ALLPOINTE Insurance Services

Application Instructions For PacifiCare

1. Print all pages of the application including instructions.
2. Complete all questions and sections of the application.
3. Complete the fax cover letter on the next page and fax to ALLPOINTE Insurance Services for review along with the completed application. If you do not have access to a fax machine, send the completed application to ALLPOINTE Insurance Services along with the required first month's payment.

HELPFUL TIPS:

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- ❏ Indicate your requested effective date.
- ❏ Select your preferred billing method.
- ❏ Sign and date the application.

IMPORTANT:

If you have requested that your monthly premium be deducted automatically from your checking account, you must attach a voided check to the area provided and also sign and date the authorization form.

Don't forget to **enclose a check for the required payment made payable to PacifiCare** if you are not paying by credit card.

Mail completed application and check to:

ALLPOINTE Insurance Services

Attn: New Enrollment

290 Missouri Street

San Francisco, CA 94107

ALLPOINTE Insurance Services will review your application for completeness and accuracy before we submit it to PacifiCare for processing. This may reduce the approval time because they cannot process unclear or incomplete applications until the missing information has been gathered.

Please contact us if you have any questions regarding the application or the application process. You may reach us at 1-888-992-2244 or e-mail us at mybroker@allpointe-is.com.

ALLPOINTE Insurance Services

FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

**Please FAX this cover letter with the completed application to:

ALLPOINTE Insurance Services
FAX# 415-520-5554

Dear ALLPOINTE Insurance Services,

Please accept my completed insurance application for submittal and contact me to confirm receipt of this application

Name ____

E-mail ____

Date ____

Time ____

☐ Please contact me at this phone number ______________________after you have reviewed my application for completeness and accuracy.

☐ I will contact ALLPOINTE Insurance Services at 1-888-992-2244 to verify receipt of my application.

**I understand that ALLPOINTE Insurance Services will not review this application until the following weekday morning if I faxed this application after 5:00PM or on a weekend

I understand that the original signed application must still be mailed to ALLPOINTE Insurance Services. I will mail the original signed application to :

ALLPOINTE Insurance Services
Attn: New Enrollment
290 Missouri Street
San Francisco, CA 94107

I will send the original application as soon as I have been contacted by ALLPOINTE Insurance Services with confirmation that my application has been received by fax and reviewed for completeness.

Signature: ___________________________________ Date: ________________

PacifiCare®

How to Apply for PacifiCare Individual Plans

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 only allows first-of-the-month effective dates. Please submit your application by the 20th of the month to be considered for the first of the following month. Actual effective dates are determined by PacifiCare. **Do not cancel any existing coverage until you are notified by PacifiCare that you have been accepted.**
- ***Select your method of payment – monthly debit or monthly direct bill.*** Determine the amount of premium you need to submit with your application by referring to the *Monthly Premium for Individual Plans* enclosed with this brochure.
  - If you and your Spouse are both applying, use the younger of your ages in determining your premium.
  - Be sure to include your first premium payment with this application.
- ***Complete the Applicant Information section.*** Please list the younger Spouse (if applying) as the Primary Applicant. If the parent/guardian is applying for a child only, list the child's name as the Primary Applicant.
- ***Complete the Enrollment Information section and list each family Member applying.*** PacifiCare SignatureValue℠ (HMO) applicants must select a Primary Care Physician. Please visit our Web site at **www.pacificare.com** for assistance. When applying for the PacifiCare SignatureValue (HMO) plan, every applicant must choose a Primary Care Physician, along with the appropriate provider number, from this directory.
- ***Enrollment Information.*** Please answer all the questions in this section. These questions will be used to assess your eligibility for guaranteed coverage available under the Health Insurance Portability and Accountability Act (HIPAA). If you wish to apply under HIPAA, you do not need to answer the Health Questionnaire. Please call Individual Sales for rates of coverage under HIPAA. You should complete the entire application and apply for the standard individual product, in case you do not qualify under HIPAA.

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 under one of the PacifiCare SignatureOptions℠ (Preferred Provider Organization PPO) plans. 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

Please note: Coverage does not become effective under any circumstances until an application has been underwritten and approved by PacifiCare.

Your Individual Plan Enrollment Application

PacifiCare®

IMPORTANT: PLEASE *PRINT* IN BLACK INK. *Every* question must be answered completely by applicant or guardian. Application must be signed to be valid.

1. Application, Plan & Payment Information

A. Please check one: ❑ New Enrollment ❑ Adding Dependents to ____________ ____________
Subscriber Name / Subscriber ID Number

❑ Plan Change ❑ HIPAA (Health Insurance Portability and Accountability Act) Attach Certificate of Creditable Coverage or other documentation showing prior coverage.

B. Requested Effective Date: 1st day of ____ – ____ (mm yy) *Note: Your requested effective date is not guaranteed. Actual effective date is determined by PacifiCare.*

C. Select ONE Plan:

PacifiCare SignatureValue℠ (HMO)
❑ 10-30/250 ❑ 15-30/80
❑ 35/70

PacifiCare SignatureOptions℠ (PPO)
❑ 80-50/750 (with maternity) ❑ 70-50/500
❑ 70-50/1000 (with maternity) ❑ 70-50/1000
❑ 70-50/1500 (with maternity) ❑ 70-50/2000
❑ 70-50/3000

PacifiCare SignatureValue℠ (HMO) HIPAA
❑ 15-30/80 ❑ 35/70

PacifiCare SignatureOptions℠ (PPO) HIPAA
❑ 70-50/2000 ❑ 70-50/3000

D. Choose your payment method:

❑ Monthly Easy Pay
For this payment method, you must enclose:
- *Your completed Easy Pay form*
- *A voided check*
- *A check for one month's premium*

❑ Monthly Bill
Please enclose a check for 1 month's premium with your application.
Amount of check enclosed: $__________

2. Applicant Information

Important: If married and both Spouses are applying for coverage, indicate younger Spouse's name as the Primary Applicant

Primary Applicant's Name ______________________
Last / First / MI

Home Address (P.O. Box not acceptable) ______________________
Street / Apt # / City / State / ZIP

Mailing Address (If different from home address) ______________________
Street / Apt # / City / State / ZIP

Billing Address (If different from mailing address) ______________________
Street / Apt # / City / State / ZIP

Phone No. (____) ____________ Home (____) ____________ Work

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Applicant's Occupation ____________ **Spouse's Occupation** ____________

3. Enrollment Information

List yourself and all eligible family Members applying for coverage. **Each applicant applying for a PacifiCare SignatureValue (HMO) plan must select a Primary Care Physician.** You may choose the same or a different Primary Care Physician for each family Member. *Please refer to the* PacifiCare SignatureValue (HMO) Provider Directory *to make your choice and find the Primary Care Physician Code Number.*

Relationship	Last Name	First Name	MI	Social Security #	Height	Weight	Birth Date Mo/Day/Yr	PacifiCare SignatureValue only Primary Care Physician (PCP) Name	PacifiCare SignatureValue Provider # (10-digits)	Current Patient of PCP? Y = Yes N = No
❑ Male ❑ Female	Applicant									
❑ Husband ❑ Wife	Spouse									
❑ Son ❑ Daughter										
❑ Son ❑ Daughter										
❑ Son ❑ Daughter										

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

____

Has the applicant or any applying family Member ever been a PacifiCare Member? ❑ Yes ❑ No

If yes, please provide the name used and the PacifiCare ID #, if known. ______________________

Section 3. Enrollment Information (Continued)

1. Do you have other coverage available to you, such as through your spouse, current employer, Medicare, or Medicaid? ❑ Yes ❑ No
2. Have you had 18 months of prior coverage, with no greater than a 62-day gap in coverage? ❑ Yes ❑ No
3. Was the last coverage you had a GROUP (employer-sponsored), Government or Church Plan? ❑ Yes ❑ No
4. Was the last coverage you had terminated due to non-payment of premium or fraud? ❑ Yes ❑ No

5a. Was COBRA or Cal-COBRA available to you when your last coverage was terminated? ❑ Yes ❑ No

5b. If yes, did you elect and exhaust your COBRA or Cal-COBRA coverage? ❑ Yes ❑ No

4. Health Questionnaire

A. Have you or any other family Member listed on this application ever had or been treated for any of the following conditions? Please indicate either "yes" or "no." If yes, provide more details in Section B below. **Incomplete information will result in a processing delay.**

All questions must be answered | **Incomplete information will result in a processing delay**

#	YES	NO	CONDITION
1	◯	◯	Acquired Immune Deficiency (AIDS)/AIDS Related Complex (ARC)
2	◯	◯	ADD (Attention Deficit Disorder)/ADHD
3	◯	◯	Alcoholism and/or Drug Abuse
4	◯	◯	Allergies and/or Asthma
5	◯	◯	Anemia
6	◯	◯	Arthritis or Rheumatism
7	◯	◯	Back/Spinal Condition
8	◯	◯	Bacterial Infections, Multiple or Reoccurring
9	◯	◯	Birth Defect
10	◯	◯	Bladder Condition
11	◯	◯	Blood Condition – Past 10 Years
12	◯	◯	Bone Infection or Disorder
13	◯	◯	Breast Conditions/Implants
14	◯	◯	Cancer
15	◯	◯	Chronic Fatigue
16	◯	◯	Colon, Rectal, Bowel Condition
17	◯	◯	Cysts, Tumors, Growths or Fibroids
18	◯	◯	Depression/Anxiety/ Emotional Condition(s)
19	◯	◯	Diabetes
20	◯	◯	Disability/Disabled
21	◯	◯	Ear Condition
22	◯	◯	Emphysema
23	◯	◯	Epilepsy, Convulsions, Seizures
24	◯	◯	Eye Condition
25	◯	◯	Fibromyalgia
26	◯	◯	Gallbladder Condition
27	◯	◯	Headaches or Migraines
28	◯	◯	Heartburn/Gastroesophageal Reflux Disease (GERD)
29	◯	◯	Heart Problems or Disorders
30	◯	◯	Hemorrhoids
31	◯	◯	Hepatitis
32	◯	◯	Hernia
33	◯	◯	High Blood Cholesterol and/or Triglycerides If yes, Last Reading ________ **(Please explain below.)**
34	◯	◯	High Blood Pressure If yes, Last Reading ________ **(Please explain below.)**
35	◯	◯	Impotence
36	◯	◯	Jaw Condition or TMJ
37	◯	◯	Joint Condition
38	◯	◯	Kaposi's Sarcoma
39	◯	◯	Kidney Condition
40	◯	◯	Liver Condition
41	◯	◯	Lung or Respiratory Condition
42	◯	◯	Lupus
43			Mental Health Conditions
	◯	◯	Schizophrenia
	◯	◯	Schizoaffective Disorder
	◯	◯	Bipolar Disorder
	◯	◯	Major Depressive Disorder
	◯	◯	Panic Disorder
	◯	◯	Obsessive-Compulsive Disorder
	◯	◯	Autism and other pervasive developmental disorders
	◯	◯	Anorexia
	◯	◯	Bulimia Nervosa
	◯	◯	Any other mental or nervous conditions? (If yes, please explain below.)
44	◯	◯	Muscle Disorder
45	◯	◯	Neurological Condition
46	◯	◯	Non-Hodgkin's Lymphoma
47	◯	◯	Paralysis
48	◯	◯	Phlebitis or Blood Clot
49	◯	◯	Prostate Disorder
50	◯	◯	Sexually Transmitted Diseases
51	◯	◯	Skin Condition
52	◯	◯	Stomach or Abdominal Condition
53	◯	◯	Stroke
54	◯	◯	Thyroid Condition
55	◯	◯	**Do you have any other conditions not described above?** (If yes, please explain below.)

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 #	Applicant/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	

C. Has any applicant listed on this application seen a physician, for any reason, in the past two years? ◯ Yes ◯ No
If yes, please provide details below:

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

D. Please complete the following for ALL applicants listed on this application.
If you need more space for explanation, please attach a separate piece of paper.

Incomplete information will result in a processing delay

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

2. Has any applicant listed on this application ever been advised to have an operation or treatment (including dental work) **that has not yet been performed?** ◯ Yes ◯ No
If yes, state individual's name(s) and explain (include date):

3. Has any applicant listed on this application been refused or restricted life or health insurance coverage within the last five years? ◯ Yes ◯ No If yes, state family Member's name(s) and give details:

4. Has any applicant listed on this application used tobacco products in the past 12 months? ◯ Yes ◯ No
If yes, please provide the following information:

NAME | START DATE | STOP DATE | DAILY AMOUNT

NAME | START DATE | STOP DATE | DAILY AMOUNT

5. 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

6. 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? ◯ Yes ◯ No
If yes, state family Member's name(s) and explain **(include date and duration):**

7. 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

NAME | DRUG | DOSAGE/DATE STARTED

8. 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 five years? ◯ Yes ◯ No If yes, state applicant's name(s) and explain **(include date and duration):**

9. Is any applicant listed on this application currently covered by medical insurance or a health care plan? ◯ Yes ◯ No ◯ Group or ◯ Individual If yes, provide the name of the insurance company or health care plan and effective date of coverage:

FEMALES ONLY (including Spouse and Dependents)

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

11. Please provide the date of last Pap smear:

Results:

12. Please provide the date of last menstrual cycle for all females under age 45 (if no menstrual cycle, state reason).

NAME | MONTH | DAY | YEAR

NAME | MONTH | DAY | YEAR

13. Are any females applying for coverage currently pregnant? ◯ Yes ◯ No

MALES ONLY (including Spouse and Dependents)

14. 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:

5. Terms & Conditions

1. I understand that all health care services under the PacifiCare SignatureValue (HMO) Coverage Options must be provided or arranged for by PacifiCare, except for Emergency or Urgently Needed Services.
2. I understand that PacifiCare is not liable for bills incurred before the effective date.
3. I agree that if this application is approved, PacifiCare will notify the applicant in writing of the effective date of coverage.
4. I understand that this application is not a contract. The contract consists of the PacifiCare Health Plan Individual Subscriber Agreement or Policy, including but not limited to all applications, health questionnaires and information submitted by the Subscriber or Insured and his or her Dependents in applying for coverage, appropriate attachments and addenda, and any amendments hereto. Should my application be accepted, PacifiCare will send me a Subscriber Agreement or Policy which details the exact terms and conditions of coverage to which I will be legally bound.
5. I understand that any agent or broker or other producer selling PacifiCare coverage does not have the authority to approve my application, change any terms of the agreement or waive any PacifiCare requirements.
6. I agree that failure to provide full, complete, true and accurate information may result in the denial of benefits, termination and/or rescission of membership in PacifiCare for myself and/or my Dependents.
7. If the applicant is a minor, as the parent/legal guardian of the minor child (the "applicant") and on behalf of the applicant, I request PacifiCare to provide health care coverage under its Individual Plan to the applicant. I hereby assume responsibility for the applicant's compliance with the terms and conditions of the PacifiCare Individual Plan selected as set forth in the applicable Subscriber Agreement or Policy and agree to be responsible for making Health Plan Premium and Copayments, on behalf of the applicant.
8. I hereby authorize any "Provider of health care" to disclose or provide to PacifiCare, its agents or employees, all information and medical records pertaining to any examination or treatment, including treatment for alcohol abuse, substance abuse, psychiatric disorders and/or acquired immune deficiency syndrome (AIDS), regarding myself or any applying family Member. I understand this information is collected for purposes of evaluating my application and determining both initial and continuing eligibility for benefits. This authorization will remain valid for 30 months from the date below. A photocopy of this authorization is valid as the original.
9. By signing below, I attest and agree that all of the information is correct and that the submission of this application to PacifiCare constitutes an offer to obtain the PacifiCare individual coverage summarily described in the Subscriber Agreement or Policy. I have read the disclosure brochure outlining the benefits, limitations and exclusions and other elements of the disclosure, the above terms and conditions and the authorization to disclose personal information.
10. **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 PACIFICARE OF CALIFORNIA 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 HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.**

6. Signatures

SIGNATURE OF APPLICANT/PARENT OR LEGAL GUARDIAN *(Required)*	**TODAY'S DATE** *(Required)*	SIGNATURE OF APPLICANT'S SPOUSE *(Required if applying)*	**TODAY'S DATE** *(Required)*
X		X	
SIGNATURE OF APPLICANT'S DEPENDENT AGE 18 OR OVER *(Required)*	**TODAY'S DATE** *(Required)*	SIGNATURE OF APPLICANT'S DEPENDENT AGE 18 OR OVER *(Required)*	**TODAY'S DATE** *(Required)*
X		X	

▪ Important – All Signatures Must Include Today's Date ▪

For Agent's Use Only

Agent Name	Firm Name	License No.	Tax I.D. No.
Bradley Vaccaro	ALLPOINTE Insurance Services		

Payee ☐ AGENT ☐ FIRM

Is payee currently contracted with PacifiCare? ☐ Yes ☐ No If no, please submit a copy of payee's license

GA Name/Number: 1006583

Street Address	City	State	ZIP
290 Missouri Street	San Francisco	CA	94107

Agent's Signature	Date	Phone Number	Fax Number
		(888) 992-2244	(415) 520-5554

Is this the payee's first individual application with PacifiCare? ☐ Yes ☐ No

Are you aware of any information not disclosed in this Health Questionnaire which may have a bearing on this risk? ☐ Yes ☐ No If yes, explain: ____________

Did you see the applicant and did you ask each question on the Health Questionnaire exactly as set forth? ☐ Yes ☐ No If no, explain: ____________

Was this Health Questionnaire completed by the applicant? ☐ Yes ☐ No

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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