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Continuation Coverage

Is your group subject to Federal COBRA (20 or more total employees during at least 50% of the working days in the previous Calendar Year) or Cal-Cobra (less than 20 Eligible Employees during at least 50% of the working days in the previous Calendar Year or previous calendar quarter)? Federal COBRA Cal-COBRA

Please provide details on ALL COBRA participants below. In addition, please provide a list of AB1401 COBRA, Cal-COBRA and/or Senior COBRA enrollees from your current carrier.

Name	<input type="checkbox"/> Federal COBRA <input type="checkbox"/> Cal-COBRA	<input type="checkbox"/> AB1401 COBRA <input type="checkbox"/> Extended/Disabled COBRA	Qualifying Event	Date
Name	<input type="checkbox"/> Federal COBRA <input type="checkbox"/> Cal-COBRA	<input type="checkbox"/> AB1401 COBRA <input type="checkbox"/> Extended/Disabled COBRA	Qualifying Event	Date
Name	<input type="checkbox"/> Federal COBRA <input type="checkbox"/> Cal-COBRA	<input type="checkbox"/> AB1401 COBRA <input type="checkbox"/> Extended/Disabled COBRA	Qualifying Event	Date
Name	<input type="checkbox"/> Federal COBRA <input type="checkbox"/> Cal-COBRA	<input type="checkbox"/> AB1401 COBRA <input type="checkbox"/> Extended/Disabled COBRA	Qualifying Event	Date

If AB1401 COBRA, Cal-COBRA and/or Senior COBRA enrollees are added after the initial group enrollment, the group may be subject to re-rate.

Plan Coverage

Requested effective date:
(coverage must begin 1st of the month)

Note: PacifiCare SignatureOptions®, PacifiCare SignatureIndependence® and PacifiCare SignatureFreedom® plans are underwritten by PacifiCare Life and Health Insurance Company.

Medical Plans

Select one or more plans, up to a maximum of four.	PacifiCare SignatureValue® (HMO) and PacifiCare SignatureValue® Advantage (HMO)	PacifiCare SignatureOptions® (PPO)	PacifiCare SignatureOptions® (HSA-Compatible PPO)
Plans indicated with an asterisk (*) are only available on a Stand Alone basis. Groups must have at least five eligible employees enrolling with PacifiCare to purchase more than one plan. PacifiCare SignatureValue plans may not be offered alongside PacifiCare SignatureValue Advantage plans.	HMO HMO Advantage	<input type="checkbox"/> 15/90-50/250	<input type="checkbox"/> 100-50/5000
	10-30/100 <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> 20/80-60/250	<input type="checkbox"/> 80-50/2700
	15-30/250a <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> 30/70-50/250	<input type="checkbox"/> 70-50/3500 (HSA-Compatible)
	10/500d ¹ <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> 35/80-60/500	PacifiCare SignatureIndependence® (Indemnity)
	20-40/500d ¹ <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> 35/70-50/1000	<input type="checkbox"/> 80/1000 ²
	35/600d ¹ <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> 35/50-50/1000	PacifiCare SignatureFreedom® (SDHP)
	20/1500ded ¹ <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> 70-50/2000 (PPO)*	<input type="checkbox"/> 80-50/2000*
	40-60/2000ded ¹ <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> 70-50/3500 (PPO)*	<input type="checkbox"/> 80-50/2000 with Dental*
	PacifiCare SignaturePOS® (POS)		<input type="checkbox"/> 70-50/2000 (SDHP)*
	<input type="checkbox"/> 15/80-60*		<input type="checkbox"/> 70-50/2000 with Dental*
		<input type="checkbox"/> 50-50/3000*	
		<input type="checkbox"/> 50-50/3000 with Dental*	

Please answer the following question:

Will you self-fund any portion of your employees' cost-sharing by offering a wrap-around plan, such as a Health Reimbursement Account (HRA), in addition to your PacifiCare Small Group plan? Yes No

If **No**, and a group does not indicate they have an HRA or adds one after the initial group enrollment, the group may be subject to re-rate.

- 1 By selecting this plan, the Group has chosen not to offer Infertility Services to its employees. The Group understands that PacifiCare covers Infertility Services in other Small Business plans.
- 2 This plan is not available on a Stand Alone basis.

Supplemental Benefits		Other Coverage (required)
<input type="checkbox"/> Group Term Life (Separate Group Application required)	<input type="checkbox"/> Chiropractic/Acupuncture Supplemental Chiropractic/ Acupuncture through an arrangement with American Specialty Health Plans (for PacifiCare SignatureValue, PacifiCare SignatureValue Advantage and PacifiCare SignaturePOS only)	Domestic Partners Coverage All PacifiCare plans include Domestic Partner coverage as required by state law.

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Dental and Vision Plans					
Dual Choice Dental: Select one PacifiCare SignatureValue and one PacifiCare SignatureOptions Dental and/or PacifiCare SignatureIndependence plan.					
PacifiCare SignatureValue (HMO)	PacifiCare SignatureOptions® (PPO)			PacifiCare SignatureIndependence® (Indemnity)	
Contributory	Contributory	Voluntary	Contributory	Contributory	Voluntary
<input type="checkbox"/> Dental 140 <input type="checkbox"/> Dental 142 <input type="checkbox"/> Dental 144 <input type="checkbox"/> Dental 146	<input type="checkbox"/> Dental 410 <input type="checkbox"/> Dental 440 <input type="checkbox"/> Child-Only Orthodontic Rider Please choose: Calendar Year Max <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 Endo, Perio, OS in Major <input type="checkbox"/> Yes <input type="checkbox"/> No	Deductible <input type="checkbox"/> \$50 In / \$100 Out <input type="checkbox"/> Dental 410 <input type="checkbox"/> Dental 440	<input type="checkbox"/> Vision 480 <input type="checkbox"/> Vision 490 <input type="checkbox"/> Vision 499 Please choose: Material Deductible <input type="checkbox"/> \$0 <input type="checkbox"/> \$10 <input type="checkbox"/> \$20	<input type="checkbox"/> Dental 815 <input type="checkbox"/> Child-Only Orthodontic Rider	<input type="checkbox"/> Dental 815

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH CARE SERVICE PLANS AND INSURANCE COMPANIES AS A CONDITION OF OBTAINING COVERAGE.

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Signature Required for Terms and Conditions and Arbitration Disclosure

Terms and Conditions

I hereby certify that all statements on this document are complete and true to the best of my knowledge and belief, and I understand that PacifiCare will rely on these statements and this information as the basis for approving this Application. I have read and understand the information herein. Further, the authorized person agrees to PacifiCare's payment terms and conditions. Undersigned represents that he/she is an authorized person of the small employer group applying for the coverage indicated above and is authorized to enter into a PacifiCare Health Plan Medical and Hospital Group Subscriber Agreement and/or PacifiCare Life and Health Insurance Co. Group Policy on the small employer group's behalf. It is understood for the purposes of compliance with ERISA, the undersigned employer is to be named fiduciary of the employee benefit plan covered under this policy.

Arbitration Disclosure

EMPLOYER AGREES AND UNDERSTANDS THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE (THAT IS AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR CLAIMS SUBJECT TO ERISA, BETWEEN ITSELF, MEMBERS (INCLUDING ANY HEIRS OR ASSIGNS) AND PACIFICARE OF CALIFORNIA, 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.

Authorized Signature	Date
Print Name	Title

Check here if you do not have a broker of record. If you do, please complete the information below:

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.

Broker Information

(Signature above acknowledges broker assignment) If a split commission, please attach payee information including percentages for each payee.

Agent Name	Firm Name	Phone ()	E-mail Address
Address	City	State	ZIP Fax ()
Payee: <input type="checkbox"/> Agent or <input type="checkbox"/> Firm			
Payee's SS# or Tax ID #:	Payee's California License #:	Expiration Date	
Broker Signature			

General Agent Information

General Agent Name	Phone ()			
Address	City	State	ZIP	TIN #

FOR INTERNAL USE ONLY:

G.A. #	A.P. #	MKTG. #	G.C. #
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PacifiCare products and services are offered by one or more of the following PacifiCare family of companies: Health plan products and services are offered by PacifiCare of California, PacifiCare Behavioral Health of California, Inc., and PacifiCare Dental (in California). Indemnity insurance products (including PPO products) are underwritten by PacifiCare Life and Health Insurance Company. Other products and services are offered by PacifiCare Health Plan Administrators, Inc., RxSolutions, Inc., and PacifiCare Behavioral Health, Inc. PacifiCare® is a federally registered trademark of PacifiCare Life and Health Insurance Company.

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Dental & Vision Administrators Employer Agreement

Small employer groups who are electing dental and/or vision coverage

- I understand the pre-existing conditions limitations of the insurance plan and understand that coverage is renewable at the option of the Underwriting Company.
- I understand the underwriting and participation requirements and understand that the initial participation (if applicable) must be maintained or exceeded in order for coverage to remain in force. The Open Enrollment period shall be during group's 11th month of annual continuous coverage.
- For the PacifiCare SignatureIndependence Plan and the PacifiCare SignatureOptions Plan, I understand that there is a one-year waiting period for "Major" dental services. This waiting period will be waived for employees/Dependents listed on the prior carrier's billing at the time of transfer to a PacifiCare SignatureIndependence or PacifiCare SignatureOptions plan. New hires are subject to a one-year waiting period for all "Major" dental services. "Major" dental services include crowns, dentures and bridges OR crowns, dentures, bridges, oral surgery, periodontics and endodontics.
- The PacifiCare SignatureIndependence and PacifiCare SignatureOptions dental and vision plans are underwritten by PacifiCare Life and Health Insurance Company.
- The PacifiCare SignatureValue dental plans are offered by PacifiCare Dental.

For the PacifiCare SignatureIndependence plans only, please initial the following statement:

The undersigned employer hereby adopts and enrolls in the group insurance plan of the Vanguard Group Dental Trust and subscribes to the terms of the Trust agreement which established such Trust. It is understood that no coverage is in force until notice of approval has been furnished by the Trust Administrator and premium has been received by the Trust Administrator.

I further acknowledge and agree that no one other than the Trustees or a person designated in writing by the Trustees may accept this application on behalf of the Vanguard Group Dental Plan Trust, and that no agent or broker has the authority to change any provision of the master policy or of the Trust. _____ (Initials of authorized person)

I hereby certify that all of the information contained in the agreement and application is correct to the best of my knowledge. I have complied with the underwriting rules and have explained to the applicant in detail the coverages of this plan. Any exceptions are detailed here or on an additional sheet attached.

Signature of Authorized Person for Employer _____ Date Signed _____

Broker or General Agent Signature _____ Date Signed _____

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For Case Submission instructions, please contact your PacifiCare Sales Representative at 1-866-288-4993.

www.pacificare.com

Customer Service:

- PacifiCare SignatureValue® (HMO): 1-800-624-8822
or 1-800-442-8833 (TDHI)
- PacifiCare SignaturePOS® (POS): 1-800-913-9133
or 1-800-442-8833 (TDHI)
- PacifiCare SignatureOptions® (PPO) or
PacifiCare SignatureIndependence® (Indemnity): 1-866-316-9776
or 1-866-816-2018 (PPO/Indemnity TDHI)
- PacifiCare SignatureFreedom® (SDHP): 1-866-867-0700
or 1-866-867-0701 (TDHI)
- PacifiCare Dental and Vision Administrators: 1-800-228-3384



A UnitedHealthcare Company