

Declarations

Read each of the following statements carefully. Any untrue or inaccurate responses may be reason for loss of enrollment or application of other sanctions. By signing this application you are responsible for each statement.

- 1) I, the COBRA/Cal-COBRA applicant, will abide by the Program premium payment requirements and the laws and rules governing the program.
- 2) I have reviewed the services, coverage offered and rates of the participating health plan.
- 3) I understand that I must meet the Program requirements and the requirements of federal or state law for continuation of coverage under COBRA or Cal-COBRA.
- 4) I certify that I reside in the service area of the participating plan(s) that I have selected.
- 5) I understand that if I do not enroll my eligible dependents at this time, they cannot enroll through the Program until the next open enrollment period as authorized by the Program governing rules.
- 6) I understand that the plan may have waiting periods for certain dental services.
- 7) I declare that I will abide by the rules of participation, the utilization review process and the dispute resolution process of any participating plan in which I am enrolled.
- 8) I understand that the selected plan may require disputes to be resolved through binding arbitration. (See disclosure below.)
- 9) By signing this application, I certify that the information is true and correct. I understand that any untrue or inaccurate responses may be reason for loss of eligibility and enrollment.
- 10) I understand that if the former employer terminates its participation in the Program that my coverage under the Program will cease, although I may have continuation coverage through a successor plan with the former employer.

Authorization for Disclosure of Personal Information

I hereby authorize health care providers to release medical, dental, vision, and complementary care information, including medical information regarding substance abuse or mental/emotional conditions, pertaining to me or my dependents to the health plan(s) which I have selected and to Pacific Health Advantage (also known as The Health Insurance Plan of California). This information may be used for any purpose related to enrollment and plan administration, including but not limited to utilization management, quality improvement, disease or case management programs, and premium risk adjustment. I further authorize payment of medical/dental/vision/complementary care benefits to the provider of care. A photocopy of this authorization is as valid as the original. My authorized representative or I am entitled to receive a copy of this authorization.

Arbitration Notice

Enrollment in many of the plans constitutes an agreement to have any dispute decided by binding arbitration and waiver of any right to a jury or court trial. Refer to the plan's Evidence of Coverage or Certificate of Insurance to determine whether the plan(s) you have selected require binding arbitration. If you choose a medical, dental, vision, or complementary care plan which requires resolution of disputes through binding arbitration, you, your dependents and the plan are waiving any right to a jury or court trial.

I, the COBRA/Cal-COBRA applicant certify the information provided on this application is true and correct.

SIGNATURE OF APPLICANT (REQUIRED)

DATE SIGNED

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SIGNATURE OF APPLICANT'S SPOUSE (REQUIRED IF LISTED ON APPLICATION)

DATE SIGNED

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SIGNATURE OF APPLICANT'S DEPENDENT (REQUIRED IF AGE 18 OR OVER AND LISTED ON APPLICATION)

DATE SIGNED

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