

# 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will be eligible for benefits if any known material information is false or incomplete, and that coverage may be rescinded based on such a finding. If rescinded, the contract will be deemed to never have existed, and I will be financially responsible for any cost incurred while under the plan.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 there is no coverage unless an application is approved by either PacifiCare of Nevada, Inc. or PacifiCare Life Assurance Company Underwriting Department. PacifiCare and PacifiCare Life Assurance Company (PLAC) 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 Nevada, 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 # CY24-155  
P.O. Box 3069  
Cypress, CA 90630-9962**

**HMO Questions? Call the Customer Service Department at 1-800-347-8600.  
POS Questions? Call the Customer Service Department at 1-800-459-3224.  
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 Easy 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](http://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 # CY24-155  
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 Nevada, 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.***

**HMO Questions? Call the Customer Service Department at 1-800-347-8600.  
POS Questions? Call the Customer Service Department at 1-800-459-3224.  
PPO Questions? Call the Customer Service Department at 1-866-316-9776.  
SDHP Questions? Call the Customer Service Department at 1-866-867-0700.**

Requested Effective Date: \_\_\_\_\_  
**Subject to Approval**

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

**For Office Use Only** Date \_\_\_\_\_ Group # \_\_\_\_\_  
 Effective Date \_\_\_\_\_  Appr/  Den by \_\_\_\_\_

## 1. Application, Plan and 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.*

**Medical Plan Options: (choose one)**

- PacifiCare SignatureValue® (HMO) Plan 4B – \$10/\$25/\$100 per day
- PacifiCare SignatureValue® (HMO) Plan 5B – \$25/\$50/\$200 per day
- PacifiCare SignatureOptions<sup>SM</sup> (PPO) Plan 1 – \$30/80-50/\$1,500
- PacifiCare SignatureOptions<sup>SM</sup> (PPO) Plan 2 – \$20/80-50/\$500
- PacifiCare SignatureOptions<sup>SM</sup> (PPO) Plan 3 – \$30/70-50/\$2,000
- PacifiCare SignatureFreedom<sup>SM</sup> (SDHP) Plan 1 – 70-50/\$3,000

**HIPAA Eligible**

- PacifiCare SignatureValue® (HMO) HIPAA Basic \$25/\$300 per day
- PacifiCare SignatureValue® (HMO) HIPAA Standard \$10/\$100 per day
- PacifiCare SignatureOptions<sup>SM</sup> (PPO) HIPAA Basic \$20/70-50/\$1,500
- PacifiCare SignatureOptions<sup>SM</sup> (PPO) HIPAA Standard \$10/80-60/\$500

**Dental Plan Options:**

- PacifiCare SignatureValue® (HMO) Dental 350
- Dentist Name: \_\_\_\_\_
- Dentist ID Number: \_\_\_\_\_

**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 Easy Pay (For this payment method, you must enclose your completed Easy 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

Work Address \_\_\_\_\_  
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 County State ZIP

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Applicant's Occupation \_\_\_\_\_ Spouse's Occupation \_\_\_\_\_

Ethnicity (optional)  Caucasian  Black or African-American  Hispanic or Latino  Asian, Native Hawaiian, other Pacific Islander  
 American Indian or Alaskan Native  Not provided by member

Preferred Language (optional)  English  Spanish

## 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</p> <p style="padding-left: 20px;">If yes, last reading _____</p> | <p>29. High Blood Cholesterol and/or Triglycerides . . . . . <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">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: \_\_\_\_\_

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

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 Federal COBRA or State mini-COBRA an available option?  Yes  No  
 (If yes, which one?) \_\_\_\_\_

If yes, did you apply for COBRA?  Yes  No  
 (If yes, which one?) \_\_\_\_\_

- What was your Qualifying Event? (check one)
- 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 Nevada, 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.

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.

**Agent Information – To be completed by Agent only**

Agent Name Gary Jackson		Company Name JustHealthplans			Agent Number 20120	
Agent Address 1344 Disc Dr. #210	City Sparks	State NV	ZIP 89436	Agent Phone Number 800 721-2618	Agent Fax Number 800 905-6750	

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

**5. Sign and Date Application**

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

**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 CY24-155  
P.O. Box 3069  
Cypress, CA 90630**

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

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