

## **Application Instructions**

Thank you for giving us the opportunity to help in your insurance request. We know that you have a choice of online health insurance services and we appreciate that you chose us.

To submit your application:

1. Review the application for accuracy and completeness. You can make changes on the printed copy – Please initial your changes.
2. Sign & Date the application
3. Include the payment. Made payable to PacifiCare
4. Mail your application to:

Assurance Benefits  
PO Box 41454  
Phoenix, Az 85080

It is necessary to mail us your application so we can:

- Review your application for completeness – An application submitted to the carrier that is not complete delays the process.
- Request any additional information the carrier requires
- Keep you informed during the underwriting process
- Let you know when your application has been approved and the effective date.

We will contact you immediately when your application arrives to clarify or complete.

**Questions? Call 800-799-2893**

***Thank you and we look forward to working with you.***

Please note: If carrier has a credit card option and you elect to pay via your credit card, please fax your application to:  
623-322-4607 otherwise please mail to above address. Thank you.

## HOW TO APPLY FOR PACIFICARE INDIVIDUAL PLANS

### You Are Now Ready to Apply

Here are the steps to follow to ensure your application is processed as quickly as possible.

#### 1. Complete the Enrollment Application

Be sure to answer all questions completely and provide all the requested information. Incomplete information may result in a processing delay.

- **Print clearly using black ink.** Please don't type on your form. You, as the applicant, must complete the application in your own handwriting.
- **Select the date you wish coverage to become effective.** PacifiCare 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 – monthly debit or monthly direct bill.** Determine the amount of premium you need to submit with your application 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.
  - Be sure to include your first premium payment.
- **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, list the child's name as the Primary Applicant.
- **Complete the Enrollment Information section and list each family Member applying.** All PacifiCare SignatureValue (HMO) applicants must select a Primary Care Physician from the enclosed *PacifiCare SignatureValue (HMO) Provider Directory*.

#### 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:**

Assurance Benefits & Consulting  
PO Box 41454  
Phoenix, Az 85080

Before sealing the envelope, be sure to enclose:

- Your completed Enrollment Application
- Your first premium check

**Please note: Coverage does not become effective under any circumstances until an application has been underwritten and approved by PacifiCare of Arizona, Inc. for HMO plans, and PacifiCare Life Assurance Company for PPO plans.**

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 & Payment Information**

**Application for:**  New Individual Plan Membership  Existing PacifiCare Individual Plan Member – adding Dependent  
 Guaranteed Availability (HIPAA)  Current PacifiCare Member Applying for Individual Plan  
*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:**  PacifiCare SignatureValue<sup>SM</sup> (HMO) Plan 3 - \$15/\$30/\$250 per day  
 PacifiCare SignatureValue<sup>SM</sup> (HMO) Plan 4 - \$20/\$40/\$350 per day  
 PacifiCare SignatureValue<sup>SM</sup> (HMO) Plan 5 - \$25/\$45/\$500 per day  
 PacifiCare SignatureOptions<sup>SM</sup> (PPO) Plan 1 - \$20/80-60/\$500  
 PacifiCare SignatureOptions<sup>SM</sup> (PPO) Plan 2 - \$35/70-50/\$1,000  
 PacifiCare SignatureOptions<sup>SM</sup> (PPO) Plan 3 - \$30/80-50/\$1,500  
 PacifiCare SignatureOptions<sup>SM</sup> (PPO) Plan 4 - \$30/70-50/\$2,000

**HIPAA Eligible:**  PacifiCare SignatureValue<sup>SM</sup> (HMO) Plan 5 - \$25/\$45/\$500 per day  
 PacifiCare SignatureOptions<sup>SM</sup> (PPO) Plan 1 - \$20/80-60/\$500  
 PacifiCare SignatureOptions<sup>SM</sup> (PPO) Plan 2 - \$35/70-50/\$1,000  
 PacifiCare SignatureOptions<sup>SM</sup> (PPO) Plan 3 - \$30/80-50/\$1,500  
 PacifiCare SignatureOptions<sup>SM</sup> (PPO) Plan 4 - \$30/70-50/\$2,000

**Payment Options:**  Monthly EZPay  Monthly Billing  
*If my application is approved, my premium will be paid as follows:* *For this payment method, you must enclose:* *Please enclose a check for one month's premium with your application.*  
 Your completed EZPay form  A voided check  
 A check for one month's premium

**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).

**Primary Applicant's Name** \_\_\_\_\_  Married  Single  
Last First MI

**Home Address** \_\_\_\_\_  
P.O. Box not acceptable Street Apt # City State ZIP

**Mailing Address**  
 for Premium  
 for Medical Information  
 for Both  
If different from home address Street Apt # 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*.

Relationship	Last Name	First Name	MI	Social Security Number	Height	Weight	Birth Date Mo/Day/Yr	Primary Care Physician (PCP) Name HMO only	PacifiCare Provider # HMO only	Network (PMG)
<input type="checkbox"/> Male <input type="checkbox"/> Female	Applicant									
<input type="checkbox"/> Husband <input type="checkbox"/> Wife	Spouse									
<input type="checkbox"/> Son <input type="checkbox"/> Daughter										
<input type="checkbox"/> Son <input type="checkbox"/> Daughter										
<input type="checkbox"/> Son <input type="checkbox"/> Daughter										

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

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 at any time 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 . . . . . <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, 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</p> <p style="padding-left: 20px;">If yes, last reading _____</p> | <p>29. High Blood Cholesterol and/or Triglycerides . . . . . <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">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	

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

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

**D. Has any applicant received any alternative, complementary, holistic or natural therapies within the last 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.**

If you need more space for explanation, please attach a separate piece of paper.

- 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
- Has surgery (major/minor, inpatient/outpatient) ever been performed for any applicant? . . . . .  Yes  No
- Has surgery (major/minor, inpatient/outpatient) ever been advised but not performed for any applicant? . .  Yes  No
- Has any applicant been aware of, evaluated, diagnosed, treated or advised regarding any other conditions or injuries not listed? . . . . .  Yes  No  
 If yes, please state individual's name(s) and explain **(include date)**: \_\_\_\_\_

- Have you or any person applying ever used tobacco products? . . . . .  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? _____		

- 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 .

- Does any applicant listed on this application use narcotics, hallucinogenics, amphetamines, barbiturates, or other illegal drugs, or has used drugs other than in accordance with the instructions or prescription for use? . .  Yes  No  
 If yes, state name(s) and explain **(include date and duration)**: \_\_\_\_\_

- 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

- Has any applicant listed on this application been hospitalized, been seen in an emergency room or been in therapy/counseling (mental, physical or emotional) within the last five years? . . . . .  Yes  No  
 If yes, state applicant's name(s) and explain **(include date and duration)**: \_\_\_\_\_

- 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

- Has any application for a policy of life or health insurance on any applicant ever been declined, postponed, modified or required an extra premium? . . . . .  Yes  No

NAME	TYPE OF INSURANCE	
DATE	INSURANCE CARRIER	REASON

- 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	

- 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)**

- Is any family member currently pregnant? . . . . .  Yes  No  
 If yes, expected date of delivery: \_\_\_\_\_

- List the name of each female applicant and the date of their last menstrual period.

NAME	MONTH	DAY	YEAR
NAME	MONTH	DAY	YEAR

- List the name of each female applicant and the date of their last Pap smear and the results: \_\_\_\_\_

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

**MALES ONLY (including Spouse and Dependents)**

- 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: \_\_\_\_\_

1. I understand that all health care services under the HMO Coverage options must be provided or arranged for by PacifiCare, except for in 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 Arizona, 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.
9. **APPLICANT (AND DEPENDENTS) AGREES AND UNDERSTANDS THAT AS AN ENROLLED MEMBER ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE (THAT IS AS TO**

**WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR DISPUTES OVER BENEFIT DENIALS SUBJECT TO ERISA, BETWEEN ITSELF, MEMBERS (INCLUDING ANY HEIRS OR ASSIGNS) AND PACIFICARE OF ARIZONA, 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.**

**Authorization for disclosure of personal information:**

I hereby authorize any health care facility, Physician or surgeon, or any other health care professional to disclose to PacifiCare of Arizona, 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, PO Box 3069, Cypress, CA, 90630-9962.**

By my signature below, I have read and understand the above conditions.

SIGNATURE OF APPLICANT OR LEGAL GUARDIAN <i>(Required)</i> <b>X</b>	TODAY'S DATE <i>(Required)</i>
SIGNATURE OF APPLICANT'S DEPENDENT AGE 18 OR OVER <i>(Required)</i> <b>X</b>	TODAY'S DATE <i>(Required)</i>
SIGNATURE OF PERSONAL REPRESENTATIVE OR CUSTODIAN <i>(if applicable)</i> <b>X</b>	TODAY'S DATE <i>(Required)</i>

SIGNATURE OF APPLICANT'S SPOUSE <i>(Required if applying)</i> <b>X</b>	TODAY'S DATE <i>(Required)</i>
SIGNATURE OF APPLICANT'S DEPENDENT AGE 18 OR OVER <i>(Required)</i> <b>X</b>	TODAY'S DATE <i>(Required)</i>
PRINT NAME OF PERSONAL REPRESENTATIVE OR CUSTODIAN <i>(if applicable)</i> <b>X</b>	

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 COBRA an available option? . . . . .  Yes  No  
 \_\_\_\_\_  
 If yes, did you apply for COBRA? . . . . .  Yes  No  
 \_\_\_\_\_  
 What was your qualifying event?  
 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

SIGNATURE OF APPLICANT <b>X</b>	DATE
SIGNATURE OF APPLICANT'S DEPENDENT AGE 18 OR OVER (Required) <b>X</b>	DATE
SIGNATURE OF PERSONAL REPRESENTATIVE OR CUSTODIAN (if applicable) <b>X</b>	DATE

SIGNATURE OF APPLICANT'S SPOUSE (if applying) <b>X</b>	DATE
SIGNATURE OF APPLICANT'S DEPENDENT AGE 18 OR OVER (Required) <b>X</b>	DATE
PRINT NAME OF PERSONAL REPRESENTATIVE OR CUSTODIAN (if applicable) <b>X</b>	

This questionnaire will be used by PacifiCare of Arizona, 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		Company Name <b>Assurance Benefits &amp; Consulting</b>			Agent Number	
Agent Address <b>PO Box 41454</b>	City <b>Phoenix</b>	State <b>AZ</b>	ZIP <b>85080</b>	Agent Phone Number <b>623-322-4608</b>	Agent Fax Number <b>623-322-4607</b>	

**PacifiCare Individual Plans  
 Individual Underwriting  
 M/S CY38-224  
 P.O. Box 3069  
 Cypress, CA 90630**

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

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