



health insurance • life insurance • disability insurance • retirement planning

Enclosed is the **PacifiCare PPO** 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 PPO Plan 1, Plan 2, Plan 3 or the new SDHP. 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 or complete the credit card payment authorization.

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 made your initial payment by credit card, you can fax your application to 201.1326. Please give us a call at 686.6010 with any questions.

One E Liberty, 6th Reno, NV 89504 • (775) 686.6010 • Fax (775) 201.1326
www.nevadabenefits.com • Nevada License # 6266

PacifiCare SignatureFreedomSM a fully insured self directed health plan for those who want real freedom of choice.

PacifiCare SignatureFreedomSM Self Directed Health Plan (SDHP) is a simple plan design, similar to a traditional PPO. Participants pay an annual deductible before the plan covers their health care expenses. The key difference is that covered persons receive a Self Directed Account (SDA), which provides first-dollar coverage for a select set of services.

PacifiCare SignatureFreedom SM Plan Design Sample		
Prescription Drug Coverage \$250 Deductible then \$15 generic \$40 brand \$60 non-Formulary	Self Directed Account (SDA) \$250/ Calendar Quarter Individual only	\$500/ Calendar Quarter Family
	PPO Benefits Individual-Paid Deductible \$3,000 Individual only	
	In-Network Coinsurance 70%	Out-of-Network Coinsurance 50%

PacifiCare SignatureFreedom plans are underwritten by PacifiCare Life Assurance Company.

Choice with added security. Perfect for today's health care consumer.

If a participant depletes his or her SDA, the PacifiCare SignatureFreedom plan defaults to a high-deductible PPO plan. A portion of the yearly deductible for their PPO plan may have already been satisfied through their SDA.

If a participant requires services that are not covered by the SDA (such as inpatient surgery or emergency room services), he or she will need to meet the applicable PPO deductible.

Once the remaining portion of the deductible not covered by the SDA is satisfied, a participant can take advantage of the coverage afforded by the coinsurance portion of the plan. Even if the PPO deductible has been met, there may be funds available in their SDA for SDA-eligible coinsurance expenses.

*This is merely a summary, and the *Policy* and *Schedule of Benefits* need to be referenced for specific details of conditions, limitations and exclusions. Premium will vary depending on the age and gender of the enrollee.

The Self Directed Account gives today's health care consumers real freedom.

With PacifiCare SignatureFreedom, plan participants can go to any provider for services covered by the SDA. If they choose a provider from PacifiCare's extensive plan provider network, they often pay lower, PacifiCare-negotiated rates.

Here are just a few examples of the services included (but not limited) to the SDA:

- Physician office visits
- Covered diagnostic X-ray and lab services
- Preventive care for children with immunizations (through age 18)
- Mammography screening
- Breast and pelvic exams
- Prostate cancer screening
- Periodic health evaluations

Services not covered by the SDA include (and are not limited to) such expenses as hospitalization and outpatient surgery, prescription drug benefits, emergency room services, and nontraditional medical expenses including acupuncture and infertility services.

Unused portions of the SDA can be rolled over, quarter after quarter.

The SDA's rollover feature allows covered persons to "save" the unused SDA balance by rolling it over to the next quarter. And they can continue to roll over the remaining balance, quarter after quarter. This allows them to save funds for health care expenses while encouraging them to make smarter choices about their care. The unused SDA balance is forfeited only if the policy is terminated.



Questions & Answers about the PacifiCare SignatureFreedomSM Plan?

What is the Self Directed Account (SDA)?

The SDA can be used to pay for specified eligible medical plan expenses from the beginning of your coverage. The SDA is available to satisfy part of the annual PPO deductible. The amount of the SDA is disclosed in the *Schedule of Benefits*.

What are the PPO benefits under the PacifiCare SignatureFreedom plan?

PacifiCare PPO benefits work just like those of any other PPO plan. The covered person can see any physician or specialist but may enjoy greater benefits by seeing participating providers who have contracted with PacifiCare to provide services at prenegotiated rates.

What are the Prescription Drug benefits under this plan?

The covered person must satisfy a \$250 deductible, but then has prescription coverage at the following copayment amounts: \$15 generic, \$40 brand and \$60 non-Formulary.

What will the covered person have to pay for?

Here are a few scenarios where a covered person will pay for services:

1. *The SDA has not been used, covered person has not met the plan year deductible, and the covered person is visiting his or her physician for a routine check-up.* In this scenario, the covered person would not be responsible for paying as long as the cost of the office visit does not exceed the amount of the SDA balance. The cost of the visit will be deducted from the SDA, and the same amount would be subtracted from the Deductible.
2. *The covered person has used all the funds available in the SDA (the balance of the SDA is zero) and has not met the plan year deductible.* In this scenario, the covered person would be responsible for paying the difference between the amount of the annual deductible and the amount already satisfied by the SDA. The annual deductible must be met before the coinsurance would apply.
3. *The SDA balance is zero and the covered person has met the plan year deductible.* In this scenario, the covered person would be responsible for paying his or her share of the coinsurance as specified in the PacifiCare PPO *Schedule of Benefits*.
4. *The SDA has not been used, the covered person has not met the plan year deductible, and the covered person is hospitalized for surgery.* In this scenario, the covered person would pay up to the annual deductible

amount because hospitalization is not covered by the SDA. The plan then begins paying a percentage of the covered expense under the PacifiCare PPO benefits. The funds in the SDA are still available to the insured for eligible expenses.

How does the SignatureFreedom plan pay claims for health care services?

Once the covered person has received health care from a participating or non-participating provider, the health care provider bills the plan for the cost of services. Once the bill is received by the plan and the SDA is reviewed, the claim will be paid as follows:

1. *If the service is covered by the SDA and the covered person has enough funds in the SDA to cover the bill, it is paid in full by the SDA for in-network services and 100% of usual and customary/limited fee schedule for out-of-network services.* The covered person will owe nothing for in-network services; they are responsible for amounts above usual and customary/limited fee schedule for out-of-network services.
2. *If the service is covered by the SDA but the covered person doesn't have enough funds in the SDA to cover the bill, the plan pays up to the amount left in the SDA.* At this point, the covered person is responsible for the rest of the health care expenses until his or her portion of the annual deductible is met.
3. *If the service is not covered by the SDA, the covered person is responsible for the health care expenses until he or she satisfies the annual deductible.*

Once the PPO annual deductible has been satisfied, the bill will be paid at the PPO coinsurance level.

1. *If the covered person still has funds available in their SDA after the annual deductible has been met, the SDA will pay the covered person's share of the coinsurance for the specified eligible medical expenses until the SDA is exhausted.*
2. *If the covered person does not have funds available in the SDA, he or she pays a share of the PacifiCare PPO coinsurance up to the annual coinsurance maximum.*

Will a member ever have to pay out-of-pocket for services that are applicable to the SDA?

It is possible that a provider may require a participant to pay out-of-pocket for services that qualify for SDA funds. If this occurs, the participant should save his or her receipt and contact customer service for reimbursement.

Self Directed Account (SDA) Covered Services Summary

The following is a summary of SDA covered and non-covered services. Please note, this is not a complete list. Refer to the *Schedule of Benefits* and *Certificate* for additional plan information, including exclusions and limitations.

SDA covered services are made up of a compilation of services commonly performed during a routine office visit, subject to a proprietary medical coding table. If a physician

refers a participant to a facility or hospital for SDA-eligible radiology, laboratory, pathology or diagnostic tests, the services will be covered by the SDA. Eligible services covered by the SDA apply to the deductible. Participants and providers may call Customer Service to determine if a specific service code is payable under the SDA or if it is subject to deductible and coinsurance.

SDA Covered Services

- Annual physical exams
- Immunizations and injections (excluding allergy injections)
- Office-based diagnostic procedures, including, but not limited to:
 - Ambulatory blood pressure monitoring, recording, analysis
 - Electrocardiograms
 - Eye refractions and exams
 - Metabolic panel, basic and comprehensive
 - Muscle and range-of-motion testing
 - Pacemaker analysis
 - Pap smears
 - Prostate exams
 - Sigmoidoscopy
 - Vascular and breathing analysis
- Office pathology and laboratory
- Office radiology, including, but not limited to:
 - Mammograms
 - X-rays
- Physician consultations
- Physician home visits
- Physician office visits
- Well-Baby
- Well-Child
- Well-Woman

Non-Covered Services Under the SDA

- Allergy injections
- Allergy testing (skin, eye, nose, food, etc.)
- Ambulance
- Antigen therapy and immunotherapy services
- Chemical dependency visits
- Chiropractic services
- Colonoscopy (except for qualified individuals as part of a Colorectal Cancer Screening)
- Durable medical equipment
- Electroencephalogram (EEG)
- Emergency room
- Hospital and facility services
- Maternity care
- Mental health-related visits
- Oxygen
- Physician services (other than physician office visits)
- Prosthetic devices
- Rehabilitative services
- Sterilization
- Surgical procedures
- Therapeutic services
- Transplants
- Urgent care facility services

Indemnity insurance products (including PPO products) offered in California are underwritten by PacifiCare Life and Health Insurance Company. Indemnity insurance products (including PPO products) offered in Arizona, Colorado, Nevada, Washington, Oregon, Texas and Oklahoma are underwritten by PacifiCare Life Assurance Company.

INDIVIDUAL PLAN SDHP RATES (2004 SERIES)
EFFECTIVE – 1/1/2006

Age Group	SDHP Plan 1 70%-50%/\$3,000 and \$15/\$40/\$60 Rx					
	Las Vegas		Reno		Other	
	Male	Female	Male	Female	Male	Female
00-01	\$142	\$142	\$179	\$179	\$223	\$223
02-17	\$59	\$59	\$74	\$74	\$94	\$94
18-24	\$72	\$101	\$92	\$129	\$114	\$160
25-29	\$78	\$145	\$99	\$182	\$124	\$229
30-34	\$88	\$149	\$111	\$189	\$138	\$237
35-39	\$107	\$152	\$135	\$192	\$169	\$240
40-44	\$137	\$177	\$173	\$222	\$217	\$279
45-49	\$166	\$199	\$208	\$252	\$262	\$315
50-54	\$230	\$253	\$290	\$319	\$363	\$400
55-59	\$320	\$324	\$404	\$408	\$507	\$511
60-64	\$411	\$383	\$519	\$483	\$650	\$604

Note: PacifiCare may rate up to 150% of the customary rates based on health status of the individual.

6000. OOP max
750 deductible. EX
then 15 Generic
\$40 Brand

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 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 # CY38-224
P.O. Box 3069
Cypress, CA 90630-9962**

**HMO Questions? Call the Customer Service Department at 1-800-347-8600.
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 EZ 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:**
 - 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 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.
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



Requested Effective Date: _____
Subject to Approval

For Office Use Only
Date _____
Group Number _____ Effective Date _____
Approved/Denied _____ Approved by _____

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

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.

Plan Options: (choose one)
 PacifiCare SignatureValue™ (HMO) Plan 4 – \$10/\$25/\$100 per day
 PacifiCare SignatureValue™ (HMO) Plan 5 – \$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

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

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 _____ State _____ ZIP _____

Home Phone _____ Work Phone _____

Applicant's Occupation _____ Spouse's Occupation _____

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
If yes, last reading _____</p> | <p>29. High Blood Cholesterol and/or Triglycerides <input type="checkbox"/> Yes <input type="checkbox"/> No
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?
<input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Other	_____	_____
Has the person(s) quit? <input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> 0 - 1 drinks per day <input type="checkbox"/> 2 - 3 drinks per day <input type="checkbox"/> 4+ drinks per day
NAME	<input type="checkbox"/> 0 - 1 drinks per day <input type="checkbox"/> 2 - 3 drinks per day <input type="checkbox"/> 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.

Agent Information - To be completed by Agent only

Agent Name <u>Nevada Benefits</u>	Company Name <u>AWK (Kandaroo)</u>	Agent Number <u>30143</u>
Agent Address <u>One S Liberty</u>	City <u>Reno</u>	State <u>NV</u>
ZIP <u>89504</u>	Agent Phone Number <u>686 6012</u>	Agent Fax Number <u>2011326</u>

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

5. Signature Required on Arbitration Disclosure - READ CAREFULLY

By signing below, I acknowledge that I have read, understand and agree to the Terms and Conditions and Binding Arbitration on all the pages of this form.

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), BETWEEN MYSELF AND MY DEPENDENTS ENROLLED IN THE PLAN (INCLUDING ANY HEIRS OR ASSIGNS) AND PACIFICARE OF NEVADA, INC. 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. RIGHTS AFFORDED UNDER THE INTERNAL APPEALS PROCESS AND INDEPENDENT EXTERNAL REVIEW ARE NOT AFFECTED BY THIS PROVISION. DISPUTES NOT FULLY RESOLVED THROUGH THE INDEPENDENT EXTERNAL REVIEW PROCESS ARE SUBJECT TO THIS PROVISION.

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

6. Sign and Date Application

SIGNATURE OF APPLICANT OR LEGAL GUARDIAN (required) X	TODAY'S DATE (required)	SIGNATURE OF APPLICANT'S SPOUSE (required if applying) X	TODAY'S DATE (required)
SIGNATURE OF APPLICANT'S DEPENDENT AGE 18 OR OVER (required) X	TODAY'S DATE (required)	SIGNATURE OF APPLICANT'S DEPENDENT AGE 18 OR OVER (required) X	TODAY'S DATE (required)
SIGNATURE OF PERSONAL REPRESENTATIVE OR CUSTODIAN (if applicable) X	TODAY'S DATE (required)	PRINT NAME OF PERSONAL REPRESENTATIVE OR CUSTODIAN (if applicable) 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 CY38-224
 P.O. Box 3069
 Cypress, CA 90630**

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

©2004 by PacifiCare Health Systems, Inc.
 CM 304 61997
 PNV1015-002 Rev 3/04
 Form Number: 2004-NV-IPLAN APP

**PacifiCare SignatureOptions (PPO) and PacifiCare SignatureFreedom (SDHP) are Underwritten by
 PacifiCare Life Assurance Company. PacifiCare SignatureValue (HMO) is offered by PacifiCare of Nevada, Inc.**

CREDIT CARD PAYMENT AUTHORIZATION

Only for first month's premium

Applicant's Information

Applicant's First Name	Applicant's Middle Name	Applicant's Last Name
------------------------	-------------------------	-----------------------

Cardholder's Information

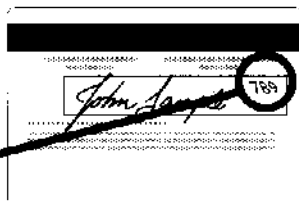
Cardholder's First Name (as it appears on card)	Cardholder's Middle Initial	Cardholder's Last Name	Cardholder's Phone #
Cardholder's Billing Address		City	State ZIP

Card Information

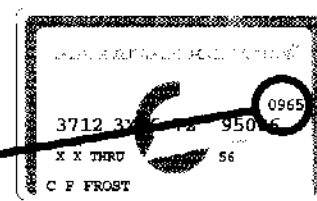
Card Type	Account Number (note: American Express = 15 digits)	Exp. Date (mm/yyyy)
<input type="checkbox"/> Visa <input type="checkbox"/> Discover <input type="checkbox"/> Master Card <input type="checkbox"/> American Express		

Verification Code:

For Visa, Master Card, or Discover, 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.



For American Express, you may find your 4 digit card verification number on the front of your credit card above your credit card number on either the right or the left side of your credit card.



Determine your verification code and enter it here: _____

Amount to Be Charged to Credit Card \$ _____

Authorization

As a convenience, I request and authorize PacifiCare of Nevada, Inc. or PacifiCare Life Assurance Company (PacifiCare) to charge my credit card account identified above for the payment of the applicant's initial health plan premium. I agree that PacifiCare shall be fully protected in honoring this **one-time** credit card transaction. I further agree that should this card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, PacifiCare shall be under no liability whatsoever, including any fees imposed by the card issuer, should my card be rejected even though such dishonor may 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 CY38-224
 P.O. Box 3069
 Cypress, CA 90630-9962



EZ Pay Program Authorization

Desert Region

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

If applying for PPO/SDHP: **Individual Plans**, P.O. Box 6006, Mail Stop CY24-593, Cypress, CA 90630. Fax: 1-866-220-0855

If applying for HMO: **Individual Plans**, P.O. Box 52078, Mail Stop AZ74-142, Phoenix, AZ 85072-2078. Fax: (480) 303-7500

- The monthly premium will be deducted on or after the 6th of the month for the coverage month.
- 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.
- You may be subject to a \$25 administrative fee by PacifiCare for each return payment from your bank.

Check one: HMO new set-up PPO/SDHP new set-up Bank Account change (for current Subscribers/Insureds only)
Subscriber/Insured Number: _____

Subscriber/Insured Information

Last Name		First Name		Phone #	
Street Address			City		State ZIP

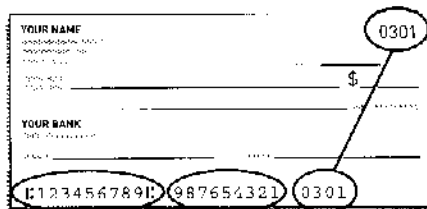
Bank Draft Authorization

Account Holder		Bank Name		State	
Routing/Transit # (9 Digits) (Required)		Account # (Required) (include all zeroes and omit spaces/special characters)		Check # (Required)	

Determining Your Routing Number

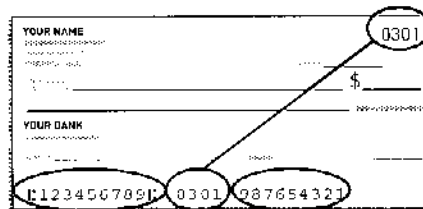
To determine your routing number, refer to your personal check. The routing number is ALWAYS 9 digits long and it is enclosed by colons. The location of the routing number and account number on your personal check varies depending on your bank, for example:

Bank 1



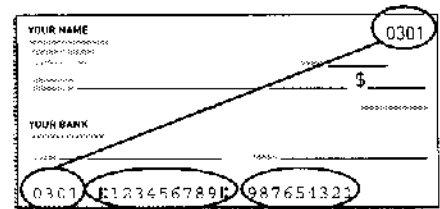
Routing # Account # Check #

Bank 2



Routing # Check # Account #

Bank 3



Check # Routing # Account #

If you are unsure what the routing number/transit number is, your bank can assist you. If you desire, you may also enclose your voided check with this form to avoid any confusion.

Payment Authorization (this section must be completed in full)

I authorize PacifiCare to initiate debit entries to the banking account number listed above. For applications submitted electronically, the applicant and the account holder must be the same person. If not, this form will have to be printed, signed by each party and mailed to the address listed.

Signature of Primary Applicant/Parent or Legal Guardian	Date
Signature of Account Holder	Date

This authorization is to remain in full force and effect until PacifiCare has received written notice thirty (30) calendar days in advance of your intended cancellation date of this agreement.

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.