Enclosed is the **PacifiCare** application you requested. To avoid unnecessary delays in the underwriting process, please be sure to complete the application in full. The following tips may help you:

1. Read and Sign the enclosed "Health Insurance Application Disclosure Statement/Acknowledgement". This document must be included with your application to ensure prompt processing.

2. On the Enrollment Application Form please complete all applicant, plan and payment information, choosing either PPO Plan 1, Plan 2 or Plan 3. Complete pages 3 and 4, answering all health questions and giving details to any questions you answered "yes" to.

3. Please sign and date at the bottom of page 5.

4. You may choose make your monthly premium payments using their EZ Pay Program. The Authorization form is included and will require a voided check for the checking account you authorize.

5. Please also submit the first month's premium, payable to "Pacificare" by check or money order.

Once your application is received, the review process normally takes 4 to 6 weeks. If medical records are requested, the review process will be slightly longer. Rates are subject to change, based on review of Pacificare's underwriting guidelines

Please mail the application, along with your first month's premium, to our address as listed below or use the postage paid envelope that has been included. If you have any questions, please give us a call at 258-1995.

9505 Hillwood Drive, Suite 100 • Las Vegas, Nevada 89134 • (702) 258-1995 • Fax (702) 877-0956
www.nevadabenefits.com • Nevada License # 42429

HEALTH INSURANCE APPLICATION
DISCLOSURE STATEMENT/ACKNOWLEDGEMENT

I understand that I must complete, sign and return this Statement/Acknowledgement to Nevada Benefits prior to the start of the insurance application process.

I understand that as an application for health insurance coverage, it may take from four to six weeks (or longer), from the date I have completed and returned my application to **Nevada Benefits** until I am notified as to whether I have been approved for the coverage for which I apply.

I acknowledge that neither **Nevada Benefits** nor anyone else employed by or affiliated with **Nevada Benefits** has advised me or even suggested that I cancel or replace any existing insurance policy. Moreover, by executing this Statement/Acknowledgement I am affirmatively stating that I will not cancel any existing insurance coverage, which the policy I am applying for may replace, prior to receiving my approved policy from **Nevada Benefits** and determining that such policy is satisfactory for my individual needs.

I further agree and understand that should I cancel or replace any existing policy prior to being approved for the policy from Nevada Benefits, that I will be without insurance coverage if the policy for which I have applied is not approved. **Nevada Benefits** does not make underwriting decisions. The insurance company makes all underwriting decisions.

While I have made payment on the policy for which I have applied, I understand that said payment provides conditional coverage only. I also acknowledge that said payment in no way guarantees that my application will be approved. I further acknowledge that even though I have made a payment, I am prohibited by this Statement/Acknowledgement from canceling any existing insurance coverage the **Nevada Benefits'** policy might be replacing until I have first received my approved policy from **Nevada Benefits** and have determined that such policy is satisfactory for my individual needs.

I have read and I understand the pre-existing clause of the policy I have applied for.

Finally, I understand that any person who omits factual information or includes any false or misleading information on an application for insurance will void any insurance coverage, which would otherwise be afforded to me, and I agree to hold **Nevada Benefits** harmless from any claim (including any damages or cause of action) related to any denial of benefits because of any omitted, false, or misleading information, and I acknowledge that I will be responsible to pay all costs (including attorneys' fees) reasonably incurred by **Nevada Benefits** to defend against any such claim or to otherwise enforce the provisions of this document.

Applicant's Name: ______________________________

Applicant's Signature: ______________________________

Legal Guardian's Name: ______________________________

Legal Guardian's Signature: ______________________________

Date: ______________________________

THIS DISCLOSURE FORM MUST BE SIGNED AND RETURNED WITH THE ENCLOSED APPLICATION.

Pacificare

Nevada PPO I Plan

	Plan 1 ($1500)	Plan 2 ($500)	Plan 3 ($2000)
Outpatient Provider Services			
Physician's Office Visit [2]	100% after $30 Copayment, up to 4 visits per Calendar Year maximum/50% after Deductible	100% after $20 Copayment/50% after Deductible	100% after $30 Copayment, up to 4 visits per Calendar Year maximum/50% after Deductible
Wellness and Preventive Services			
Breast and Pelvic Exams [2]			100% after $30 Copayment/50% after Deductible
Mammogram Screening [2]	80%/50% after Deductible	80%/50% after Deductible	70%/50% after Deductible
Osteoporosis Screening [2]			
Prostate Cancer Screening [2]			
Children With Immunizations [2]			Not covered
Periodic Health Evaluations *(age 19 and over)*	$300 per Calendar Year maximum	$300 per Calendar Year maximum	
Physician Services			
Laboratory Services			
X-Ray Services	80%/50% after Deductible	80%/50% after Deductible	70%/50% after Deductible
Diagnostic Testing			
Hospital Services			
Inpatient Care	80%/50% after Deductible *($500 per day maximum at Non-Participating Providers)*	80%/50% after Deductible *($500 per day maximum at Non-Participating Providers)*	70%/50% after Deductible *($500 per day maximum at Non-Participating Providers)*
Outpatient Surgery			
Emergency Services			
Ambulance *(Medically Necessary transport)*	60% after Deductible	60% after Deductible	60% after Deductible
Emergency room services *(waived if admitted)*	$100 additional Deductible	$100 additional Deductible	$100 additional Deductible
Urgent Care	80%/50% after Deductible	80%/50% after Deductible	70%/50% after Deductible
Behavioral Health - Inpatient			
Chemical Dependency Inpatient [1] *($9,000 per Calendar Year maximum)*		80%/50% after Deductible *($200 per day maximum at Non-Participating Providers)*	
Chemical Dependency Inpatient Detoxification [1] *($1,500 per Calendar Year maximum)*	80%/50% after Deductible *($500 per day maximum at Non-Participating Providers)*		70%/50% after Deductible *($500 per day maximum at Non-Participating Providers)*
Severe Mental Illness Inpatient *(up to 40 days per Calendar Year maximum)*		80%/50% after Deductible *($500 per day maximum at Non-Participating Providers)*	
Mental Illness *(other than Severe Mental Illness)*	Not covered	Not covered	Not covered
Behavioral Health - Outpatient			
Chemical Dependency Outpatient [1] *($2,500 per Calendar Year maximum)*	80%/50% after Deductible	80%/50% after Deductible	70%/50% after Deductible
Severe Mental Illness Outpatient *(up to 40 visits per Calendar Year maximum)*			
Mental Illness *(other than Severe Mental Illness)*	Not covered	Not covered	Not covered

PacifiCare®
A UnitedHealthcare Company

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:

Nevada Benefits
9505 Hillwood Drive Suite 100
Las Vegas, Nevada 89134

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**.

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:***

Nevada Benefits
9505 Hillwood Drive Suite 100
Las Vegas, Nevada 89134

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.

Nevada Enrollment Application

PacifiCare®
A UnitedHealthcare Company

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

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℠ (PPO) Plan 1 – $30/80-50/$1,500
- ☐ PacifiCare SignatureOptions℠ (PPO) Plan 2 – $20/80-50/$500
- ☐ PacifiCare SignatureOptions℠ (PPO) Plan 3 – $30/70-50/$2,000
- ☐ PacifiCare SignatureFreedom℠ (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℠ (PPO) HIPAA Basic $20/70-50/$1,500
- ☐ PacifiCare SignatureOptions℠ (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				☐ M ☐ F							
Spouse				☐ M ☐ F							
Child				☐ M ☐ F							
Child				☐ M ☐ F							
Child				☐ M ☐ 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

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

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.*

Form #: ENRFRM-IP-5/05

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	Company Name	Agent Number
Phil Randazzo	Nevada Benefits	30143

Agent Address	City	State	ZIP	Agent Phone Number	Agent Fax Number
9505 Hillwood Dr.	Las Vegas	NV	89134	702·258·1995	702·877·0956

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)*	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	

SIGNATURE OF PERSONAL REPRESENTATIVE OR CUSTODIAN *(if applicable)*	TODAY'S DATE *(required)*	PRINT NAME OF PERSONAL REPRESENTATIVE OR CUSTODIAN *(if applicable)*
X		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 CY24-155
P.O. Box 3069
Cypress, CA 90630

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

Form #: ENRFRM-IP-5/05
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PNV143013-001

PacifiCare SignatureOptions (PPO and HDHP) and PacifiCare SignatureFreedom (SDHP) are Underwritten by PacifiCare Life Assurance Company. PacifiCare SignatureValue (HMO) and PacifiCare SignaturePOS® (POS) are offered by PacifiCare of Nevada, Inc.

PacifiCare®

Credit Card Payment Authorization

Payment Option

First Month's Premium (due at time of application)		One-Time Credit Card Charge	
☐ Premium Payment Amount:	$________	☐ Premium to be Charged to Card:	$________
☐ Application Fee (TX/OK):	$25	☐ Total Fees (if applicable):	$________

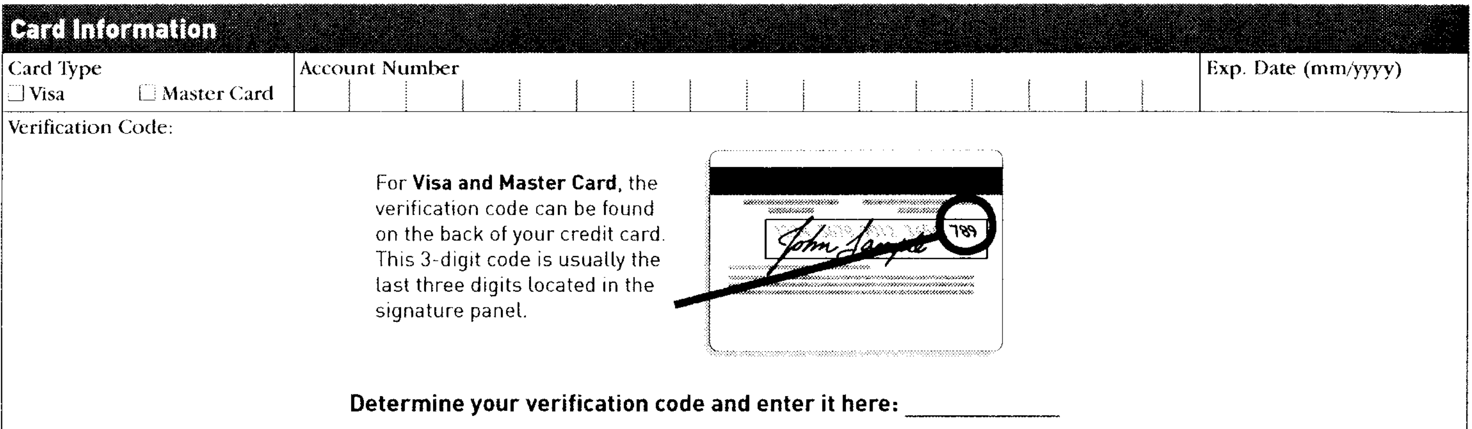
Applicant's Information

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	Account Number	Exp. Date (mm/yyyy)
☐ Visa ☐ Master Card		

Verification Code:

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.

Determine your verification code and enter it here: ________

Authorization

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.

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

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PEW147083-000

DESERT REGION

PacifiCare®

EZ PAY PROGRAM AUTHORIZATION

______ New Setup ______ Change of Account

Member Information

Member Name	Phone	Member Number	
Address	City	State	ZIP

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

- Your first (1st) deduction will occur on approximately the 10th of the month following receipt of this form and on approximately the 10th of each month thereafter. Please note: a deduction may include any retroactive adjustments.
- **Be sure to attach a voided check for the checking account you authorize. <u>No copies are accepted.</u>**
- 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.

Bank Draft Authorization

Bank Name	Branch		
Bank Address	City	State	ZIP
Account #	Routing/Transit #		

It is important that you complete the routing/transit number. The 1st seven (7) numbers are your routing numbers. If you are unsure what the routing/transit number is, refer to the illustration or phone your bank and it can assist you.

To start the automatic Banking process, it is important that you enclose a voided check with your account number and banking information on it. Deposit slips cannot be accepted.

Payment Authorization (this section must be completed in full)

I hereby authorize PacifiCare to initiate debit entries to the banking account number listed above. In the event PacifiCare is unable to debit my account for the first month's premium, I authorize PacifiCare to debit my account for two month's premiums the following month. PacifiCare may also initiate, if necessary, any credit entries or adjustments for any debit recorded in error. I will not hold PacifiCare responsible for delay, loss or misapplication of funds due to incorrect or incomplete information supplied by me or my depository, or failure of my depository to correctly debit my account. I understand that an unforeseen delay in processing by an outside entity (financial institution) due to computer downtime, power outages or other unavoidable occurrences might affect the date of charge to funds in my account.

Note: This authorization is to remain in full force and effect until PacifiCare has received written notice of my intention to terminate this agreement.

Signature of Primary Subscriber	Date
Signature of Depositor	Date

This authorization is to remain in effect until PacifiCare has received written notice of our intention to terminate this agreement. PACIFICARE MUST RECEIVE NOTIFICATION TO TERMINATE THIS AGREEMENT BY THE 15th DAY OF THE MONTH PRECEDING THE MONTH OF COVERAGE. NOTIFICATION MUST BE IN A LETTER REQUESTING TERMINATION OF EZ PAY WITHDRAWALS.

Membership Accounting
P.O. Box 52078
Phoenix, AZ 85072-2078

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