ENROLLMENT APPLICATION

QUESTIONS?
Call Customer Services:
(858) 637-6500 or
(800) 359-2002
FAX: (858) 637-6504

EMPLOYER'S USE

GROUP NAME	
GROUP NUMBER	EFFECTIVE DATE

REASON FOR THIS APPLICATION

☐ **DECLINE COVERAGE (MUST Complete Section - Bottom of Form)**

☐ New Hire ____ Date of Hire ☐ Rehire ____ Date of Rehire ☐ Open Enrollment

☐ Add Dependent: ____ Date of Marriage ____ Date of Birth ____ Date of Adoption

☐ Cal-COBRA Plan ☐ COBRA ☐ Conversion Plan

☐ Terminate Coverage

Termination Date ____ Employer Signature ____

☐ Address Change (List Change Below) ☐ Name Change (List Change Below) ☐ Delete Dependent (List Names Below)

INDICATE COVERAGE BELOW (CHECK ALL THAT APPLY)

☐ HMO Plan ☐ FOCUS ☐ Other (Indicate):

☐ PPO Plan ☐ Out-of-Area ☐ Life/ AD&D: (Underwritten by Allianz Life Insurance Company of North America)

EMPLOYEE INFORMATION

SOCIAL SECURITY NO.	NAME (LAST, FIRST, MIDDLE INITIAL)	HOME PHONE NUMBER	WORK PHONE NUMBER	EXTENSION
STREET ADDRESS	CITY	STATE	ZIP CODE	COUNTY	BIRTHDATE
MARRIED ☐ Yes ☐ No	SEX ☐ M ☐ F	PRIMARY CARE PHYSICIAN (IF BLANK, PLAN WILL ASSIGN PCP)	EXISTING PATIENT? ☐ Yes ☐ No	PCP OFFICE LOCATION
EMPLOYER'S NAME	JOB TITLE / OCCUPATION	NO. OF WORK HOURS PER WEEK	ARE YOU ACTIVELY AT WORK? ☐ Yes ☐ No

DEPENDENT INFORMATION -- IF YOU ARE COVERING YOUR DEPENDENTS, PLEASE COMPLETE THE FOLLOWING INFORMATION

LAST NAME, FIRST, M.I.	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX M/F	PRIMARY CARE PHYSICIAN (IF BLANK, PLAN WILL ASSIGN PCP)	EXISTING PATIENT? YES	NO
SPOUSE						
DEP.						
DEP.						
DEP.						
DEP.						

OTHER MEDICAL COVERAGE

DO YOU OR YOUR DEPENDENTS INTEND TO CONTINUE OTHER MEDICAL COVERAGE IF THE APPLICATION IS APPROVED?
☐ Yes ☐ No (If "yes" complete the following:) ☐ Self ☐ Spouse ☐ Dependent

NAME OF INSURED		SOCIAL SECURITY NO.
NAME OF OTHER INSURANCE COMPANY	GROUP NO.	EMPLOYER OF INSURED
EMPLOYER'S ADDRESS (STREET, CITY, STATE, ZIP CODE)		
DEPENDENTS ENROLLED UNDER OTHER MEDICAL COVERAGE		

LIFE INSURANCE (IF APPLICABLE)

LIFE INSURANCE ONLY	TOTAL LIFE AND AD & D AMOUNT $	ANNUAL SALARY $
LIFE INSURANCE BENEFICIARY	NAME (LAST, FIRST, MIDDLE INITIAL)	
	RELATIONSHIP	

DECLINATION OF COVERAGE

I have been notified that I, and/or my eligible dependents, are eligible for enrollment in my employer's health benefits plan. By listing individuals for whom I am declining coverage and signing below, **I voluntarily decline to enroll my self and/or individuals and acknowledge that my decision to not elect coverage permits my employer's health benefits plan (depending on carrier) to impose a 12 month exclusion from coverage following application, or until open enrollment, should I or these individuals later apply for coverage.**

I AM DECLINING COVERAGE FOR:

NAME (LAST, FIRST, MIDDLE INITIAL)	
NAME (LAST, FIRST, MIDDLE INITIAL)	
NAME (LAST, FIRST, MIDDLE INITIAL)	

ENTER 1 OR 2 FROM BELOW:

#1 - The individual declining coverage DOES NOT have another employer health benefit plan.

#2 - The individual declining coverage DOES have another employer health benefit plan.

X SIGN HERE IF DECLINING COVERAGE ____ EMPLOYEE SIGNATURE ____ DATE

I represent that all the information supplied in this application is true and complete. **I hereby agree to the conditions of enrollment on the reverse side of this application.** *Arbitration Agreement.* I understand that any dispute or controversy that may arise regarding the performance, interpretation or breach of the agreement between myself (and/or any enrolled dependent) and Sharp Health Plan, whether arising in contract, tort or otherwise, must be submitted to arbitraton in lieu of a jury or court trial if not satisfactorily resolved through Sharp Health Plan's grievance process.

X ____ EMPLOYEE SIGNATURE ____ DATE

FORM NO. 6111 (11/00)

WHITE - SHP Enrollment **GOLD** - SHP Marketing & Sales **PINK** - Employer **YELLOW** - Employee

ACKNOWLEDGMENT

I authorize my employer to deduct from my earnings the contribution (if any) required to cover my share of the premium. I certify that I am working at the employer's place of business in permanent employment. For enrollment in Sharp Health Plan, I understand that my dependents and I must live or work in the Plan's service area.

I understand that my employer's application will determine coverage and that there is no coverage unless and until this application and an application made by my employer have been accepted and approved by Sharp Health Plan, and the applicable Companies identified on the front of this form, issuing coverage.

I understand that California law prohibits an HIV test from being required or used by health care plans as a condition of obtaining coverage.

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION. PLEASE READ CAREFULLY BEFORE SIGNING AT THE "X" ON THE REVERSE SIDE

Sharp Health Plan is authorized to obtain and release medical information in compliance with the Confidentiality of Medical Information Act. Section 56 et. seq. of the California Civil Code.

I hereby authorize any physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish an agent, designee or representative of Sharp Health Plan, or any of the Companies identified for coverage above, any and all records pertaining to medical history, services rendered, or treatment given to anyone enrolled hereunder or added hereafter for purpose of review, investigation, or evaluation of any application or a claim.