

Enrolling is Simple. Just Follow These 3 Easy Steps...

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at:
Fax:

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly (by checking account deduction), bi-monthly (every two months) or quarterly (every three months).

Step 3

SEND THE COMPLETED APPLICATION TO:

Please make your check payable to: PacifiCare of Arizona

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status.

If you have questions please contact our office at:

Thank you for choosing...

PacifiCare[®]
of ARIZONA

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 allows effective dates beginning on the 1st or the 15th of the month. Please submit your application by the 20th of the month to be considered for the 1st of the following month, or by the 5th to be considered for the 15th of the same month. Actual effective dates are determined by the Company. **Do not cancel any existing coverage until you are notified by PacifiCare or PacifiCare Life Assurance Company 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 Rate Card enclosed with this form.
 - If you and your Spouse are both applying, price yourselves individually and then add the two premiums together. Please add any Dependents, if applicable.
 - Be sure to include your first premium payment.
- **Complete the Primary Applicant Information section.** Please list yourself as the Primary Applicant and, if married, include your Spouse as a Dependent (if the Spouse is also applying). 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 family Member applying.** All PacifiCare SignatureValue (HMO) applicants must select a Primary Care Physician from the enclosed *PacifiCare SignatureValue (HMO) Provider Directory*.

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 family members 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. 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 (if applying) and any listed dependent age 18 or over, must sign and date the application.
- **Mail your application to:**

Before sealing the envelope, be sure to enclose:

- Your completed Enrollment Application
- Your first premium check

Please note: Coverage does not become effective under any circumstances until an application has been underwritten and approved by PacifiCare of Arizona, Inc. for HMO plans, and PacifiCare Life Assurance Company for PPO plans.

ARIZONA ENROLLMENT APPLICATION



Requested Effective Date:
Subject to Approval

For Office Use Only

Date _____
Group Number _____ Effective Date _____
Approved/Denied _____ Approved by _____

Type or print with a black ball-point pen. Incomplete information will delay processing.
Application must be signed to be valid.

1. Application, Plan & Payment Information

Application for: New Individual Plan Membership Existing PacifiCare Individual Plan Member – adding Dependent
 Guaranteed Availability (HIPAA) Current PacifiCare Member Applying for Individual Plan
Note: Applicants/Dependents who are eligible for Medicare Benefits (or over age 64) are not eligible for Individual Plan. Please submit Certificates of Creditable Coverage if available with application.

Plan Options: PacifiCare SignatureValueSM (HMO) Plan 3 - \$15/\$30/\$250 per day
 PacifiCare SignatureValueSM (HMO) Plan 4 - \$20/\$40/\$350 per day
 PacifiCare SignatureValueSM (HMO) Plan 5 - \$25/\$45/\$500 per day
 PacifiCare SignatureOptionsSM (PPO) Plan 1 - \$20/80-60/\$500
 PacifiCare SignatureOptionsSM (PPO) Plan 2 - \$35/70-50/\$1,000
 PacifiCare SignatureOptionsSM (PPO) Plan 3 - \$30/80-50/\$1,500
 PacifiCare SignatureOptionsSM (PPO) Plan 4 - \$30/70-50/\$2,000

HIPAA Eligible: PacifiCare SignatureValueSM (HMO) Plan 5 - \$25/\$45/\$500 per day
 PacifiCare SignatureOptionsSM (PPO) Plan 1 - \$20/80-60/\$500
 PacifiCare SignatureOptionsSM (PPO) Plan 2 - \$35/70-50/\$1,000
 PacifiCare SignatureOptionsSM (PPO) Plan 3 - \$30/80-50/\$1,500
 PacifiCare SignatureOptionsSM (PPO) Plan 4 - \$30/70-50/\$2,000

Payment Options: Monthly EZPay Monthly Billing
If my application is approved, my premium will be paid as follows: *For this payment method, you must enclose:* *Please enclose a check for one month's premium with your application.*
 Your completed EZPay form A voided check
 A check for one month's premium

2. Primary Applicant Information

Important: Indicate yourself as the Primary Applicant and if married, include your Spouse as a Dependent (if the Spouse is also applying for coverage).

Primary Applicant's Name _____ Married Single
Last First MI

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

Mailing Address
 for Premium
 for Medical Information
 for Both
If different from home address Street Apt # City State ZIP

Home Phone _____ **Work Phone** _____

Applicant's Occupation _____ **Spouse's Occupation** _____

3. Enrollment Information (Attach a separate piece of paper for additional information)

List yourself and all eligible family members applying for coverage. **Each applicant applying for HMO plan must select a Primary Care Physician.** You may choose the same or a different Primary Care Physician for each family member, using the number shown in the network pages of the *Provider Directory*.

| Relationship | Last Name | First Name | MI | Social Security Number | Height | Weight | Birth Date Mo/Day/Yr | Primary Care Physician (PCP) Name HMO only | PacifiCare Provider # HMO only | Network (PMG) |
|---|-----------|------------|----|------------------------|--------|--------|----------------------|--|--------------------------------|---------------|
| <input type="checkbox"/> Male <input type="checkbox"/> Female | Applicant | | | | | | | | | |
| <input type="checkbox"/> Husband <input type="checkbox"/> Wife | Spouse | | | | | | | | | |
| <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 applying family members reside with applicant? Yes No If no, please indicate name and mailing address of Dependent(s) below.

Please note: If the Subscriber is not applying for coverage for his or her eligible Dependents, all future applicants including newborns who are not enrolled within 31 days of birth, will be required to submit Evidence of Insurability, which is subject to approval by PacifiCare.

Important Notice: PacifiCare or PacifiCare Life Assurance Company will use the information provided in this application to make its determination about coverage for all persons named on the application. Read the application and the instructions very carefully. **If any material information about any applicant's medical background is misstated or omitted, it may result in rescission of the contract. If your contract is rescinded, it will be deemed never to have been in effect. A rescinded application will result in the applicant being billed for any expenses incurred while under the Plan.**

4. Health Questionnaire

You must disclose any and all medical information regarding any of the general categories listed below. If you are not sure whether the information is relevant, include it so PacifiCare or PacifiCare Life Assurance Company can make a determination. The information you provide will not necessarily cause a denial, but underwriting may depend on the items noted and medical information submitted by your doctor(s). **Note: Any illness, condition or change in health status of any applicant that may occur or be discovered between the date of this application and the effective date of coverage must be reported. Please notify any changes in writing to the PacifiCare Individual Plans Individual Underwriting, Mail Stop CY38-224, P.O. Box 3069, Cypress, CA 90630-9962. An unreported illness, condition or change will be treated as a nondisclosure and may result in rescission of coverage.**

Check "Yes" or "No" for each category below. Do not write N/A or leave any blanks. You must check "Yes" if any person named on this application has been aware of or has been evaluated, diagnosed, treated or received advice related to the following categories from any type of health care professional at any time prior to this application.

A. General Health Questions

- | | |
|--|--|
| <p>1. Alcoholism, Alcohol Abuse, DUI/DWI. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Allergies, Asthma, Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Arthritis, Gout, Bone/Joint Condition, TMJ, Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Anorexia, Bulimia, Eating Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Attention Deficit Disorder (ADD)/ADHD <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Autism and other pervasive developmental disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Back, Neck, Spine, Disc Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Birth/Physical Defect, Deformity, Congenital Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Blood Disease, Blood Condition (past 10 years), Leukemia, Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Blood Vessel/Circulation Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Breast Disease, Implants <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Broken Bones, Bone Disease or Infections <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Cancer. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Colon, Rectal or Bowel Condition <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15. Concussion, Head Injury. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>17. Ear, Nose, Throat (Diseases, Infections). <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>18. Epilepsy, Seizure Disorder, Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>19. Eyes (Cataracts, Glaucoma, Strabismus, Crossed Eyes) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>20. Female Organs, Abnormal Pap, Menstrual Disorder, Hysterectomy. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>21. Fibromyalgia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>22. Gallbladder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>23. Heartburn/Gastroesophageal Reflux Disease (GERD). <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>24. Heart Conditions of Any Kind <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>25. Hemorrhoids <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>26. Hepatitis, Liver Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>27. Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>28. High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, last reading _____</p> | <p>29. High Blood Cholesterol and/or Triglycerides <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, last reading _____</p> <p>30. Hormonal/Endocrine (Thyroid, Pituitary) Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>31. Illicit Drug Use/Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>32. Immune System Disorder, AIDS/HIV+, AIDS Related Complex (ARC), Lupus. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>33. Intestinal/Stomach, Colitis, Crohn's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>34. Kaposi's Sarcoma. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>35. Kidney/Urinary Tract/Bladder (Stones/Infections) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>36. Liver Conditions <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>37. Lung Conditions, Chronic Obstructive Pulmonary Disease, Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>38. Male Sex Organs, Prostate, Impotence. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>39. Nervous System Conditions, Multiple Sclerosis, Paralysis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>40. Mental/Nervous, Anxiety, Depression, Psychiatric Counseling. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>41. Schizoaffective Disorder, Bipolar Disorder, Major Depressive Disorder, Panic Disorder, Obsessive-Compulsive Disorder. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>42. Migraines/Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>43. Muscle/Tendon Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>44. Non-Hodgkin's Lymphoma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>45. Phlebitis or Blood Clot <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>46. Prosthetic Implants, Artificial Limb <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>47. Reconstructive/Cosmetic Surgery. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>48. Sexually Transmitted Diseases <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>49. Skin Disorders, Lesions, Cancer. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>50. Steroid Use (Anabolic, Prednisone) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>51. Stroke/Transient Ischemic Attacks (TIA) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>52. Stomach or Abdominal Condition <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>53. Thyroid Condition. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>54. Tumors, Cysts, Polyps, Growths <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>55. Ulcers, Digestive Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>56. Weight Problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|--|--|

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 # | Family Member 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 Physician, for any reason, in the past two years? Yes No
 If yes, please provide details below:

| Applicant(s) Name | Physician Name | Address/Telephone | Date | Reason/Result and Treatment/Recommendation |
|-------------------|----------------|-------------------|------|--|
| | | | | |
| | | | | |
| | | | | |

D. Has any applicant received any alternative, complementary, holistic or natural therapies within the last 12 months? Examples include acupuncture, ayurveda, biofeedback, chelation therapy, chiropractic, herbal medicines, homeopathy, imagery, reiki, shiatsu and visualization.
 Yes No If yes, please explain:

| Applicant(s) Name | Physician Name | Address/Telephone | Date | Reason/Result and Treatment/Recommendation |
|-------------------|----------------|-------------------|------|--|
| | | | | |
| | | | | |

E. 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.

- In the event one or more applicant(s) listed on this application is denied coverage, should PacifiCare or PacifiCare Life Assurance Company continue the underwriting and enrollment process for the remaining eligible family members? . . . Yes No
- Has surgery (major/minor, inpatient/outpatient) ever been performed for any applicant? Yes No
- Has surgery (major/minor, inpatient/outpatient) ever been advised but not performed for any applicant? . . Yes No
- Has any applicant been aware of, evaluated, diagnosed, treated or advised regarding any other conditions or injuries not listed? Yes No
 If yes, please state individual's name(s) and explain (include date): _____

- Have you or any person applying ever used tobacco products? Yes No
 If yes, please provide the following information:
 NAME How many packs per day? How many years?
 Cigarettes Cigars Pipe Other: _____
 Has the person(s) quit? Yes No If yes, when? _____

- Does any applicant listed on this application presently consume alcoholic beverages? Yes No
 If yes, please provide the following information:
 NAME 0 - 1 drinks per day 2 - 3 drinks per day 4+ drinks per day
 NAME 0 - 1 drinks per day 2 - 3 drinks per day 4+ drinks per day .

- 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 name(s) and explain (include date and duration): _____

- 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

- 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): _____

- Is any applicant currently receiving any type of physical or mental disability insurance benefits? Yes No
 If yes, state name(s) and explain:

| NAME | NATURE OF DISABILITY (specify body part) | % OF DISABILITY |
|------|--|-----------------|
| | | |
| | | |

- Has any application for a policy of life or health insurance on any applicant ever been declined, postponed, modified or required an extra premium? Yes No

| NAME | TYPE OF INSURANCE |
|------|-------------------|
| | |
| | |

| DATE | INSURANCE CARRIER | REASON |
|------|-------------------|--------|
| | | |
| | | |

- Will this coverage for which you are applying replace any other coverage you have? Yes No

| TYPE OF INSURANCE | DATE | INSURANCE CARRIER |
|-------------------|------|-------------------|
| | | |
| | | |

| EXPIRATION DATE | REASON |
|-----------------|--------|
| | |
| | |

- Do you or any other person applying have or ever had PacifiCare coverage? Yes No
 If yes: (a) You should understand that this is not a conversion or extension of that coverage. Yes, I understand.
 (b) You should understand that there may be a lapse in coverage, new waiting periods, new copayments and each listed member may be accepted or denied. Yes, I understand.

FEMALES ONLY (including Spouse and Dependents)

- Is any family member currently pregnant? . . . Yes No
 If yes, expected date of delivery: _____

- List the name of each female applicant and the date of their last menstrual period.

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

- List the name of each female applicant and the date of their last Pap smear and the results: _____

- 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): _____

MALES ONLY (including Spouse and Dependents)

- 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: _____

1. I understand that all health care services under the HMO Coverage options must be provided or arranged for by PacifiCare, except for in Emergency or Urgently Needed Services.
2. I certify that the answers in any part of this application are true and complete. I acknowledge that the discovery of facts known and not disclosed may result in the rescission of my PacifiCare Individual Plan Agreement. I alone am responsible for the accuracy and completeness of the application and related documents. I understand that neither I, nor my Dependents, will be eligible for benefits if any known material information is false or incomplete, and that coverage may be rescinded based on such a finding. If rescinded, the contract will be deemed to never have existed and I will be financially responsible for any cost incurred while under the plan.
3. I understand that if I choose to enroll in a PPO health plan there will be a twelve (12)-month waiting period before coverage for pre-existing medical conditions will begin, for either myself, and/or my dependents who have these medical conditions, even if I am or my Dependents are on another PacifiCare plan, unless Guaranteed Availability is applied for and approved.
4. I understand that there is no coverage unless an application is approved by either PacifiCare of Arizona, Inc. or PacifiCare Life Assurance Company Underwriting Department. PacifiCare and PacifiCare Life Assurance Company are not liable for bills incurred before the effective date of coverage. PacifiCare and PacifiCare Life Assurance Company are not liable for the cost in obtaining medical records or the cost of special tests such as, but not limited to, X-rays, EKGs, or mammograms that may be required to determine eligibility.
5. If this application is approved, the date coverage begins will be provided to me by the PacifiCare or PLAC Underwriting Department.
6. The agent selling PacifiCare health coverage does not have the authority to approve my application and cannot change any terms of the PacifiCare Individual Plan Agreement or waive any requirements.
7. I understand that I am responsible for reporting to PacifiCare or PacifiCare Life Assurance Company any changes in the health status, which occur before the effective date of the PacifiCare Individual Plan Agreement. This applies to every person listed on the application.
8. I understand that any applicant listed herein may be required to undergo a basic physical and/or basic laboratory testing as part of the application process.
9. **APPLICANT (AND DEPENDENTS) AGREES AND UNDERSTANDS THAT AS AN ENROLLED MEMBER 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 DISPUTES OVER BENEFIT DENIALS SUBJECT TO ERISA, BETWEEN ITSELF, MEMBERS (INCLUDING ANY HEIRS OR ASSIGNS) AND PACIFICARE OF ARIZONA, INC., 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. RIGHTS AFFORDED UNDER THE INTERNAL APPEALS PROCESS AND INDEPENDENT EXTERNAL REVIEW ARE NOT AFFECTED BY THIS PROVISION. DISPUTES NOT FULLY RESOLVED THROUGH THE INDEPENDENT EXTERNAL REVIEW PROCESS ARE SUBJECT TO THIS PROVISION.

Authorization for disclosure of personal information:

I hereby authorize any health care facility, Physician or surgeon, or any other health care professional to disclose to PacifiCare of Arizona, Inc., or any of its parents, subsidiaries, or affiliates, their agent or employees, all information from my medical records pertaining to any past or future examination or treatment, including treatment for substance abuse and mental or emotional disorders furnished to me or my dependents who are also applying for this coverage, and to any illness, injury or condition that I or these Dependents have had at any time in the past or in the future, up until the expiration of this authorization. I understand that this information is collected in connection with the evaluation and processing of an application for coverage, to determine continuing eligibility for benefits and to process claims. This authorization also includes PacifiCare or PacifiCare Life Assurance Company disclosing any medical information that they may have in their files to the same entities in connection with the advance consideration of providing services or subsequent payment for such services. This authorization is valid for eighteen (18) months from the date inserted below. A photocopy or other reproduction of this authorization is as valid as the original. My authorized representative or I am entitled to receive a copy of this form. I understand that I may revoke this authorization at any time before I become a PacifiCare Member, except for instances that PacifiCare has already taken action based on the authorization, by mailing my written revocation to: **PacifiCare Individual Plans, Individual Underwriting, M/S # CY38-224, PO Box 3069, Cypress, CA, 90630-9962.**

By my signature below, I have read and understand the above conditions.

| | |
|--|--------------------------------|
| SIGNATURE OF APPLICANT OR LEGAL GUARDIAN <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> |
| SIGNATURE OF PERSONAL REPRESENTATIVE OR CUSTODIAN <i>(if applicable)</i> X | TODAY'S DATE <i>(Required)</i> |

| | |
|---|--------------------------------|
| SIGNATURE OF APPLICANT'S SPOUSE <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> |
| PRINT NAME OF PERSONAL REPRESENTATIVE OR CUSTODIAN <i>(if applicable)</i> X | |

Note: Until you have received written approval of this application, do not cancel any insurance you may have.

If you are applying for Guaranteed Availability, please complete this section.

Health Insurance Portability and Accountability Act (HIPAA) Questionnaire

1. Have you had at least 18 months of Creditable Coverage? Yes No
2. Was your most recent coverage under a (check one):
 Group Plan Government Plan Church Plan
3. Are you eligible for any other coverage, including group, Medicare, Medicaid, etc.? Yes No
 If yes, please explain: _____

4. Was your previous coverage terminated for nonpayment of premium or fraud? Yes No

5. Was COBRA an available option? Yes No

 If yes, did you apply for COBRA? Yes No

 What was your qualifying event?
 Voluntary termination Involuntary termination
 Reduction of hours Death of employee
 Employee's Medicare entitlement
 Divorce or legal separation
 Dependent child ceasing to be a dependent
 Provide the dates of coverage under COBRA: ____ to ____
 Did you remain on COBRA until it was no longer available? Yes No
 If no, please provide details: _____
6. Has there been a gap in coverage of more than 63 days? Yes No

| | |
|---|------|
| SIGNATURE OF APPLICANT X | DATE |
| SIGNATURE OF APPLICANT'S DEPENDENT AGE 18 OR OVER (Required) X | DATE |
| SIGNATURE OF PERSONAL REPRESENTATIVE OR CUSTODIAN (if applicable) X | DATE |

| | |
|--|------|
| SIGNATURE OF APPLICANT'S SPOUSE (if applying) X | DATE |
| SIGNATURE OF APPLICANT'S DEPENDENT AGE 18 OR OVER (Required) X | DATE |
| PRINT NAME OF PERSONAL REPRESENTATIVE OR CUSTODIAN (if applicable) X | |

This questionnaire will be used by PacifiCare of Arizona, Inc. or PacifiCare Life Assurance Company in evaluating the applicant's eligibility for guaranteed individual health insurance. It does not constitute an offer of coverage. If you would like detailed information concerning guaranteed availability and renewability of individual coverage, please contact your insurance broker.

Agent Information - To be completed by Agent only

| | | | | | | |
|---------------|------|--------------|-----|--------------------|------------------|--|
| Agent Name | | Company Name | | | Agent Number | |
| Agent Address | City | State | ZIP | Agent Phone Number | Agent Fax Number | |

**PacifiCare Individual Plans
 Individual Underwriting
 M/S CY38-224
 P.O. Box 3069
 Cypress, CA 90630**

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

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