

# Small Business Employee Enrollment Form/Waiver of Coverage

Effective March 1, 2009

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## Instructions

Complete the information requested in each section according to the guidelines provided below. Please be thorough and fill out all sections that apply. Submit the completed enrollment form to your employer for processing.

### Section A: Employee Information

- Please complete all information requested;
- If enrolling in a PacifiCare HMO or POS plan, you must select a Primary Care Physician. Select a PCP from the *Provider Directory* for yourself and each of your family members by writing the PCP name and Provider number in the area provided. You may choose a different PCP for each member of your family. If you do not select a PCP when selecting one of these plans, a PCP will be automatically assigned to you. PCP selection is only required if enrolling in a PacifiCare SignatureValue® (HMO), PacifiCare SignatureValue® Advantage (HMO) or PacifiCare SignaturePOS® plan.
- If enrolling in a PacifiCare Dental HMO Plan, select a Primary Care Dentist from the Dental Provider Directory for yourself and each of your family members. Write the PCD name and Provider Number in the area provided. You may choose a different Primary Care Dentist for each enrolling member, however PCDs cannot be automatically assigned and are only required for the PacifiCare Dental HMO plans.

### Section B: Dependent Information

- Complete all information for each enrolling dependent, including any enrolling Dependent's Social Security number.
- For each dependent enrolling in a PacifiCare HMO or POS Plan, select a Primary Care Physician (PCP) from the *Provider Directory* by writing the PCP name and Provider Number in the area provided. You may choose a different PCP for each member in your family. If you do not select a PCP when selecting one of these plans, a PCP will be automatically assigned to you.
- For each dependent enrolling in a PacifiCare Dental HMO Plan, select a Primary Care Dentist from the Dental Provider Directory. Write the PCD name and Provider Number in the area provided. You may choose a different Primary Care Dentist for each enrolling member, however

PCDs cannot be automatically assigned and are only required for the PacifiCare Dental HMO plans.

- Verify that spousal and domestic partner coverage is available through your Employer.
- Over-age (19-24 years) Dependents require proof of full-time student status or permanent disability status within 31 days of enrollment.

### Section C: Product Selection

- Benefit offerings are dependent on your Employer selections. Check with your employer for available plan options being offered to you.
- Check the box for each plan you or your dependents are enrolling in. If enrolling in Life or AD&D plans, indicate the dollar amount selected.
- All enrolling family members must select the same medical and dental plan.
- When selecting a UnitedHealthcare medical plan, check the box next to UnitedHealthcare Plan Code and write the three-digit plan code of your selection in the space provided. For example: UnitedHealthcare Plan Code: **D6-M**.
- When selecting a PacifiCare Plan, check the box next to PacifiCare Plan Description and write the name of the plan you wish to enroll in. For example, PacifiCare Plan Description: **PacifiCare SignatureValue 10-30/100**.

### Section D: Prior Medical Insurance/Health Plan Coverage Information

- Complete this section to receive credit for prior medical insurance/health plan coverage. If you have not had prior medical insurance/health plan coverage, please indicate by checking NO.

### Section E: Other Medical Insurance/Health Plan Coverage Information

- If you, your spouse/domestic partner, or any dependent will be covered under any other medical insurance plan/health plan, including Medicare, on the day this insurance/health plan coverage begins, please complete this section. If no other medical plan/coverage exists, please indicate by checking NO.

**Section F: Other Dental Insurance/Coverage Information**

- If you, your spouse/domestic partner, or any dependent will be covered under any other dental insurance plan/coverage on the day this insurance/coverage begins, please complete this section. If no other dental plan/coverage exists, please indicate by checking NO.

**Section G: Waiver of Coverage**

- You can waive the health care services coverage provided through your Employer for yourself and/or any of your family members. If waiving coverage for yourself and/or any family member, a signature is required in this section. Please read the entire section carefully, sign and date in ink, and return the form to your Employer for processing.

**Section H: Authorization to Release Medical Information and Application Signature**

- Review this section carefully, sign and date.

**Section I: Binding Arbitration**

- Review this section carefully, sign and date.

**Section J: Census Information**

- Check all boxes that apply. The information collected in this section will only be used to help communicate with enrollees and inform them of specific programs to enhance their well-being. This information will not be used in the eligibility process.

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**Employer Instructions**

Complete the top section of the Employee Enrollment Form and confirm all required information has been completed by the employee. Submit enrollment/eligibility changes to one of the following addresses, based on the plan the employee is enrolling in:

**UnitedHealthcare**

Web: [www.employereservices.com](http://www.employereservices.com)

Fax: (248) 733-6062

Mail: PRIME Eligibility

UnitedHealthcare

P.O. Box 30964

Salt Lake City, UT 84130-0964

**PacifiCare**

Web: [www.pacificare.com](http://www.pacificare.com)

Fax: 1-866-372-1316

E-mail: [Imaging\\_elig@phs.com](mailto:Imaging_elig@phs.com)

Mail: PacifiCare Eligibility

P.O. Box 30981

Salt Lake City, UT 84130-0981

For new business groups or additional questions, contact your broker or local UnitedHealthcare sales office.

# CALIFORNIA Small Business Employee Enrollment Form

(DO NOT STAPLE)



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Unimerica Insurance Company

To speed the enrollment process, please be thorough and fill out all sections that apply.

Group Name/Number

To Be Completed by Employer		
<b>Requested Effective Date of Insurance/Health Plan Coverage/Date of Change</b> / /	<b>Reason for Application</b> <input type="checkbox"/> New Group Plan <input type="checkbox"/> Dependent Add/Delete <input type="checkbox"/> Change Name/Address <input type="checkbox"/> Termination <input type="checkbox"/> Waiving Coverage (Complete Sections A, B, and G) <input type="checkbox"/> Life Event/Date <input type="checkbox"/> Status Change <input type="checkbox"/> Other	<b>Employee Type (check all that apply)</b> <input type="checkbox"/> Active <input type="checkbox"/> Hourly <input type="checkbox"/> COBRA <input type="checkbox"/> Union <input type="checkbox"/> Salary <input type="checkbox"/> Cal-COBRA <input type="checkbox"/> Non-Union <input type="checkbox"/> Retired <input type="checkbox"/> Other Start Date ___/___/___ End Date ___/___/___
<b>Date of Hire</b> / /	<input type="checkbox"/> New Hire <input type="checkbox"/> Annual Open Enrollment <input type="checkbox"/> Late Enrollee Date: ___/___/___	<b>Indicate Qualifying Event</b> _____
<b>Position/Title</b>		<b>Original Qualifying Event Date</b> Start Date ___/___/___ End Date ___/___/___
<b>Hours Worked Per Week</b>		
<b>Salary \$</b> _____ <small>Required only if Life Plan based on salary.</small>		

A. Employee Information		Complete All Sections			
Last Name	First Name	MI	Social Security Number	Home Phone	Work Phone
Address		Apt #	City	State	Zip Code
E-mail Address					
Date of Birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Height	Weight	Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Spanish <input type="checkbox"/> Other	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partner	Permanently Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary Care Physician* (First & Last Name)/ID# Existing Patient Medical <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary Care Dentist* (First & Last Name)/ID# Existing Patient Dental <input type="checkbox"/> Yes <input type="checkbox"/> No	

B. Dependent Information		List All Enrolling (attach sheet if necessary)				
Name (Last, First, M)	Sex	Preferred Language	Relationship**	Permanently Disabled	Full Time Student	Provide Primary Care Physician* and /or Dentist Name and ID#
Address (if different from Employee)	M F	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Other	Spouse/ Domestic Partner	Birth Date	<input type="checkbox"/> Yes  <input type="checkbox"/> No	Physician: ID#: Existing Patient (Medical) <input type="checkbox"/> Yes <input type="checkbox"/> No
				Height		Dentist: ID#: Existing Patient (Dental) <input type="checkbox"/> Yes <input type="checkbox"/> No
Social Security Number				Weight		
Name (Last, First, M)	Sex	Preferred Language	Relationship**	Permanently Disabled	Full Time Student	Provide Primary Care Physician* and /or Dentist Name and ID#
Address (if different from Employee)	M F	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Other	Dependent	Birth Date	<input type="checkbox"/> Yes  <input type="checkbox"/> No	Physician: ID#: Existing Patient (Medical) <input type="checkbox"/> Yes <input type="checkbox"/> No
				Height		Dentist: ID#: Existing Patient (Dental) <input type="checkbox"/> Yes <input type="checkbox"/> No
Social Security Number				Weight		
Name (Last, First, M)	Sex	Preferred Language	Relationship**	Permanently Disabled	Full Time Student	Provide Primary Care Physician* and /or Dentist Name and ID#
Address (if different from Employee)	M F	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Other	Dependent	Birth Date	<input type="checkbox"/> Yes  <input type="checkbox"/> No	Physician: ID#: Existing Patient (Medical) <input type="checkbox"/> Yes <input type="checkbox"/> No
				Height		Dentist: ID#: Existing Patient (Dental) <input type="checkbox"/> Yes <input type="checkbox"/> No
Social Security Number				Weight		

\*IMPORTANT: Please use the PacifiCare Provider Directory to select a Primary Care Physician for yourself and each of your covered dependents for products requiring a Primary Care Physician designation. Please use the Dental Directory to select a Primary Care Dentist for yourself and each of your covered dependents for products requiring a Primary Care Dentist designation. \*\*For court-ordered dependent, legal documentation must be attached. Please see employer representative for more information about the qualifications for full-time student status.

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**B. Dependent Information (continued)**

Name (Last, First, M)	Sex	Preferred Language	Relationship**	Permanently Disabled	Full Time Student	Provide Primary Care Physician* and /or Dentist Name and ID#
Address (if different from Employee)	M F	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Other	Dependent	Birth Date	<input type="checkbox"/> Yes  <input type="checkbox"/> No	Physician: ID#: _____ Existing Patient (Medical) <input type="checkbox"/> Yes <input type="checkbox"/> No
				Height		
Social Security Number				Weight		

**C. Product Selection** Check the box for each plan you or your dependents are enrolling in; Indicate the dollar amount selected for the life and AD&D plans. Benefit offerings are dependent on employer selections. Indicate the medical and dental plan enrollees are selecting.

Person	Medical	Dental	Vision	Life/Amount	Sup Life	Sup AD&D
Employee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	_____	_____
Spouse/Domestic Partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____		
Dependents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____		

**Medical Plan Selection** – Medical Plan Selection: Check the box and write in the Plan Code or Description you wish to enroll in. Check with your employer for available benefit plans.

UnitedHealthcare Plan Code: \_\_\_\_\_

PacifiCare Plan Description: \_\_\_\_\_

**Dental Plan Selection** – Write in the Plan Code you wish to enroll in. Check with your employer for available benefit plans.

Code: \_\_\_\_\_

**D. Prior Medical Insurance/Health Plan Coverage Information** This section must be completed to receive credit for prior medical insurance/health plan coverage.

Have you or your dependents ever been a UnitedHealthcare or PacifiCare member?  Yes  No

Within the last 12 months, have you, your spouse/domestic partner, or your dependents had any other medical insurance/health plan coverage?  NO  YES (if yes, please complete this section.)

Prior medical carrier name \_\_\_\_\_ Effective date \_\_\_/\_\_\_/\_\_\_ End date \_\_\_/\_\_\_/\_\_\_

Prior insurance/health plan coverage type:  Employee  Spouse/Domestic Partner  Child(ren)  Family

**E. Other Medical Insurance/Health Plan Coverage Information** This section must be completed. (Attach sheet if necessary.)

On the day this insurance/health plan coverage begins, will you, your spouse/domestic partner or any of your dependents be covered under any other medical insurance/health plan coverage, including another UnitedHealthcare plan or Medicare?

YES (continue completing this section)  NO (If NO, then skip the rest of the Other Medical Insurance/Health Plan Coverage section.)

Name of other carrier \_\_\_\_\_

Other Group Medical Insurance/Health Plan Coverage Information (only list those covered by other plan)	Type (B/S/F) <sup>†</sup>	Effective Date MM/DD/YY	End Date MM/DD/YY	Name and date of birth of policyholder/covered employee for other insurance/health plan coverage
Employee:		/ /	/ /	
Spouse/Domestic Partner Name:		/ /	/ /	
Dependent:		/ /	/ /	
Dependent:		/ /	/ /	
Dependent:		/ /	/ /	

<sup>†</sup>B. Enter 'B' when this dependent is covered under both you and your spouse's insurance/health plan coverage (married).  
 S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.  
 F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

**If you and/or an enrolling dependent are enrolled in Medicare, complete this section (attach additional sheets if necessary):**

Medicare – Employee/Spouse/Domestic Partner/Dependent Name: \_\_\_\_\_

Medicare ID# \_\_\_\_\_ (Please attach a copy of your Medicare ID card.)

Enrolled in Part A: Effective Date \_\_\_/\_\_\_/\_\_\_  Ineligible for Part A\*  Not Enrolled in Part A (chose not to enroll)  
 Enrolled in Part B: Effective Date \_\_\_/\_\_\_/\_\_\_  Ineligible for Part B\*  Not Enrolled in Part B (chose not to enroll)  
 Enrolled in Part D: Effective Date \_\_\_/\_\_\_/\_\_\_  Ineligible for Part D\*  Not Enrolled in Part D (chose not to enroll)

Disabled  Disabled but actively at work

Reason for Medicare eligibility:  Over 65  Kidney Disease  Disabled  Disabled but actively at work

Are you receiving Social Security Disability Insurance (SSDI)?  YES  NO Start Date \_\_\_/\_\_\_/\_\_\_

\*Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are not eligible for Medicare.

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**F. Other Dental Insurance/Coverage Information** **This section must be completed. (Attach sheet if necessary.)**

On the day this dental plan coverage begins, will you, your spouse/domestic partner or any of your dependents be covered under any other dental insurance/coverage, including another UnitedHealthcare plan?

YES (continue completing this section)  NO (If NO, then skip the rest of the Other Dental Insurance/Coverage section.)

Name of other carrier \_\_\_\_\_

Other Dental Insurance/Coverage Information (only list those covered by other plan)	Type (B/S/F) <sup>†</sup>	Effective Date MM/DD/YY	End Date MM/DD/YY	Name and date of birth of policyholder/covered employee for other dental plan coverage
Employee:		/ /	/ /	
Spouse/Domestic Partner Name:		/ /	/ /	
Dependent:		/ /	/ /	
Dependent:		/ /	/ /	
Dependent:		/ /	/ /	

<sup>†</sup>B. Enter 'B' when this dependent is covered under both you and your spouse's insurance/health plan coverage (married).  
 S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.  
 F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

**G. Waiver of Coverage** **Complete only if you are waiving coverage for yourself and/or any family member.**

I decline coverage for: <input type="checkbox"/> Myself <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Dependent Children <input type="checkbox"/> Myself and all dependents	Declining coverage reason: <input type="checkbox"/> Spouse's Employer's Plan <input type="checkbox"/> Individual Plan <input type="checkbox"/> COBRA/CAL-COBRA/AB-1401 from Prior Employer <input type="checkbox"/> Covered by Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> I (we) have no other coverage at this time <input type="checkbox"/> Tri-Care <input type="checkbox"/> VA Eligibility <input type="checkbox"/> Other _____
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I acknowledge that the available coverages have been explained to me by my employer and I know that I have been given the right and have been given the chance to apply for coverage. I have decided not to enroll myself and/or my dependent(s), if any.

I now decline to enroll myself, my spouse/domestic partner and/or my dependent(s) in my employer health plan. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage. **I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UP TO TWELVE (12) MONTHS TO BE ENROLLED IN THE GROUP MEDICAL AND/OR LIFE INSURANCE PLAN AND THERE MAY BE A SIX-MONTH PRE-EXISTING CONDITION EXCLUSION UNLESS I AND/OR MY DEPENDENTS HAVE GROUP MEDICAL COVERAGE ELSEWHERE. THE TWELVE (12)-MONTH WAIT WILL NOT APPLY IF I AND/OR MY DEPENDENTS ARE ENTITLED TO AN OFF-CYCLE ENROLLMENT PERIOD DUE TO CERTAIN CHANGED CIRCUMSTANCES (E.G., ACQUISITION OF A DEPENDENT OR LOSS OF OTHER COVERAGE THROUGH A DEPENDENT.)**

- The twelve (12)-month wait will not apply if:
1. I certify at the time of initial enrollment that the coverage under another employer health benefit plan, Healthy Families Program, or no share-of-cost Medi-Cal coverage was the reason for declining enrollment, and I lose coverage under that employer health benefit plan, Healthy Families Program, or no share-of-cost Medi-Cal;
  2. my employer offers multiple health benefit plans and I elected a different plan during an open enrollment period;
  3. a court orders that I provide coverage under this plan for a spouse or minor child; or
  4. I have a new dependent as a result of marriage, domestic partnership, birth, adoption or placement for adoption and if enrollment is requested within 30 days after the marriage, domestic partnership, birth, adoption or placement for adoption.

If I am declining enrollment for myself and/or my dependent(s) (including my spouse/domestic partner) because of other health insurance or group health plan coverage, I must request enrollment within 30 days after the other coverage ends (or after the employer stops contributing toward the other coverage).

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be declined coverage entirely.

Employee Signature (only if waiving coverage for self and/or dependents)	Date _____/_____/_____
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**H. Authorization to Release Medical Information and Application Signature**

I authorize United HealthCare Insurance Company and its affiliates ("UnitedHealthcare and Affiliates") to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records (my "Confidential Health Information"). I understand my Confidential Health Information may contain information created by other persons or entities (including health care providers) as well as information regarding drug and alcohol use, HIV/AIDS, mental health treatments (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer, health care service plan or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, who are in possession of my Confidential Health Information, to disclose my information to UnitedHealthcare and Affiliates. I understand the purpose of the disclosure and use of my Confidential Health Information is to allow UnitedHealthcare and Affiliates to make decisions regarding eligibility, enrollment and rating. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my ability to enroll in the health plan or receive benefits, if permitted by law. I understand I may revoke this authorization at any time by notifying my UnitedHealthcare and Affiliates representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, UnitedHealthcare and Affiliates also request that I acknowledge the following, which I do: I understand that information I authorize a person or entity to obtain and use may be re-disclosed (with the exception of HIV/AIDS health information) and no longer protected by federal privacy regulations except as prohibited by state law. This authorization, unless revoked earlier, expires 30 months after the date it is signed.

I understand that I am completing a joint life and health application and that each response must be complete and accurate. I (we) request the indicated group medical coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contributions to be deducted from earnings. I (we) understand that UnitedHealthcare and Affiliates is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments. Please maintain a copy of this authorization for your records.

Employee Signature	Employee Name (please print)	Date _____/_____/_____
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**I. Binding Arbitration**

**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 MYSELF AND MY DEPENDENTS ENROLLED IN THE PLAN (INCLUDING ANY HEIRS OR ASSIGNS) AND PACIFICARE OF CALIFORNIA, UNITEDHEALTHCARE 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 RIGHTS TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION IN ACCORDANCE WITH CALIFORNIA ARBITRATION LAW (TITLE 9 OF THE CALIFORNIA CODE OF CIVIL PROCEDURE § 1280 ET SEQ.) EXCEPT WHERE SUCH LAWS MAY BE PREEMPTED BY FEDERAL LAW INCLUDING, BUT NOT LIMITED TO, THE FEDERAL ARBITRATION ACT, 9 U.S.C. SEC. 1, ET SEQ.**

Employee Signature (required)	Employee Name (please print) (required)	Date (required) _____/_____/_____
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**J. Census Information**

NOTE: Data collected in this section will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being. This information will not be used in the eligibility process.

1. Race, check all that apply:  White     Black, African-American     Native Hawaiian/Pacific Islander     Hispanic/Latino  
 American Indian/Alaska Native     Asian     Other Race, please specify \_\_\_\_\_

Coverage provided by "UnitedHealthcare and Affiliates":

Medical coverage provided by United HealthCare Insurance Company. Dental coverage provided by United HealthCare Insurance Company, Unimerica Insurance Company, PacifiCare Life and Health Insurance Company, or Dental Benefit Providers of California, Inc. Life Insurance coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company. Vision coverage provided by United Health Care Insurance Company or Unimerica Insurance Company.

Insurance coverage provided by or through United HealthCare Insurance Company, underwritten by PacifiCare Life and Health Insurance Company or their affiliates. Medical coverage provided by PacifiCare of California and PacifiCare Behavioral Health of California, Inc. Administrative services provided by United HealthCare Insurance Company, United HealthCare Services, Inc., PacifiCare Health Plan Administrators, Inc. or their affiliates. PacifiCare® is a federally registered trademark of PacifiCare Life and Health Insurance Company.

**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.**