

# Employee Enrollment Form

Group Sales: Tel: 1-888-371-3060 Fax: 1-415-955-8819



CCHP will provide translation or other language assistance free of charge in completing the application. The application, together with the Disclosure Form/ Evidence of Coverage ("Agreement") constitutes the plan contract, and that applicants may request a copy of the Agreement prior to enrollment to learn the terms and conditions of the plan contract.

Employer Group Information		
Employer (Group) Name:		Group Number:
Requested Effective Date (MM/DD/YY) : / /	Date of Hire (MM/DD/YY): / /	Employment Status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
Reason for Application		
<input type="checkbox"/> New Group <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> Add Dependent(s) <input type="checkbox"/> Employee Status Change, Reason _____ <input type="checkbox"/> Other Enrollment, Reason _____		
Employer Group Plan Coverage Selection		
<b>Medical Plans</b> <input type="checkbox"/> Ruby <sup>10</sup> HMO Platinum <input type="checkbox"/> Ruby <sup>20</sup> HMO Platinum <input type="checkbox"/> Ruby <sup>40</sup> HMO Platinum <input type="checkbox"/> Opal <sup>25</sup> HMO Gold <input type="checkbox"/> Opal <sup>50</sup> HMO Silver <input type="checkbox"/> Platinum <sup>90</sup> HMO <input type="checkbox"/> Gold <sup>80</sup> HMO <input type="checkbox"/> Silver <sup>70</sup> HMO <input type="checkbox"/> Bronze <sup>60</sup> HMO <input type="checkbox"/> Bronze <sup>60</sup> HDHP HMO <b>Optional Riders (Applies to all Balance Enrollees)</b> <input type="checkbox"/> Adult Vision (VSP) <input type="checkbox"/> Adult Dental (Delta) <input type="checkbox"/> Other _____		
Note(s) (CCHP Use Only):		

1. Employee Information				
Last Name:		First Name:		M.I. :
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner		Date of Birth (MM/DD/YY) : / /	SSN:
Email:		Cell Phone:	Home Telephone:	
Home Address, City, State, ZIP (No P.O. Box) :				
Mailing Address, City, State, ZIP (if different than home address) :				
Primary Care Physician (PCP) :			Medical Group:	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

Optional Questions	
What is your ethnic origin?	
<input type="checkbox"/> Asian Indian <input type="checkbox"/> Black or African American <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Hmong <input type="checkbox"/> Hispanic, Latino or Spanish Origin <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> White <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____	

2. Dependent(s) to be covered or added			
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	Last Name:	First Name:	M.I. :
Date of Birth (MM/DD/YY): / /		SSN:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Primary Care Physician (PCP) (Required for HMO Plans Only) :		Medical Group:	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Dependent # 1</b>	Last Name:	First Name:	M.I. :
Date of Birth (MM/DD/YY) : / /		SSN:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Primary Care Physician (PCP) :		Medical Group:	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Dependent # 2</b>	Last Name:	First Name:	M.I. :
Date of Birth (MM/DD/YY) : / /		SSN:	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Primary Care Physician (PCP) :		Medical Group:	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Dependent # 3</b>	Last Name:	First Name:	M.I. :
Date of Birth (MM/DD/YY) : / /		SSN:	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Primary Care Physician (PCP) :		Medical Group:	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Dependent # 4</b>	Last Name:	First Name:	M.I. :
Date of Birth (MM/DD/YY) : / /		SSN:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Primary Care Physician (PCP) :		Medical Group:	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

### 3. Medicare Information

Is any person applying for coverage currently enrolled with Medicare?

No  Yes, Please attach a copy of your Medicare card(s) & Name: \_\_\_\_\_

### 4. Disclosure of Personal and Health Information

CCHP understands the importance of keeping your and your dependents' personal and health information private. CCHP protects this information in electronic, written, and oral forms when used throughout our company. CCHP will not disclose this information without your authorization except as permitted by law. For the purpose of administering your CCHP coverage, CCHP is permitted by state and federal law to obtain your and your dependents' health information from a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent. Also, by state and federal law, CCHP is permitted to disclose your and your dependents' health information to a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent. A complete explanation of CCHP policies and procedures ("Notice of Confidentiality and Privacy Practices") for preserving the confidentiality of your personal and health information is available and will be furnished to you upon request by calling the Customer Service Department or by accessing CCHP's website.

### 5. Arbitration Agreement

I understand that (except for Small Claims cases) any and all disputes, including 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), which may arise under the agreement between me and CCHP and any of this affiliates shall be determined by submission to binding arbitration as provided by California law. Any such dispute will not be resolved by a lawsuit or resort to court process except as applicable law provides for judicial review of arbitration proceedings. ALL PARTIES TO THIS CONTRACT, BY ENTERING INTO IT, 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. For more information regarding binding arbitration, please refer to your Evidence of Coverage.

Employee Signature X	Employee Name:	Date (MM/DD/YY): / /
Signature of Employer/Authorized Representative: X	Employer/Authorized Representative Name & Title:	Date (MM/DD/YY): / /