TEXAS

PacifiCare®

Small Employer Group Application

IMPORTANT: PLEASE TYPE OR PRINT ALL SECTIONS IN INK.

Part I – Employer Information

Employer's Legal Name	DBA	Phone ( )		
☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Other		Tax ID #		
Address	City	County	State	ZIP
E-mail	Fax ( )			
Administrative Contact	Title	Phone ( )		
Billing Contact	Title	Phone ( )		
Executive Contact	Title	Phone ( )		

Is this employer group subject to ERISA regulations? ☐ Yes ☐ No
If no, explain why: ______________________________

Part II – Business Information

Nature of Business	SIC Code	Number of Years in Operation
Total number of individuals employed by firm	Employer Group #	
Total number of full-time employees usually working a minimum of 30 hours per week		
Total number of full-time employees working within this state		
Total number of eligible employees requesting coverage with PacifiCare		
Is this business currently in Chapter 11 or has it filed for bankruptcy within the last 12 months? ☐ Yes ☐ No		
Proposed Effective Date / /	Proposed Renewal Date / /	
Employer Contributions: ☐ % ☐ $	Employee	Dependent

Part III – Carrier Information

This plan is intended to replace the following coverage:

Medical Insurance Carrier	Anticipation Termination Date
The following carrier supplies Workers' Compensation coverage	
Names of employees not covered by Workers' Compensation	
Reason:	

Underwritten by
PacifiCare Life Assurance Company

Part IV – Benefits and Rates – Please check the box next to the product being purchased

PacifiCare SignatureOptions℠ (PPO)* (HSA-Compatible)*

☐ Medical Plan ____________ Medical Plan Code ____________

Calendar Year Deductible $ ______ | Coinsurance % ____ / ____ | Office Visit Copayment $______

Coinsurance Maximum In-Network $ ______ Out-of-Network $ ______

☐ Multiple Plan Package

High Option Plan ____________ Medical Plan Code ____________

Coinsurance % In-Network ____% Out-of-Network ____% | Office Visit Copayment $ ____________

Calendar Year Deductible: In-Network $________ Out-of-Network $________ | Coinsurance Maximum: In-Network $________ Out-of-Network $________

Low Option Plan ____________ Medical Plan Code ____________

Coinsurance % In-Network ____% Out-of-Network ____% | Office Visit Copayment $ ____________

Calendar Year Deductible: In-Network $________ Out-of-Network $________ | Coinsurance Maximum: In-Network $________ Out-of-Network $________

☐ Rx Plan $ ____________

☐ Other Optional Benefits ____________

PacifiCare SignatureFreedom℠ (SDHP)*

☐ Medical Plan ____________ Medical Plan Code ____________

Plan Year Deductible $ ______ | Coinsurance % ____ / ____ | Office Visit Copayment $______

Coinsurance Maximum In-Network $ ______ Out-of-Network $ ______

☐ Rx Plan $ ____________

☐ Other Optional Benefits ____________

PacifiCare SignatureIndependence℠ (Indemnity)*

☐ Medical Plan ____________ Medical Plan Code ____________

Calendar Year Deductible $ ______ | Coinsurance % ____ / ____ | Coinsurance Maximum $______

☐ Rx Plan $ ____________

☐ Other Optional Riders ____________

Group Term Life Insurance

☐ $15,000 ☐ $25,000 ☐ $50,000 ☐ Other

Underwritten by American Medical Security Life Insurance Company. Group Term Life requires a separate application.

MANDATED BENEFIT OFFERINGS

	Accept	Reject		Accept	Reject
Speech and Hearing	☐	☐	Serious Mental Illness	☐	☐
In Vitro Fertilization	☐	☐	Therapies for Children with Developmental Delays	☐	☐

*Underwritten by PacifiCare Life Assurance Company

Part V – Rates Applied For

The rates shown on the attached sheet are acceptable to this small employer group. The Employer's signature on the rate sheet authorizes PacifiCare to proceed with processing this group application.

Part VI – Risk Evaluation

PacifiCare requires the Employer to answer the questions below. The answers to these questions are not material to the acceptance of the Small Employer's Application for group coverage. This form should be filled out by the person responsible for operation of the current benefit plan. Please answer each question to the best of your knowledge with respect to all eligible employees and dependents that you intend to have covered under PacifiCare's plan, including those that will be on continuation of benefits under COBRA, or state continuation.

Are you aware of any employee or dependent diagnosed as having or has been or is being treated by a member of the medical profession for any of the following conditions in the past 3 years?

a.	Cardiac disorder	☐ Yes ☐ No	d.	Kidney disorder	☐ Yes ☐ No
b.	Cancer (any form)	☐ Yes ☐ No	e.	Respiratory disorder	☐ Yes ☐ No
c.	Diabetes	☐ Yes ☐ No	f.	Liver disorder	☐ Yes ☐ No

Risk Evaluation (Continued)

g.	AIDS/Immune System Deficiency	☐ Yes	☐ No	j.	Neuromuscular disorder	☐ Yes	☐ No
h.	Alcohol/Drug abuse	☐ Yes	☐ No	k.	Transplant candidate	☐ Yes	☐ No
i.	Psychological disorder	☐ Yes	☐ No				

Are you aware of any employee or dependent who is currently disabled or receiving ongoing care for a medical disability? ☐ Yes ☐ No

Are you aware of any employee or dependent who is currently hospitalized or who is anticipating hospitalization or surgery within the next 60 days? ☐ Yes ☐ No

Are you aware of any employee who has missed more than 10 consecutive days of work in the past 12 months due to illness or injury? ☐ Yes ☐ No

Has any employee or dependent accumulated claims in excess of $25,000 in the past 12 months? ☐ Yes ☐ No

Are you aware of any employee or dependent who is currently pregnant? ☐ Yes ☐ No

Number of employees or dependents currently pregnant. Employees _______ Dependents _______ Due dates: / /

Are you required to offer COBRA or state continuation? ☐ Yes ☐ No

Name and Expiration Dates of current COBRA/State Continuation Participants

Name	COBRA/ State Continuation Expiration Date	Name	COBRA/ State Continuation Expiration Date
	/ /		/ /
	/ /		/ /
	/ /		/ /

If you answered "Yes" to any questions above, please provide the additional information requested below for each individual. Attach additional sheet if necessary.

Indicate whether employee or dependent	Nature of Illness	Date of Onset	Approximate Amount of Claim	Length of Disability	Current Health Status
☐ Employee ☐ Dependent		/ /	$		
☐ Employee ☐ Dependent		/ /	$		
☐ Employee ☐ Dependent		/ /	$		
☐ Employee ☐ Dependent		/ /	$		

Part VII – Eligibility/Billing Options

Eligibility Date for New Employees ☐ 1st of the month coinciding with or next following _______ days of employment.

Eligibility Date for Rehired Employees ☐ 1st of the month coinciding with or next following _______ days of employment.

Employer pays entire month's premium for coverage. Coverage extends through the month in which employment terminates.

Part VIII – Producer Appointment/Commissions

PacifiCare compensates Agents/Producers for the sale of certain products. Your premium is the same if you purchase coverage directly from PacifiCare or if you use an Agent/Producer. Please contact your Agent/Producer, if applicable, regarding the amount of compensation. In addition, you may request information regarding Producer commissions attributable to your group by contacting PacifiCare Membership Accounting. As a representative of the Employer, I appoint the following individual as Producer of Record and authorize that person to act on our behalf in regards to the Benefits being applied for.

Producer Name	Firm Name	Phone ( )	Fax ( )
Address	City	State	ZIP
Payee: ☐ Agent or ☐ Firm			
Payee's SS #	Payee's Tax ID #	Payee's Producer Code ( )	
Payee's Texas License #		Expiration Date / /	

If a split commission, attach payee information including percentage for each payee.

Special Notes

Part IX – Signature

1. **THE EFFECTIVE DATE** will be determined by PacifiCare and will be the latest of: (a) the date this Application is given written acceptance by the Company; (b) any Requested Effective Date not prior to the date the applicant signs this Application, provided we accept the Application; or (c) the date we establish for coverage to begin, in the event this Application is not accompanied by all information we need in order to underwrite the coverage. A full first month's payment must be received and the Application must be accepted in writing by us before the plan becomes effective.
2. **EMPLOYER CERTIFIES** that unless we agree otherwise in writing, all persons to be covered, except retirees, dependents and those former employees covered under a continuation of benefits, are bona fide employees of the applicant. A bona fide employee is a person who works on a full-time basis and who usually works at least 30 hours a week.
3. **DUTY TO PROVIDE INFORMATION:** The employer agrees to furnish all data necessary for the efficient administration of the group coverage provided for the covered employees and dependents, if any, to us.
4. **IT IS UNDERSTOOD AND AGREED** that none of our agents have the authority to: (a) modify this form; (b) waive the answer to any question; or (c) bind us in any way by giving or receiving data which is not written on this form. None of our agents has the authority to: (a) alter or amend the Group Plan or Plans; or (b) bind us by making any promise or representation.
5. **THE EMPLOYER DECLARES** that the Employer's Representative has read the above statement and the answers to all of the questions are complete and true to the best of his or her knowledge. The Employer agrees: (1) that this Application is offered as an inducement for the Group Coverage applied for; (2) that this Application will form a part of any contract issued; (3) that only the information on this Application will bind the Company; and (4) that no waiver or change will bind the Company unless signed by an Executive officer of the Company. Group coverage will only be provided for persons eligible under the plans issued.

Received from this Employer, a one month's deposit of $____________ and an application for coverage under a Group Plan. PacifiCare will hold the deposit without obligation until the application is either accepted or denied. If we accept the application, the deposit will be applied to the first premium due and payable for the coverage. If denied, coverage will not become effective and the deposit will be refunded. I certify that I have read all other information on the last page of this application.

Employer's Signature

Date / /

Title

PacifiCare Representative Signature

Date / /

Broker Signature

Date / /

PLEASE SUBMIT THE FOLLOWING

- ☐ Deposit Check
- ☐ Small Employer Group Application
- ☐ Application for Group Life Insurance and Request to Participate in Trust for Small Employer Groups
- ☐ Enrollment/Waiver Forms, # submitted __________
- ☐ Statement of Health, # submitted __________ (if required)
- ☐ Current Billing Statement(s)
- ☐ Current Benefit Booklet(s) (PPO Plans Only)
- ☐ State Quarterly Wage & Contribution Report
- ☐ Copy of Final Rate Acceptance Sheet (To be submitted after final rates are calculated by PacifiCare)