advised but not performed for any applicant within the last ten (10) years? . . . Yes No
If yes, please explain:

4. Has any applicant been aware of, evaluated, diagnosed, treated or advised regarding any other conditions or injuries not listed within the last ten (10) years? Yes No
If yes, please state individual's name(s) and explain (include date):

5. Have you or any person applying used tobacco products within the last ten (10) years? . . . Yes No
If yes, please provide the following information:

NAME How many packs per day? How many years?
 Cigarettes Cigars Pipe Other: _____
 Has the person(s) quit? Yes No If yes, when? _____

6. Does any applicant listed on this application presently consume alcoholic beverages? . . . Yes No
If yes, please provide the following information:

NAME 0 - 1 drinks per day 2 - 3 drinks per day 4+ drinks per day
 NAME 0 - 1 drinks per day 2 - 3 drinks per day 4+ drinks per day .

7. Does any applicant listed on this application use narcotics, hallucinogenics, amphetamines, barbiturates, or other illegal drugs, or has used drugs other than in accordance with the instructions or prescription for use within the last ten (10) years? Yes No
If yes, state name(s) and explain (include date and duration): _____

8. Does any applicant listed on this application currently take prescription drugs? Yes No
If yes, list applicant's name(s), drug name(s), dosage and date started:

NAME DRUG DOSAGE/DATE STARTED
 NAME DRUG DOSAGE/DATE STARTED

9. Has any applicant listed on this application been hospitalized, been seen in an emergency room or been in therapy/counseling (mental, physical or emotional) within the last ten (10) years? Yes No
If yes, state applicant's name(s) and explain (include date and duration): _____

10. Is any applicant currently receiving any type of physical or mental disability insurance benefits? . . . Yes No
If yes, state name(s) and explain:

NAME NATURE OF DISABILITY (specify body part) % OF DISABILITY
 NAME NATURE OF DISABILITY (specify body part) % OF DISABILITY

11. Has any application for a policy of life or health insurance on any applicant been declined, postponed, modified or required an extra premium within the last ten (10) years? Yes No

NAME TYPE OF INSURANCE
 DATE INSURANCE CARRIER REASON

12. Will this coverage for which you are applying replace any other coverage you have? . . . Yes No

TYPE OF INSURANCE DATE INSURANCE CARRIER
 EXPIRATION DATE REASON

13. Do you or any other person applying have or ever had PacifiCare coverage? . . . Yes No
If yes: (a) You should understand that this is not a conversion or extension of that coverage. . . . Yes, I understand.
(b) You should understand that there may be a lapse in coverage, new waiting periods, new copayments and each listed member may be accepted or denied. . . . Yes, I understand.

FEMALES ONLY (including Spouse and Dependents)

14. Is any family member currently pregnant? . . . Yes No
If yes, expected date of delivery: _____

15. List the name of each female applicant and the date of their last menstrual period.

NAME MONTH DAY YEAR
 NAME MONTH DAY YEAR

16. List the name of each female applicant and the date of their last Pap smear and the results: _____

17. Has any female applicant listed on this application been treated in the last ten (10) years for infertility or any other female disorder? . . . Yes No
If yes, state applicant's name(s) and explain (include date and duration): _____

MALES ONLY (including Spouse and Dependents)

18. Is any male applicant listed on this application an expectant father, even if the mother is not listed on this application? . . . Yes No
If yes, state applicant's name: _____

If you are applying for Guaranteed Availability, please complete this section.

Health Insurance Portability and Accountability Act (HIPAA) Questionnaire

- 1. Have you had at least 18 months of Creditable Coverage? Yes No
- 2. Was your most recent coverage under a (check one):
 Group Plan Government Plan Church Plan
- 3. Are you eligible for any other coverage, including group, Medicare, Medicaid, etc.? Yes No
 If yes, please explain: _____

- 4. Was your previous coverage terminated for nonpayment of premium or fraud? Yes No

- 5. Was COBRA an available option? Yes No

 If yes, did you apply for COBRA? Yes No

 What was your qualifying event?
 Voluntary termination Involuntary termination
 Reduction of hours Death of employee
 Employee's Medicare entitlement
 Divorce or legal separation
 Dependent child ceasing to be a dependent
 Provide the dates of coverage under COBRA: _____ to _____
 Did you remain on COBRA until it was no longer available? Yes No
 If no, please provide details: _____
- 6. Has there been a gap in coverage of more than 63 days? Yes No

This questionnaire will be used by PacifiCare of Arizona, Inc. or PacifiCare Life Assurance Company in evaluating the applicant's eligibility for guaranteed individual health insurance. It does not constitute an offer of coverage. If you would like detailed information concerning guaranteed availability and renewability of individual coverage, please contact your insurance broker.

Agent Information – To be completed by Agent only

Agent Name		Company Name			Agent Number	
Agent Address	City	State	ZIP	Agent Phone Number	Agent Fax Number	

Note: Until you have received written approval of this application, do not cancel any insurance you may have.

5. Signature Required on Binding Arbitration Disclosure – READ CAREFULLY

By signing below, I acknowledge that I have read, understand and agree to the Terms and Conditions and Binding Arbitration on all the pages of this form. A reproduction of this authorization shall be as valid as the original.

UNDER THE TERMS OF YOUR COVERAGE AND ARIZONA LAW, YOU HAVE THE RIGHT TO APPEAL DECISIONS OF YOUR HEALTH CARE PLAN. YOUR APPEAL RIGHTS ARE SET FORTH IN YOUR ENROLLMENT PACKET UNDER THE TITLE HEALTH CARE INSURER APPEALS PROCESS INFORMATION PACKET. YOU ALWAYS HAVE THE RIGHT TO PURSUE AN APPEAL. NOTHING IN THE BINDING ARBITRATION PROVISION INTERFERES WITH THOSE RIGHTS. THE BINDING ARBITRATION PROVISION ONLY APPLIES AFTER YOU AND PACIFICARE HAVE EXHAUSTED ALL THE ADMINISTRATIVE PROCESSES AVAILABLE TO YOU THROUGH THE APPEALS PROCESS AND THE ISSUE HAS NOT BEEN RESOLVED TO YOUR SATISFACTION. THE BINDING ARBITRATION PROVISION ALSO APPLIES TO ISSUES THAT ARE NOT SUBJECT TO THE APPEALS PROCESS. THE TYPES OF MATTERS THAT ARE SUBJECT TO THE APPEALS PROCESS ARE OUTLINED FOR YOU IN THE HEALTH CARE INSURER APPEALS PROCESS INFORMATION PACKET.

BINDING ARBITRATION APPLIES TO ANY AND ALL DISPUTES OF ANY KIND WHATSOEVER WHERE:

- 1. THE ISSUE IS NOT OF A TYPE SUBJECT TO THE ARIZONA APPEALS PROCESS AS OUTLINED IN THE HEALTH CARE INSURER APPEALS PROCESS INFORMATION PACKET; AND**
- 2. ISSUES THAT HAVE GONE THROUGH THE APPEALS PROCESS BUT WITH WHICH YOU CONTINUE TO BE DISSATISFIED WITH THE FINAL DETERMINATION AFTER EXHAUSTION OF ALL APPEAL RIGHTS INCLUDING SUBMISSION TO THE OFFICE OF ADMINISTRATIVE HEARINGS (OAH) AND FOR WHICH YOU WOULD OTHERWISE FILE A LAWSUIT AFTER RECEIVING THE DETERMINATION OF THE OAH.**

THIS, INCLUDES CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE HEALTH 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) BETWEEN MEMBER (INCLUDING ANY HEIRS, SUCCESSORS OR ASSIGNS OF MEMBER) AND PACIFICARE OF ARIZONA, INC. OR ANY OF ITS PARENTS, SUBSIDIARIES OR AFFILIATES (COLLECTIVELY, “PACIFICARE ENTITIES”). MEMBER UNDERSTANDS AND AGREES THAT THESE ISSUES AND DISPUTES SHALL BE SUBMITTED 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 ARE GIVING UP THEIR CONSTITUTIONAL RIGHTS TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

SIGNATURE OF APPLICANT OR LEGAL GUARDIAN <i>(required)</i> X	TODAY'S DATE <i>(required)</i>	SIGNATURE OF APPLICANT'S SPOUSE <i>(required if applying)</i> X	TODAY'S DATE <i>(required)</i>
SIGNATURE OF APPLICANT'S DEPENDENT AGE 18 OR OVER <i>(required)</i> X	TODAY'S DATE <i>(required)</i>	SIGNATURE OF APPLICANT'S DEPENDENT AGE 18 OR OVER <i>(required)</i> X	TODAY'S DATE <i>(required)</i>
SIGNATURE OF PERSONAL REPRESENTATIVE OR CUSTODIAN <i>(if applicable)</i> X	TODAY'S DATE <i>(required)</i>	PRINT NAME OF PERSONAL REPRESENTATIVE OR CUSTODIAN <i>(if applicable)</i> X	

6. Sign and Date Application

SIGNATURE OF APPLICANT OR LEGAL GUARDIAN <i>(required)</i> X	TODAY'S DATE <i>(required)</i>	SIGNATURE OF APPLICANT'S SPOUSE <i>(required if applying)</i> X	TODAY'S DATE <i>(required)</i>
SIGNATURE OF APPLICANT'S DEPENDENT AGE 18 OR OVER <i>(required)</i> X	TODAY'S DATE <i>(required)</i>	SIGNATURE OF APPLICANT'S DEPENDENT AGE 18 OR OVER <i>(required)</i> X	TODAY'S DATE <i>(required)</i>
SIGNATURE OF PERSONAL REPRESENTATIVE OR CUSTODIAN <i>(if applicable)</i> X	TODAY'S DATE <i>(required)</i>	PRINT NAME OF PERSONAL REPRESENTATIVE OR CUSTODIAN <i>(if applicable)</i> X	

Note: Until you have received written approval of this application, do not cancel any insurance you may have.

**PacifiCare Individual Plans
Individual Underwriting**
M/S CY38-224
P.O. Box 3069
Cypress, CA 90630

Individual Sales:
800-577-0001
800-442-8833 (TDHI)
www.pacificare.com

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PAZ137546-001
FORM NUMBER: 2004-AZ-IPLAN-APP

**PacifiCare SignatureOptions (PPO) and PacifiCare SignatureFreedom (SDHP) are Underwritten by PacifiCare
Life Assurance Company. PacifiCare SignatureValue (HMO) is offered by PacifiCare of Arizona, Inc.**



Medical Records Release Authorization Statement

Reference Number:
Plan Name:
Coverage Type:
Primary Applicant:
Monthly Premium:
Date Submitted:

I hereby authorize any health care facility, Physician or surgeon, or any other health care professional to disclose to PacifiCare of Arizona, Inc., or any of its parents, subsidiaries, or affiliates, their agent or employees, all information from my medical records pertaining to any past or future examination or treatment, including treatment for substance abuse and mental or 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, up 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. This authorization also includes PacifiCare or PacifiCare Life Assurance Company disclosing any medical information that 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. This authorization is valid for eighteen (18) months from the date inserted below. A photocopy or other reproduction of this authorization is as valid as the original. My authorized representative or I am entitled to receive a copy of this form. I understand that I may revoke this authorization at any time before I become a PacifiCare Member, except for instances that PacifiCare has already taken action based on the authorization, by mailing my written revocation to:

**PacifiCare Individual Plans
Individual Underwriting
M/S # CY38-224
P.O. Box 3069
Cypress, CA 90630-9962**

I have read, understand and agree to the above Medical Records Release Authorization Statement.

<hr/>	<hr/>
	Date (required)
<hr/>	<hr/>
Spouse (if applicable)	Dependent over 18 (if applicable)
<hr/>	<hr/>
Dependent over 18 (if applicable)	Dependent over 18 (if applicable)
<hr/>	<hr/>
Dependent over 18 (if applicable)	Dependent over 18 (if applicable)

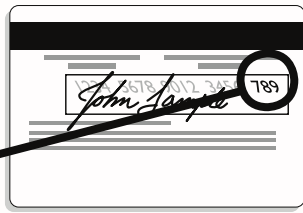
Please mail application to:
PacifiCare Individual Plans
Individual Underwriting
M/S # CY38-224
PO Box 3069
Cypress, CA 90630-9962

CREDIT CARD PAYMENT AUTHORIZATION

Payment Option			
First Month's Premium (due at time of application)		One-Time Credit Card Charge	
<input type="checkbox"/> Premium Payment Amount:	\$ _____	<input type="checkbox"/> Premium to be Charged to Card:	\$ _____
<input type="checkbox"/> Application Fee (TX/OK):	\$25	<input type="checkbox"/> Total Fees (if applicable):	\$ _____

Applicant's Information		
Applicant's First Name	Applicant's Middle Name	Applicant's Last Name

Cardholder's Information				
Cardholder's First Name (as it appears on card)	Cardholder's Middle Initial	Cardholder's Last Name	Cardholder's Phone #	
Cardholder's Billing Address		City	State	ZIP

Card Information		
Card Type <input type="checkbox"/> Visa <input type="checkbox"/> Master Card	Account Number	Exp. Date (mm/yyyy)
Verification Code:		
<p>For Visa and Master Card, the verification code can be found on the back of your credit card. This 3-digit code is usually the last three digits located in the signature panel.</p>		
<p>Determine your verification code and enter it here: _____</p>		

Authorization	
<p>As a convenience, I request and authorize PacifiCare to charge my credit card account, identified above, for the payment of my health plan premium and/or any applicable fees (application, returned payment, reinstatement, etc.) for the payment option(s) designated above. I understand that the initial premium for my Policy may be adjusted based on my medical condition (or that of any dependent to be covered under the policy) and agree that the additional amount(s) required may be charged to this account. I further agree that should this card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, PacifiCare will attempt to contact me by mail, but shall be under no liability whatsoever, including any fees imposed by the card issuer even though such dishonor may ultimately result in forfeiture of coverage.</p>	
Signature of Credit Card Account Holder (as it appears on the credit card)	Date

For PacifiCare Office Use Only		
Authorization Date	Transaction #	ID #

Return this form to:
PacifiCare Individual Plans
Individual Underwriting
M/S/ CY24-155
P.O. Box 3069
Cypress, CA 90630-9962



EZ Pay Form

Desert Region*



Now you can pay your PacifiCare Individual Plan monthly premiums automatically with EZ Pay. Automatic payment saves you time and gives you peace of mind since your premium will be paid automatically every month, by a withdrawal from your checking account, without worry about forgetting to mail a check.

How Do Preauthorized Payments Work?

When you complete and submit the authorization form on the reverse side, this allows the payments you have authorized to be withdrawn from your designated checking account. The funds are sent electronically to PacifiCare.

Note: PacifiCare must receive a thirty (30) calendar day written notification prior to implementing a change or cancellation of preauthorized payments.

When Must the Money Be in My Account?

Your bank account must have the full dollar amount due in available funds by the 6th of the month in order for the current month's preauthorized payment to be made. If your account has insufficient or uncollected funds, your bank will return the preauthorized payment and may charge you just as if you had a check returned for the same reason.

When Will My First Premium Payment Be Deducted?

PacifiCare will notify you of your initial deduction at least 10 business days prior to the transaction date. If you miss our billing cycle, you'll be invoiced by PacifiCare for one more month's premium (and must pay by check or credit card) before your first premium payment is automatically deducted. All subsequent premium payment deductions will be reflected on the statement from your financial institution.

* *Desert Region is comprised of PacifiCare of Arizona, Inc.; PacifiCare of Nevada, Inc.; and PacifiCare Life Assurance Company, an admitted insurance carrier in the state of Arizona and the state of Nevada.*

With the EZ Pay Option, You'll Take Advantage of a Variety of Benefits

- No more checks to write
- Easier reconciliation of your bank account
- On-time payment whether you're at home or traveling
- Dollar savings in postage and lower check usage

To sign up for automatic payment of your PacifiCare Individual Plan monthly premium, complete and submit this form along with your application and payment for your first month's premium to the appropriate address below.

PacifiCare SignatureValueSM (HMO)

please mail to:

Individual Plans

Membership Accounting

P.O. Box 52078

Mail Stop AZ74-142

Phoenix, AZ 85072-2078

Fax: (480) 303-7500

PacifiCare SignatureOptionsSM (PPO)

or PacifiCare SignatureFreedomSM (SDHP)

please mail to:

Individual Plans

P.O. Box 6006

Mail Stop CY24-593

Cypress, CA 90630

Fax: 1-866-220-0855

HMO Questions? Please call 1-800-347-8600
PPO/SDHP Questions? Please call 1-800-861-6611.

EZ Pay Program Authorization

Desert Region

The PacifiCare EZ Pay Program allows you to have your monthly PacifiCare premium conveniently deducted from your checking account. To participate in this program, all you have to do is fill out this form, sign where indicated and return to PacifiCare at the addresses listed below.

If applying for PPO/SDHP: **Individual Plans**, P.O. Box 6006, Mail Stop CY24-593, Cypress, CA 90630. Fax: 1-866-220-0855
 If applying for HMO: **Individual Plans**, P.O. Box 52078, Mail Stop AZ74-142, Phoenix, AZ 85072-2078. Fax: (480) 303-7500

- The monthly premium will be deducted on or after the 6th of the month for the coverage month.
- Be sure all areas of the form are completed and the authorization is signed by an authorized signer on the account.
- Please type or print the information in ink.
- You may be subject to a \$25 administrative fee by PacifiCare for each return payment from your bank.

Check one: HMO new set-up PPO/SDHP new set-up Bank Account change (for current Subscribers/Insureds only)
 Subscriber/Insured Number: _____

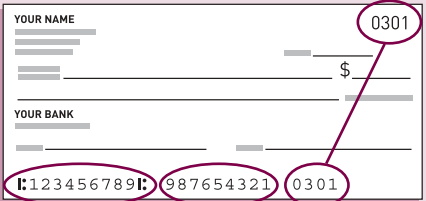
Subscriber/Insured Information				
Last Name	First Name	Phone #		
Street Address	City	State	ZIP	

Bank Draft Authorization		
Account Holder	Bank Name	State
Routing/Transit # (9 Digits) (Required)	Account # (Required) (include all zeroes and omit spaces/special characters)	Check # (Required)

Determining Your Routing Number

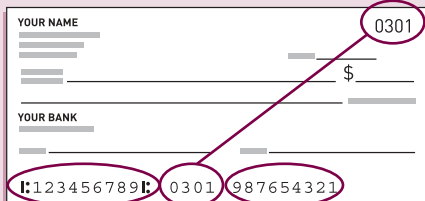
To determine your routing number, refer to your personal check. **The routing number is ALWAYS 9 digits long** and it is enclosed by colons. The location of the routing number and account number on your personal check varies depending on your bank, for example:

Bank 1



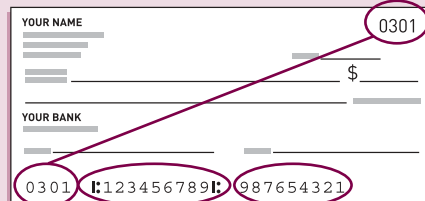
Routing # Account # Check #

Bank 2



Routing # Check # Account #

Bank 3



Check # Routing # Account #

If you are unsure what the routing number/transit number is, your bank can assist you. If you desire, you may also enclose your voided check with this form to avoid any confusion.

Payment Authorization (this section must be completed in full)

I authorize PacifiCare to initiate debit entries to the banking account number listed above. For applications submitted electronically, the applicant and the account holder must be the same person. If not, this form will have to be printed, signed by each party and mailed to the address listed.

Signature of Primary Applicant/Parent or Legal Guardian	Date
Signature of Account Holder	Date

This authorization is to remain in full force and effect until PacifiCare has received written notice thirty (30) calendar days in advance of your intended cancellation date of this agreement.