

EMPLOYEE ENROLLMENT APPLICATION

Marketing: Tel 415-955-8800 Fax: 415-955-8819
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 www.cchphmo.com

<input type="checkbox"/> New Group Enrollment	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> COBRA
<input type="checkbox"/> New Hire	<input type="checkbox"/> Special Enrollment	<input type="checkbox"/> Adding Dependent(s)	<input type="checkbox"/> Vision	<input type="checkbox"/> CAL-COBRA
Selection of coverage: <input type="checkbox"/> Employee only <input type="checkbox"/> Employee & spouse <input type="checkbox"/> Employee & child(ren) <input type="checkbox"/> Family				

Ethnicity <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> I Decline to Answer	<input type="checkbox"/> White <input type="checkbox"/> Filipino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Korean	<input type="checkbox"/> Japanese <input type="checkbox"/> Others: _____	Language Choice <input type="checkbox"/> Cantonese <input type="checkbox"/> Spanish <input type="checkbox"/> I Decline to Answer	<input type="checkbox"/> Mandarin <input type="checkbox"/> Other: _____ <input type="checkbox"/> English
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Company Name or Trust Fund Name:	Group No.:	Proposed Effective Date:
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1. EMPLOYEE INFORMATION

<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name	First Name	Mi	Chinese Name
<input type="checkbox"/> Single <input type="checkbox"/> Domestic Partner (DP)	<input type="checkbox"/> Married	Birthday Mo Day Yr _____	Social Security No.	Hire Date: Mo Day Yr
Home Address (NO P.O.BOX)		Apt. #	City	State Zip
Home Telephone ()	Daytime Telephone ()	E-mail		Doctor (Primary Care Physician)

2. DEPENDENT INFORMATION - LIST ONLY THOSE ELIGIBLE DEPENDENTS WHO ARE ENROLLING

Relations	Last Name	First Name	Social Security No.	Birthday Mo/Day/Yr	Age	FT Student	Family Doctor	Existing Patient
<input type="checkbox"/> Spouse <input type="checkbox"/> DP <input type="checkbox"/> M <input type="checkbox"/> F								<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter						<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter						<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter						<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter						<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

3. OTHER HEALTH INSURANCE INFORMATION – If any person applying for coverage currently has health insurance coverage or has had health insurance coverage with in the past six months, please complete this section. ***Proof of coverage must accompany this application. Failure to advise and provide proof of prior coverage may subject you or your family member to a six-month pre-existing condition clause.***

Covered Person(s) name	Carrier name	Coverage begin date	Coverage end date	Reason for ending coverage
<input type="checkbox"/> Self				
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner				
<input type="checkbox"/> Son <input type="checkbox"/> Daughter				
<input type="checkbox"/> Son <input type="checkbox"/> Daughter				

4. AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: Chinese Community Health Plan is authorized to obtain and release medical information in compliance with the terms of the Confidentiality of Medical Information Act, effective January 1, 1980 Section 56.10 et seq. of the California Civil Code. I hereby authorize my physician, health care practitioner, hospital, clinic, or other medically related facility to furnish an agent, designee or representative of Chinese Community Health Plan any and all records pertaining to medical history, services rendered or treatment given to anyone enrolled hereunder, or added hereafter for purpose of review, investigation, or evaluation of an application or a claim. I also authorize Chinese Community Health Plan and its affiliates, or its agents, designees 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.

5. ARBITRATION AGREEMENT: I understand that any dispute or controversy which may arise under the agreement between myself (and or any enrolled family member) and Chinese Community Health Plan will be decided by neutral arbitration in lieu of a jury or court trial.

X _____
 Employee signature Date Employer signature Date

6. Please complete if you want to decline coverage for yourself and/or any eligible dependents		
Decline for: <input type="checkbox"/> Self	<input type="checkbox"/> Spouse / DP _____ (Please Print Name)	<input type="checkbox"/> Child(ren) _____ (Please Print Name)
If you are declining coverage for yourself or for your dependents (including your spouse) under this plan because you have health coverage, you may in the future be able to enroll yourself or your dependents in the plan. Your request for enrollment must be submitted to Chinese Community Health Plan within 30 days after your other coverage involuntarily ends. In addition, if you are not enrolled under your employer's group health plan and you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. Your request for enrollment must be submitted to Chinese Community Health Plan within 30 days after the event.		
Please check the reason for declining:		
<input type="checkbox"/> I have coverage through my spouse / DP	Carrier name & ID number are: _____	
<input type="checkbox"/> Covered by Medicare		
<input type="checkbox"/> Covered by Medi-Cal		
<input type="checkbox"/> Enrolled in another insurance plan	Carrier name & ID number are: _____	
Employee Signature - If Declining Coverage	Print Name	Date