

SENIOR SUPPLEMENT ENROLLMENT FORM

All enrollees must be over age 65 and have both Medicare Part A and Part B to be eligible for coverage.

Please complete the entire form ■ Incomplete information can delay the enrollment process
(Please Print – If you need more room for your answers to any questions, please use a separate sheet of paper.)

COMPANY NAME	EFFECTIVE DATE	SOURCE OF ENROLLMENT	<input type="checkbox"/> OPEN ENROLLMENT
			<input type="checkbox"/> NEW RETIREE

SELF (Retiree)	Last Name	First Name	M.I.	Sex
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Social Security #	Birth Date	Telephone #	County
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Home Address	(Number, Street, Apartment)	City	State	Zip
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Medicare Information	Medicare Claim Number	Part A Effective Date? / /	Part B Effective Date? / /
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SPOUSE (Only if enrolling)	Last Name	First Name	M.I.	Sex
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Social Security #	Birth Date	Telephone #	County
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Home Address (If different from above)	(Number, Street, Apartment)	City	State	Zip
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Medicare Information	Medicare Claim Number	Part A Effective Date? / /	Part B Effective Date? / /
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Do you currently have medical coverage in force? **SELF:** YES NO **SPOUSE:** YES NO **OTHER DEPENDENTS:** YES NO

If "Yes," with whom? _____ What is the ID #? _____

Do you have additional medical coverage? **SELF:** YES NO **SPOUSE:** YES NO **OTHER DEPENDENTS:** YES NO

If "Yes," with whom? _____ What is the ID #? _____

Do you currently work or plan to work? **SELF:** YES NO **SPOUSE:** YES NO **OTHER DEPENDENTS:** YES NO

I certify that I have read the Terms and Conditions printed on the reverse side of this Enrollment Form and that I accept them and will abide by them. I further certify that the information provided in the Enrollment Form is true and complete to the best of my knowledge and belief.

RETIREE SIGNATURE _____

DATE _____

FOR OFFICE USE ONLY	FOR EMPLOYER USE ONLY
RETIREE <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Enrollee is eligible for retiree coverage Effective Date: ____/____/____ _____ Initial
SPOUSE <input type="checkbox"/> YES <input type="checkbox"/> NO	
GROUP # _____ PLAN CODE _____ VERIFICATION: _____ DATE ____/____/____ Initial	

PLEASE READ CAREFULLY

This insurance plan does not cover persons under the age of 65, or persons who are not insured under both Medicare Parts A and B. If you have dependents under the age of 65, please contact your employer group sponsor to determine other PacifiCare coverages that may be available for dependents under the age of 65.

TERMS AND CONDITIONS

On behalf of myself and my eligible dependents, I am requesting enrollment under PacifiCare Group Policy offered through my former employer. By signing the front of this Enrollment Form, I agree to and understand the following:

1. All coverage is subject to the terms and conditions of the PacifiCare Group Policy.
2. My former employer may deduct from my retirement income (including my pension) the employee contribution required to cover my share of the premium, if any.
3. Any differences between myself and/or my dependents and PacifiCare relating to the Group Policy or its performance are subject to binding arbitration if both parties agree. Differences between myself and/or my dependents and any health care providers, including claims of medical malpractice are not governed by the Group Policy.
4. PacifiCare or its designee shall have access and use of my medical records or the medical records of my dependents for purposes of utilization review surveys, processing of claims, financial audit or other purposes reasonably related to the performance of this Enrollment Form.
5. Any material omission or intentional misrepresentation in answering the questions on this Enrollment Form may result in the denial of benefits and the termination of my/or my dependents' coverage.
6. Coverage shall not begin until acceptance of this Enrollment Form by PacifiCare. Acceptance will not occur until after PacifiCare validates Medicare coverage and eligibility for coverage under the group retiree plan. Upon acceptance of this Enrollment Form, PacifiCare shall be bound by the terms of my PacifiCare Group Policy and the Amendments thereto (if applicable).

This is not a Medicare Supplement plan. This is an employer group retiree plan and may provide coverages that are different from a Medicare Supplement plan. If you have a Medicare Supplement plan, you may not need both the Medicare Supplement plan and the retiree Senior Supplement plan. Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance.

Underwritten by PacifiCare Life and Health Insurance Company or PacifiCare Life Assurance Company.