

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 only allows first-of-the-month effective dates. Actual effective dates are determined by PacifiCare. **Do not cancel any existing coverage until you are notified by PacifiCare 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 *Monthly Premium for Individual Plans* enclosed with this brochure.
 - If you and your Spouse/Domestic Partner are both applying, use the younger of your ages in determining your premium.
 - Be sure to include your first premium payment with this application.
- **Complete the Applicant Information section.** Please list the younger Spouse/Domestic Partner (if applying) as the Primary Applicant. 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 applicant applying.** PacifiCare SignatureValueSM (HMO) applicants must select a Primary Care Physician. Please visit our Web site at www.pacificare.com for assistance. When applying for the PacifiCare SignatureValue (HMO) plan, every applicant must choose a Primary Care Physician, along with the appropriate provider number, from this directory.
- **Enrollment Information.** Please answer all the questions in this section. These questions will be used to assess your eligibility for guaranteed coverage available under the Health Insurance Portability and

Accountability Act (HIPAA). If you wish to apply under HIPAA, you do not need to answer the Health Questionnaire. Please call Individual Sales for rates of coverage under HIPAA. You should complete the entire application and apply for the standard individual product, in case you do not qualify under HIPAA.

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 applicants 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 under one of the PacifiCare SignatureOptionsSM (Preferred Provider Organization PPO) plans. 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/Domestic Partner (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 # CY24-155
P.O. Box 3069
Cypress, CA 90630

Before sealing the envelope be sure to enclose:

- Your completed Enrollment Application
- Your first premium payment (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.

IMPORTANT: PLEASE PRINT IN BLACK INK. Every question must be answered completely by applicant or guardian. Application must be signed to be valid.

1. Application, Plan & Payment Information

A. Please check one: New Enrollment Adding Dependents to _____
Subscriber Name Subscriber ID Number

Plan Change HIPAA (Health Insurance Portability and Accountability Act) Attach Certificate of Creditable Coverage or other documentation showing prior coverage.

B. Requested Effective Date: 1st day of – Note: Your requested effective date is not guaranteed. Actual effective date is determined by PacifiCare.
mm yy

C. Select ONE Plan:

PacifiCare SignatureValueSM (HMO) <input type="checkbox"/> 10-35/250d <input type="checkbox"/> 20-35/80 <input type="checkbox"/> 35/70 <input type="checkbox"/> 35/50	PacifiCare SignatureOptionsSM (PPO) <input type="checkbox"/> 70-50/1000 (with maternity) <input type="checkbox"/> 70-50/500 <input type="checkbox"/> 70-50/1500 (with maternity) <input type="checkbox"/> 70-50/1000 <input type="checkbox"/> 60-50/2500 <input type="checkbox"/> 70-50/2000 <input type="checkbox"/> 70-50/5000 <input type="checkbox"/> 70-50/3000 PacifiCare SignatureOptionsSM (HSA-Compatible) <input type="checkbox"/> 100-50/5000 <input type="checkbox"/> 35/80-50/2700	PacifiCare SignatureValueSM (HMO) HIPAA <input type="checkbox"/> 10-35/250d <input type="checkbox"/> 35/70 PacifiCare SignatureOptionsSM (PPO) HIPAA <input type="checkbox"/> 70-50/2000 <input type="checkbox"/> 70-50/3000
PacifiCare SignatureFreedomSM (SDHP) <input type="checkbox"/> 70-50/3000 <input type="checkbox"/> 70-50/5000		

D. Payment Options Choose your payment method for: 1. First month payment; and 2. Recurring monthly Payment will be deducted only if application is approved.	First Month Payment (please select one option) <input type="checkbox"/> Check enclosed: amount of \$ _____ <input type="checkbox"/> Credit card (for this payment method you must enclose your completed Credit Card Payment Authorization Form)	Recurring Monthly Payment (please select one option. Credit card payment is not available for monthly option) <input type="checkbox"/> Monthly Bill <input type="checkbox"/> Monthly Easy Pay (For this payment method, you must enclose your completed Easy Pay form and a voided check)
--	---	--

2. Applicant Information

Important: If married and both Spouses/Domestic Partners are applying for coverage, indicate younger Spouse's/Domestic Partner's name as the Primary Applicant

Primary Applicant's Name _____
Last First MI

Home Address _____
P.O. Box not acceptable Street Apt # City State ZIP

Mailing Address _____
If different from home address Street Apt # City State ZIP

Billing Address _____
If different from mailing address Street Apt # City State ZIP

Phone No. (____) _____ (____) _____ **Marital Status** Single Married Domestic Partner
Home Work

Applicant's Occupation _____ **Spouse's/Domestic Partner's Occupation** _____

3. Enrollment Information

List yourself and all eligible Dependents applying for coverage. **Each applicant applying for a PacifiCare SignatureValue (HMO) plan must select a Primary Care Physician.** You may choose the same or a different Primary Care Physician for each applicant. *Please refer to the PacifiCare SignatureValue (HMO) Provider Directory to make your choice and find the Primary Care Physician Code Number.*

Relation	Last Name	First Name	MI	Social Security #	Height	Weight	Birth Date Mo/Day/Yr	PacifiCare SignatureValue only Primary Care Physician (PCP) Name	PacifiCare SignatureValue Provider # (10-digits)	Current Patient of PCP? Y = Yes N = No
<input type="checkbox"/> Male <input type="checkbox"/> Female	Applicant									
<input type="checkbox"/> Male <input type="checkbox"/> Female	Spouse/Domestic Partner									
<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 applicants reside with primary applicant? Yes No If no, please indicate name and mailing address of Dependent(s) below.

3. Enrollment Information (continued)

Has any applicant ever been a PacifiCare Member? Yes No

If yes, please provide the name used and the PacifiCare ID #, if known. _____

1. Do you have other coverage available to you, such as through your spouse/domestic partner, current employer, Medicare, or Medicaid? Yes No
2. Have you had 18 months of prior coverage, with no greater than a 62-day gap in coverage? Yes No
3. Was the last coverage you had a GROUP (employer-sponsored), Government or Church Plan? Yes No
4. Was the last coverage you had terminated due to non-payment of premium or fraud? Yes No
- 5a. Was COBRA or Cal-COBRA available to you when your last coverage was terminated? Yes No
- 5b. If yes, did you elect and exhaust your COBRA or Cal-COBRA coverage? Yes No

4. Health Questionnaire

A. Have any applicants listed on this application ever had or been treated for any of the following conditions? Please indicate either “yes” or “no.” If yes, provide more details in Section B below. **Incomplete information will result in a processing delay.**

All questions must be answered			Incomplete information will result in a processing delay					
YES	NO	CONDITION	YES	NO	CONDITION	YES	NO	CONDITION
1	<input type="radio"/>	<input type="radio"/> Acquired Immune Deficiency (AIDS)/AIDS Related Complex (ARC)	23	<input type="radio"/>	<input type="radio"/> Epilepsy, Convulsions, Seizures		<input type="radio"/>	<input type="radio"/> Schizoaffective Disorder
2	<input type="radio"/>	<input type="radio"/> ADD (Attention Deficit Disorder)/ADHD	24	<input type="radio"/>	<input type="radio"/> Eye Condition		<input type="radio"/>	<input type="radio"/> Bipolar Disorder
3	<input type="radio"/>	<input type="radio"/> Alcoholism and/or Drug Abuse	25	<input type="radio"/>	<input type="radio"/> Fibromyalgia		<input type="radio"/>	<input type="radio"/> Major Depressive Disorder
4	<input type="radio"/>	<input type="radio"/> Allergies and/or Asthma	26	<input type="radio"/>	<input type="radio"/> Gallbladder Condition		<input type="radio"/>	<input type="radio"/> Panic Disorder
5	<input type="radio"/>	<input type="radio"/> Anemia	27	<input type="radio"/>	<input type="radio"/> Headaches or Migraines		<input type="radio"/>	<input type="radio"/> Obsessive-Compulsive Disorder
6	<input type="radio"/>	<input type="radio"/> Arthritis or Rheumatism	28	<input type="radio"/>	<input type="radio"/> Heartburn/Gastroesophageal Reflux Disease (GERD)		<input type="radio"/>	<input type="radio"/> Autism and other pervasive developmental disorders
7	<input type="radio"/>	<input type="radio"/> Back/Spinal Condition	29	<input type="radio"/>	<input type="radio"/> Heart Problems or Disorders		<input type="radio"/>	<input type="radio"/> Anorexia
8	<input type="radio"/>	<input type="radio"/> Bacterial Infections, Multiple or Reoccurring	30	<input type="radio"/>	<input type="radio"/> Hemorrhoids		<input type="radio"/>	<input type="radio"/> Bulimia Nervosa
9	<input type="radio"/>	<input type="radio"/> Birth Defect	31	<input type="radio"/>	<input type="radio"/> Hepatitis		<input type="radio"/>	<input type="radio"/> Any other mental or nervous conditions? (If yes, please explain below.)
10	<input type="radio"/>	<input type="radio"/> Bladder Condition	32	<input type="radio"/>	<input type="radio"/> Hernia		<input type="radio"/>	<input type="radio"/> Muscle Disorder
11	<input type="radio"/>	<input type="radio"/> Blood Condition – Past 10 Years	33	<input type="radio"/>	<input type="radio"/> High Blood Cholesterol and/or Triglycerides If yes, Last Reading _____ (Please explain below.)		<input type="radio"/>	<input type="radio"/> Neurological Condition
12	<input type="radio"/>	<input type="radio"/> Bone Infection or Disorder	34	<input type="radio"/>	<input type="radio"/> High Blood Pressure If yes, Last Reading _____ (Please explain below.)		<input type="radio"/>	<input type="radio"/> Non-Hodgkin’s Lymphoma
13	<input type="radio"/>	<input type="radio"/> Breast Conditions/Implants	35	<input type="radio"/>	<input type="radio"/> Impotence		<input type="radio"/>	<input type="radio"/> Paralysis
14	<input type="radio"/>	<input type="radio"/> Cancer	36	<input type="radio"/>	<input type="radio"/> Jaw Condition or TMJ		<input type="radio"/>	<input type="radio"/> Phlebitis or Blood Clot
15	<input type="radio"/>	<input type="radio"/> Chronic Fatigue	37	<input type="radio"/>	<input type="radio"/> Joint Condition		<input type="radio"/>	<input type="radio"/> Prostate Disorder
16	<input type="radio"/>	<input type="radio"/> Colon, Rectal, Bowel Condition	38	<input type="radio"/>	<input type="radio"/> Kaposi’s Sarcoma		<input type="radio"/>	<input type="radio"/> Sexually Transmitted Diseases
17	<input type="radio"/>	<input type="radio"/> Cysts, Tumors, Growths or Fibroids	39	<input type="radio"/>	<input type="radio"/> Kidney Condition		<input type="radio"/>	<input type="radio"/> Skin Condition
18	<input type="radio"/>	<input type="radio"/> Depression/Anxiety/Emotional Condition(s)	40	<input type="radio"/>	<input type="radio"/> Liver Condition		<input type="radio"/>	<input type="radio"/> Stomach or Abdominal Condition
19	<input type="radio"/>	<input type="radio"/> Diabetes	41	<input type="radio"/>	<input type="radio"/> Lung or Respiratory Condition		<input type="radio"/>	<input type="radio"/> Stroke
20	<input type="radio"/>	<input type="radio"/> Disability/Disabled	42	<input type="radio"/>	<input type="radio"/> Lupus		<input type="radio"/>	<input type="radio"/> Thyroid Condition
21	<input type="radio"/>	<input type="radio"/> Ear Condition	43	<input type="radio"/>	<input type="radio"/> Mental Health Conditions		<input type="radio"/>	<input type="radio"/> Does any applicant listed on this application have any other conditions not described above? (If yes, please explain below.)
22	<input type="radio"/>	<input type="radio"/> Emphysema		<input type="radio"/>	<input type="radio"/> Schizophrenia			

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 #	Applicant 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 Medical Practitioner, for any reason, in the past two years? Yes No
 If yes, please provide details below:

Applicant(s) Name	Medical Practitioner Name	Complete Address/Telephone	Date	Reason/Result and Treatment/Recommendation

D. 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.

Incomplete information will result in a processing delay

1. In the event one or more applicant(s) listed on this application is denied coverage, should PacifiCare continue the underwriting and enrollment process for the remaining eligible applicants?
 Yes No

2. Has any applicant listed on this application ever been advised to have an operation or treatment (including dental work) **that has not yet been performed?** Yes No
 If yes, state individual's name(s) and explain (include date):

3. Has any applicant listed on this application been refused or restricted life or health insurance coverage within the last five years? Yes No If yes, state applicant's name(s) and give details: _____

4. Has any applicant listed on this application used tobacco products in the past 12 months? Yes No
 If yes, please provide the following information:

NAME	START DATE	STOP DATE	DAILY AMOUNT
------	------------	-----------	--------------

NAME	START DATE	STOP DATE	DAILY AMOUNT
------	------------	-----------	--------------

5. 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
------	---	---	--

6. 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 applicant's name(s) and explain (include date and duration): _____

7. 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
------	------	---------------------

NAME	DRUG	DOSAGE/DATE STARTED
------	------	---------------------

8. 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):

9. Is any applicant listed on this application currently covered by medical insurance or a health care plan? Yes No
 Group or Individual If yes, provide the name of the insurance company or health care plan and effective date of coverage:

FEMALES ONLY (including Spouse/Domestic Partner and Dependents)

10. 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):

11. Please provide the date of last Pap smear: _____

Results: _____

12. Has every female applying for coverage had, during the last 6 months, a menstrual period every month, including in the last 30 days? If no, state name and reason.

NAME	MONTH	DAY	YEAR
------	-------	-----	------

NAME	MONTH	DAY	YEAR
------	-------	-----	------

13. Are any females applying for coverage currently pregnant?
 Yes No

MALES ONLY (including Spouse/Domestic Partner and Dependents)

14. 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:

5. Terms & Conditions

1. I understand that all health care services under the PacifiCare SignatureValue (HMO) Coverage Options must be provided or arranged for by PacifiCare, except for Emergency or Urgently Needed Services.
2. I understand that PacifiCare is not liable for bills incurred before the effective date.
3. I agree that if this application is approved, PacifiCare will notify the applicant in writing of the effective date of coverage.
4. I understand that this application is not a contract. The contract consists of the PacifiCare Health Plan Individual Subscriber Agreement or Policy, including but not limited to all applications, health questionnaires and information submitted by the Subscriber or Insured and his or her Dependents in applying for coverage, appropriate attachments and addenda, and any amendments hereto. Should my application be accepted, PacifiCare will send me a Subscriber Agreement or Policy which details the exact terms and conditions of coverage to which I will be legally bound.
5. I understand that any agent or broker or other producer selling PacifiCare coverage does not have the authority to approve my application, change any terms of the agreement or waive any PacifiCare requirements.
6. I agree that failure to provide full, complete, true and accurate information may result in the denial of benefits, termination and/or rescission of membership in PacifiCare for myself and/or my Dependents.
7. If the applicant is a minor, as the parent/legal guardian of the minor child (the "applicant") and on behalf of the applicant, I request PacifiCare to provide health care coverage under its Individual Plan to the applicant. I hereby assume responsibility for the applicant's compliance with the terms and conditions of the PacifiCare Individual Plan selected as set forth in the applicable Subscriber Agreement or Policy and agree to be responsible for making Health Plan Premium and Copayments, on behalf of the applicant.
8. I hereby authorize any "Provider of health care" to disclose or provide to PacifiCare, its agents or employees, all information and medical records pertaining to any examination or treatment, including treatment for alcohol abuse, substance abuse, psychiatric disorders and/or acquired immune deficiency syndrome (AIDS), regarding myself or any applying applicant. I understand this information is collected for purposes of evaluating my application and determining both initial and continuing eligibility for benefits. This authorization will remain valid for 30 months from the date below. A photocopy of this authorization is valid as the original. I understand that I may revoke this authorization in writing at any time before I become a PacifiCare member, except for instances where PacifiCare has already taken action based on the authorization. I agree to send my revocation to PacifiCare Individual Underwriting, M/S CY24-155, 5701 Katella Avenue, Cypress CA 90630. I understand that if my information is shared with someone who is not required to follow state or federal privacy laws, my information may no longer be protected. I understand that if I refuse to provide this authorization, PacifiCare will not make an eligibility determination, and I will not be considered for membership in a PacifiCare plan.
9. By signing below, I attest and agree that all of the information is correct and that the submission of this application to PacifiCare constitutes an offer to obtain the PacifiCare individual coverage summarily described in the Subscriber Agreement or Policy. I have read the disclosure brochure outlining the benefits, limitations and exclusions and other elements of the disclosure, the above terms and conditions and the authorization to disclose personal information.

Arbitration Disclosure By signing below, I acknowledge that I have read, understand and agree to the Terms and Conditions and Arbitration Disclosure on all the pages of this form. A reproduction of this authorization shall be as valid as the original.

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), EXCEPT FOR CLAIMS SUBJECT TO ERISA, BETWEEN ME AND MY DEPENDENTS ENROLLED IN THE PLAN (INCLUDING ANY HEIRS OR ASSIGNS) AND PACIFICARE OF CALIFORNIA 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.

6. Signatures

SIGNATURE OF APPLICANT/PARENT OR LEGAL GUARDIAN <i>(Required)</i> X	TODAY'S DATE <i>(Required)</i>	SIGNATURE OF APPLICANT'S SPOUSE/DOMESTIC PARTNER <i>(Required if applying)</i> X	TODAY'S DATE <i>(Required)</i>
SIGNATURE OF APPLICANT'S DEPENDENT AGE 18 OR OVER <i>(Required)</i> X	TODAY'S DATE <i>(Required)</i>	SIGNATURE OF APPLICANT'S DEPENDENT AGE 18 OR OVER <i>(Required)</i> X	TODAY'S DATE <i>(Required)</i>

■ 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. ■

For Agent's Use Only

California Well Being Insurance Agency, LLC	No Firm	0642830	
Agent Name	Firm Name	License No.	Tax I.D. No.
Payee <input type="checkbox"/> AGENT <input type="checkbox"/> FIRM	Is payee currently contracted with PacifiCare? <input type="checkbox"/> Yes <input type="checkbox"/> No	GA Name/Number	
If no, please submit a copy of payee's license			
10603 Haledon Ave	Downey	CA	90241
Street Address	City	State	ZIP
	(562) 869-5323	(562) 869-3553	customer@medical-ins.com
Agent's Signature	Date	Phone Number	Fax Number
			E-mail Address
Is this the payee's first individual application with PacifiCare? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Best way to contact: _____			
Are you aware of any information not disclosed in this Health Questionnaire which may have a bearing on this risk? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, explain: _____			
Did you see the applicant and did you ask each question on the Health Questionnaire exactly as set forth? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If no, explain: _____			
Was this Health Questionnaire completed by the applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No			

**PacifiCare Individual Plans
Individual Underwriting
M/S CY24-155
5701 Katella Avenue
Cypress, CA 90630**

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

©2005 by PacifiCare Health Systems, Inc.
PCA077845-002



Medical Records Release Authorization Statement

Reference Number:
Plan Name:
Coverage Type:
Primary Applicant:
Monthly Premium:
Date Submitted:

I hereby authorize any physician, health care practitioner, hospital or other health care facility, clinic, medical group, health care service plan, or any other person or entity to release to PacifiCare Life or its designee my medical records and the medical records of my dependents, including mental health medical records from drug and alcohol abuse treatment or prevention, for the following purposes: diagnosis or treatment; payment of health care services rendered; billing, claims management, medical data processing, or other administrative functions of PacifiCare; peer review, including reviewing the competence or qualifications of health care professionals; utilization review and quality assurance, including reviewing health care services with respect to medical necessity, level of care, or justification of charges; handling of member grievances or appeals, external independent review, or other health dispute resolution; coordination of care with providers of health care or other health care service plans; administering the PacifiCare health benefit plan; chronic disease management programs, to monitor or administer care of a member for a covered benefit, other uses specifically authorized by law. This authorization is effective immediately and remains in effect for the duration of coverage under my PacifiCare health plan. I understand that I have a right to receive a copy of this authorization upon request.

I have read, understand and agree to the above Medical Records Release Authorization Statement.

_____	_____
	Date (required)
_____	_____
Spouse (if applicable)	Dependent over 18 (if applicable)
_____	_____
Dependent over 18 (if applicable)	Dependent over 18 (if applicable)
_____	_____
Dependent over 18 (if applicable)	Dependent over 18 (if applicable)

Please mail application to:
PacifiCare Individual Plans
Individual Underwriting
M/S # CY24-155
5701 Katella Avenue
Cypress, CA 90630
