

APPLICATION & ENROLLMENT FORM

New Enrollment: Requested Effective Date

Month	Day	Year

Addition of Dependent(s)

Change of CMG/IPA Physician

Check Desired Plan as Offered by Employer: Full Network ChampionHEALTH P.O.S.



Universal Care®

Healthcare you can feel good about.

1600 E. Hill Street • Signal Hill, CA 90755

(800) 635-6668 ext. 4848

www.universalcare.com

Applicant Information: Applicant must complete this section.

Last Name		First Name		M.I.	Home Phone	
					() ()	
Home Address <small>Must be complete. P.O. Box not acceptable.</small>			<input type="checkbox"/> Single <input type="checkbox"/> Married		Date of Marriage	
					Month Day Year	
City		State	Zip Code	E-Mail Address		
Employer		Group # (if assigned)		Occupation		Date of Hire
						Month Day Year

Applicant/Family Information: List yourself and all eligible family members to be enrolled. If a listed family member's last name is different from yours, please explain below.

Provider Selection: Please select a Primary Care Physician for each family member to assure prompt processing of this application.

Last Name	First Name	M.I.	Date of Birth	Social Security Number	Name of Primary Care Physician	PCP#/CMG#	Current Doctor?
<small>Applicant</small> <input type="checkbox"/> M <input type="checkbox"/> F			Month Day Year				Y N
<small>Spouse</small> <input type="checkbox"/> M <input type="checkbox"/> F							
<small>Dependent</small> <input type="checkbox"/> M <input type="checkbox"/> F							
<small>Dependent</small> <input type="checkbox"/> M <input type="checkbox"/> F							
<small>Dependent</small> <input type="checkbox"/> M <input type="checkbox"/> F							
<small>Dependent</small> <input type="checkbox"/> M <input type="checkbox"/> F							

Different last name explanation:

If available, I would prefer to receive materials in the following language _____.

The following information is voluntary and will help us to better serve your needs. Please check the ethnicity with which you most closely identify.

Alaskan/Native American Caucasian African American Hispanic Asian/Pacific Islander Other _____

Other Health Insurance:

Please fill out this section if you and any of your eligible family members are currently covered by other medical insurance, or had previous health insurance.

Name of Member(s)	Previous Insurer	Policy Number	Policy Effective Date	Employer's Name
			Month Day Year	
Name of Member(s)	Current Insurer	Policy Number	Policy Effective Date	Employer's Name
	Name		Month Day Year	
	Address			
	City State Zip			
Are you or any member(s) of your family eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	Name	Name	Name	

Universal Care may require prior medical records and that the applicant agrees to sign a Medical Records Release form so we can obtain the records.

Authorization to Obtain or Release Medical Information: I hereby authorize my physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish an agent, designee, or representative of Universal Care and all records pertaining to medical history, services rendered, or treatment given to anyone enrolled hereunder or added hereunder for purpose of review, investigation, or evaluation of an application or claim. I authorize Universal Care or its agents, designee, or representatives to disclose to a hospital or health care service plan, self-insurer or insurer any such medical information obtained if such disclosure is necessary to allow the processing of any claim. This authorization shall become effective immediately and shall remain in effect as long as is necessary to enable Universal Care to process claims.

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Subscriber Signature (Applicant)	Date
	Month Day Year

Coverage Declination

To be completed if any Universal Care coverage is declined or refused by an eligible employee and/or their eligible family members.

1. Health Plan Coverage (check if declined)

I decline coverage for:

Myself Children Only
 Spouse Only Spouse and Children

2. Reason for Declining Health Plan Coverage (check one)

- Covered by Spouse's Group Coverage
Carrier Name & ID Number
- Spouse covered by Employer's Group Medical Coverage
- Covered by CHAMPUS or CHAMPVA
- Enrolled in another Group Plan
Carrier Name
- Medicare Other (explain): _____

I acknowledge that the eligible coverages have been explained to me by my employer, and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage. **I know that if I later decide to elect coverage, and I was not covered under another employer health benefit plan during the initial enrollment period, I and/or my dependents will be considered a late Enrollee and will be subject to a 12 month waiting period from the date I later decide to elect coverage.** I may also be subject to a six-month pre-existing condition exclusion. My decision not to apply for coverage now could leave me without coverage later.

Employee Signature (Sign only if declining coverage for yourself or eligible family member.)	Date
	Month Day Year