Employee Enrollment Form

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

Balance by CCHP

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: ☐ Full-time ☐ Part-time

Reason for Application

☐ New Group ☐ Open Enrollment ☐ New Hire ☐ Add Dependent(s)

☐ Employee Status Change, Reason _____ ☐ Other Enrollment, Reason _____

Employer Group Plan Coverage Selection

Medical Plans

☐ Ruby[10] HMO Platinum ☐ Ruby[20] HMO Platinum ☐ Ruby[40] HMO Platinum ☐ Opal[25] HMO Gold ☐ Opal[50] HMO Silver

☐ Platinum[90] HMO ☐ Gold[80] HMO ☐ Silver[70] HMO ☐ Bronze[60] HMO ☐ Bronze[60] HDHP HMO

Optional Riders (Applies to all Balance Enrollees)

☐ Adult Vision (VSP) ☐ Adult Dental (Delta) ☐ Other _____

Note(s) (CCHP Use Only):

1. Employee Information

Last Name:		First Name:		M.I. :
Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Domestic Partner	Date of Birth (MM/DD/YY) : / /	SSN:	Preferred Language : (Optional) ☐ Chinese ☐ English ☐ Spanish ☐ Others:
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? ☐ Yes ☐ No

Optional Questions

What is your ethnic origin?

☐ Asian Indian ☐ Black or African American ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Hmong

☐ Hispanic, Latino or Spanish Origin ☐ Japanese ☐ Korean ☐ Laotian ☐ Native Hawaiian ☐ Samoan

☐ White ☐ Vietnamese ☐ Other _____

2. Dependent(s) to be covered or added

☐ **Spouse** ☐ **Domestic Partner**	Last Name:	First Name:	M.I. :
Date of Birth (MM/DD/YY): / /		SSN:	Gender: ☐ Male ☐ Female
Primary Care Physician (PCP) (*Required for HMO Plans Only*) :		Medical Group:	Existing Patient? ☐ Yes ☐ No

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