

SMALL BUSINESS GROUP ACCEPTANCE/CHANGE APPLICATION

PacifiCare®

Effective July 1, 2005

Source Code
Tracking #

Please indicate reason for application:

- New Business:** Acceptance of new coverage
Renewals: Acceptance of renewal with new renewal rates: **Group #** _____
 Change existing coverage: **Group #** _____

Important: Please Print or Type All Sections in Black Ink				
Legal Name of Group/DBA	Telephone ()		Fax ()	
Address	City	County	State	ZIP
Employer Contribution (Medical Only): Employee Premium = _____% Dependent Premium = _____%				
Total Permanent Full-Time Employees: (working 30 or more hours per week)	Total Permanent Part-Time Employees: (working 20-29 hours per week)		Do you wish to offer coverage to ALL employees working 20-29 hours per week? <input type="checkbox"/> Yes Effective Date _____ <input type="checkbox"/> No	

Please Indicate New or Changed Coverage Below	
Plan of Coverage PacifiCare SignatureOptions SM , PacifiCare SignatureIndependence SM and PacifiCare SignatureFreedom SM plans are underwritten by PacifiCare Life and Health Insurance Company.	
<input type="checkbox"/> Age Rates <input type="checkbox"/> Composite Rates (not available for groups purchasing the Choice Series and for groups with less than 16 enrolled employees)	

Please Select All Medical Plans for the Contract Year			
Stand Alone – Select any plan, except PacifiCare SignatureIndependence Dual Option¹ – Select 1 PacifiCare SignatureValue and 1 of the following plans: any of the PacifiCare SignatureFreedom or PacifiCare SignatureOptions plans (except 70-50/2000 (PPO) and 70-50/3500 (PPO)) Choice Series² – Select up to 4 PacifiCare SignatureValue and/or PacifiCare SignatureOptions plans, except 70-50/2000 (PPO), 70-50/3500 (PPO) and all HSA-Compatible plans	PacifiCare SignatureValueSM (HMO) <input type="checkbox"/> 10-30/100 <input type="checkbox"/> 15-30/250a <input type="checkbox"/> 10/500d ³ <input type="checkbox"/> 20-40/500d ³ <input type="checkbox"/> 35/600d ³ PacifiCare SignaturePOSSM (POS) <input type="checkbox"/> 15/80-60	PacifiCare SignatureOptionsSM (PPO) <input type="checkbox"/> 15/90-50/250 <input type="checkbox"/> 20/80-60/250 <input type="checkbox"/> 30/70-50/250 <input type="checkbox"/> 35/80-60/500 <input type="checkbox"/> 35/70-50/1000 <input type="checkbox"/> 35/50-50/1000 <input type="checkbox"/> 70-50/2000 (PPO) <input type="checkbox"/> 70-50/3500 (PPO)	PacifiCare SignatureOptionsSM (HSA-Compatible) <input type="checkbox"/> 100-50/5000 <input type="checkbox"/> 80-50/2700 <input type="checkbox"/> 70-50/3500 (HSA-Compatible) PacifiCare SignatureIndependenceSM (Indemnity) <input type="checkbox"/> 80/1000 ⁴ PacifiCare SignatureFreedomSM (SDHP) <input type="checkbox"/> 80-50/2000 <input type="checkbox"/> 80-50/2000 with Dental <input type="checkbox"/> 70-50/2000 (SDHP) <input type="checkbox"/> 70-50/2000 with Dental <input type="checkbox"/> 50-50/3000 <input type="checkbox"/> 50-50/3000 with Dental

Supplemental Benefits			Other Coverage (required)
Group Life <input type="checkbox"/> Add \$ _____ <input type="checkbox"/> Cancel <input type="checkbox"/> Renew <input type="checkbox"/> Change to \$ _____	Long Term Disability (must be sold with Group Life) <input type="checkbox"/> Add <input type="checkbox"/> Cancel <input type="checkbox"/> Renew	Chiropractic/Acupuncture Supplemental Chiropractic/Acupuncture through an arrangement with American Specialty Health Plans (for PacifiCare SignatureValue and PacifiCare SignaturePOS only) <input type="checkbox"/> Add <input type="checkbox"/> Cancel <input type="checkbox"/> Renew	Domestic Partners Coverage All PacifiCare plans include Domestic Partner coverage as required by state law.

¹ Groups must have at least 5 eligible employees enrolling with PacifiCare to purchase this option.
² Groups must have at least 10 eligible employees enrolling with PacifiCare to purchase this option.
³ By electing 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.
⁴ Must purchase at least one PacifiCare SignatureValue, PacifiCare SignaturePOS, PacifiCare SignatureOptions or PacifiCare SignatureFreedom plan with this plan.

The undersigned is authorized by the above Small Employer Group to apply for or change group coverage offered by PacifiCare of California, PacifiCare Dental & Vision and/or PacifiCare Life and Health Insurance Company at the attached premium rates guaranteed for 12 months effective _____ and is authorized to enter into a Medical and Hospital Group Subscriber Agreement and/or Group Master Policy.

Further, the undersigned agrees to make full monthly premium payments to PacifiCare for the benefits received in accordance with the terms of the contract.

Authorized Signature	Date
Print Name	Title
For renewals only, please fax to Account Management Team Fax # 1-800-926-2951	
UNDERWRITING APPROVAL D.P. Only	
INTERNAL USE ONLY: G.C. #	

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.