

C. PRIOR INSURANCE INFORMATION 先前醫療保健公司資料

1. Has any applicant been a member of CCHP within the last 5 years 申請人在過去5年曾否是華人保健計劃會員..... Yes 是 No 否
2. Has any applicant had **group** coverage in the last 63 days? 申請人在過去63天裏曾經有公司醫療保健計劃..... Yes 是 No 否

If you answered "Yes" to 1 or 2 above, please provide the following information: 如以上的答案是“是”請提供資料如下：

Name of applicant(s): _____ Certificate/Policyholder No.: _____
 申請人姓名 會員卡號碼

Current carrier name: _____ Most recent coverage start date: _____ End Date _____
 現時保健計劃公司名稱 生效日期 終止日期

Covered person(s) 受保人員	Prior Carrier Name and Policy No. 前保健計劃名稱	Coverage start date 保障開始日期	Coverage end date 保障終止日期
<input type="checkbox"/> Self 自己 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Dependent(s) 家屬			
<input type="checkbox"/> Self 自己 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Dependent(s) 家屬			
<input type="checkbox"/> Self 自己 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Dependent(s) 家屬			

HEALTH HISTORY 健康歷史

D. Include information on ALL family members you wish to enroll. ALL QUESTIONS MUST BE ANSWERED.
 Give **COMPLETE** details of any "Yes" answers in Section E on the following page.

資料包括所有投保人，必須回答每一條問題。如有任何“是”的答案，請在E部份解釋。

Has any person listed on this application, in the last 5 years, had any signs or symptoms, seen a health care provider, had treatment recommended including prescription medications, received treatment, or been hospitalized for any of the following conditions as stated in questions 1 through 20?

在過去五年內，有任何申請人有過下列1-20號問題的症狀，見過醫務人員、接受過治療、被推薦藥物治療、需要接受治療或住院。

California law prohibits an HIV test from being required or used by health care service plans as a condition of obtaining coverage.
 加州法例禁止醫療保健公司要求申請人作愛滋病測試，而作為得到醫療保障的條件。

If answer Yes, please circle the symptoms:	如答“是”，請圈出症狀	NO 否	Yes please indicate 是
1. Brain/Nervous – frequent and/or severe headaches, migraines, seizures, epilepsy, dizziness, weakness, fainting, numbness/tingling, head injury, paralysis, stroke, confusion, memory loss, loss of consciousness, sleep apnea, used a sleep monitoring device, etc.	腦部/神經 —經常性及/或嚴重的頭痛、偏頭痛、羊癲瘋、癲癇、頭暈、虛弱、昏厥、麻木/針刺痛、頭部受傷、癱瘓、中風、錯覺、失憶、失去意識、失眠、使用睡眠監視器等。		<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Dep 1 家屬1 <input type="checkbox"/> Dep 2 家屬2 <input type="checkbox"/> Dep 3 家屬3
2. Heart/Circulatory – chest pain, angina, high or low blood pressure, heart disease, heart attack, heart murmur, palpitations, valve replacement, pacemaker, defibrillator; or blood clot, phlebitis, varicose veins, enlarged lymph nodes, blood/bleeding disorder, etc.	心臟/血液循環系統 —胸痛、心絞痛、高或低血壓、心臟疾病、突發性心臟病、心雜音、心跳不整、節律器、人工瓣膜、去纖維顫動器或血凝塊、靜脈炎、靜脈曲張、淋巴肥大、流血不止、等。		<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Dep 1 家屬1 <input type="checkbox"/> Dep 2 家屬2 <input type="checkbox"/> Dep 3 家屬3
3. Lungs/Respiratory – allergies, infections, sinusitis, asthma, bronchitis, emphysema, pneumonia, tuberculosis, difficulty breathing, shortness of breath, chronic cough, spitting/coughing up blood, etc.	肺/呼吸 —過敏、感染、鼻腔過敏、氣喘、支氣管炎、肺氣腫、肺炎、肺結核、呼吸困難、呼吸不順、慢性咳嗽、咳血等。		<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Dep 1 家屬1 <input type="checkbox"/> Dep 2 家屬2 <input type="checkbox"/> Dep 3 家屬3

If answer Yes, please circle the symptoms:	如答“是”，請圈出症狀	NO 否	Yes please indicate 是
<p>4. Digestive – jaw/chewing problems, gastric reflux, ulcers, hernia, colitis system, chronic diarrhea, rectal problems/bleeding, polyps, hemorrhoids, gallbladder, pancreatitis, appenticitis, cirrhosis, hepatitis, jaundice, unexplained weigh loss, etc.</p>	<p>消化系統—下顎問題、胃病、潰瘍、疝氣、大腸炎、腹瀉、直腸毛病／出血、息肉、痔瘡、膽結石、胰臟炎、肝病、肝硬化、肝炎、黃疸、無故體重減輕等。</p>		<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Dep 1 家屬1 <input type="checkbox"/> Dep 2 家屬2 <input type="checkbox"/> Dep 3 家屬3
<p>5. Urinary – kidney, bladder, urinary tract infections, stones, urinary incontinence, blood in urine, etc.</p>	<p>泌尿—腎臟、膀胱、尿道感染、結石、失禁、便尿出血等。</p>		<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Dep 1 家屬1 <input type="checkbox"/> Dep 2 家屬2 <input type="checkbox"/> Dep 3 家屬3
<p>6. Male reproductive system – Prostate problems, infertility, sexual dysfunction, penile or scrotal implant, sexually transmitted disease, herpes, genital warts, undescended testes, etc.</p>	<p>男性生殖系統—前列腺、不孕、性功能衰退、陰莖擴張、性病、疱疹、疣、隱罩等。</p>		<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Dep 1 家屬1 <input type="checkbox"/> Dep 2 家屬2 <input type="checkbox"/> Dep 3 家屬3
<p>7. Female Reproductive – Breast disorder, cyst, lump, tumors, endometriosis, pelvic pain, menstruation disorders, abnormal/absent menstrual bleeding, uterine fibroids, ovarian cysts, infertility, miscarriages, sexually transmitted disease,</p> <p>a) Does any proposed female member menstruate? If yes, indicate if <input type="checkbox"/> Applicant/spouse <input type="checkbox"/> Dependent(s) Dependent name(s): _____</p> <p>b) Has it been more than 40 days since her/their last menstrual period? If yes, explain: _____</p> <p>c) Has any female applicant had a pelvic exam/Pap smear? If yes, complete below, date and result of last pelvic exam/Pap smear for each female over age 16 Name: _____ Mo/Day/Yr: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Name: _____ Mo/Day/Yr: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</p> <p>d) Is any female applicant pregnant, or in the process of adoption or surrogate pregnancy?</p>	<p>女性生殖—乳房疾病、腫塊、隆乳、腺瘤、子宮內膜異位、骨盆疼痛、月經不順、月經不正常出血、子宮肌瘤、卵巢囊腫、不孕、流產、性病。</p> <p>a)有任何女性申請者有月經? 如果是，為 <input type="checkbox"/>申請人/配偶 <input type="checkbox"/>家屬 家屬姓名: _____</p> <p>b)她/她們從上次來月經至今是否超過40天? 如果是，請解釋: _____</p> <p>c)有任何女性申請人做過子宮/子宮膜片檢查? 如果是，請填寫下方 十六歲以上的女性最近一次的子宮/子宮膜片檢查的日期及結果。 姓名: _____ 月/日/年 _____ <input type="checkbox"/>正常 <input type="checkbox"/>不正常 姓名: _____ 月/日/年 _____ <input type="checkbox"/>正常 <input type="checkbox"/>不正常</p> <p>d)有任何女性申請人懷孕，或正在領養或為代母?</p>		<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Dep 1 家屬1 <input type="checkbox"/> Dep 2 家屬2 <input type="checkbox"/> Dep 3 家屬3
<p>8. Musculoskeletal – bone, joint and/or muscle pain, injury or disorder of joint/tendon/ligament/disc, weakness of back/spine/joint, amputation, polio, arthritis, gout, prosthesis, joint replacement, internal fixations(i.e., pins, plates, screws), fractures, TMJ, etc.</p>	<p>肌骨—骨頭、關節及／或肌肉痛、關節／筋／韌帶／骨受傷或疾病、背／脊骨／關節衰弱、切除、小兒麻痺，關節炎，痛風，義肢，人工關節、骨頭打釘、顎骨等。</p>		<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Dep 1 家屬1 <input type="checkbox"/> Dep 2 家屬2 <input type="checkbox"/> Dep 3 家屬3
<p>9. Endocrine/Metabolic</p> <p>a) Diabetes, thyroid, anemia, adrenal disorders, pituitary disorders, lupus, AIDS/ARC, immune disorders, scleroderma, Epstein-Barr/chronic fatigue syndrome, etc.</p> <p>b) Is any applicant a candidate for, or a recipient of an organ or bone marrow transplant? If yes, Name: _____</p> <p>c) Is any applicant on the waiting list to donate an organ or bone marrow (excluding DMV donor card) transplant? If yes, Name: _____</p>	<p>內分泌／新陳代謝系統</p> <p>a)糖尿病、甲狀腺、貧血、腎上腺激素疾病、腦下垂體疾病、狼瘡、愛滋病、免疫疾病、硬皮病、Epstein-Barr／慢性疲勞併發症等。</p> <p>b)有任何申請人是器官或骨髓移植捐贈或接納者？</p> <p>c)有任何申請人是在捐贈器官或骨髓名單中（DMV捐贈者除外）？ 姓名: _____</p>		<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Dep 1 家屬1 <input type="checkbox"/> Dep 2 家屬2 <input type="checkbox"/> Dep 3 家屬3

If answer Yes, please circle the symptoms:	如答“是”，請圈出症狀	NO 否	Yes please indicate 是
<p>10. Has any applicant ever had cancer, tumor/growth, leukemia, cyst? If yes, specify: <input type="checkbox"/> Cancer <input type="checkbox"/> Tumor/growth <input type="checkbox"/> Leukemia <input type="checkbox"/> Cyst</p>	<p>是否有申請人曾經罹患癌症、腫瘤、白血球過多、囊腫? 若有，請註明 <input type="checkbox"/> 癌症 <input type="checkbox"/> 腫瘤 <input type="checkbox"/> 白血球過多 <input type="checkbox"/> 囊腫</p>		<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Dep 1 家屬1 <input type="checkbox"/> Dep 2 家屬2 <input type="checkbox"/> Dep 3 家屬3
<p>11. Skin disorder/Problems – cancer, melanoma, pre – cancerous lesion, psoriasis, warts, 2nd or 3rd degree burns, acne, fungal infections, eczema, dermatitis, herpes, scars/keloids, or revisions of cosmetic or reconstructive surgery, infections, etc.</p>	<p>皮膚病／問題—癌症、黑色素瘤、非癌症皮膚龜裂、牛皮癬、疣、2-3級燙傷、青春痘、黴菌感團、濕疹、皮膚炎、泡疹、瘤／疙瘩、美容或重整外科手術、感染等。</p>		<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Dep 1 家屬1 <input type="checkbox"/> Dep 2 家屬2 <input type="checkbox"/> Dep 3 家屬3
<p>12. Eyes, Ears, Nose and Throat – diseases or problems of the eyes or sight, ears or hearing, nose or breathing, throat or swallowing – such as: any infections, crossed eyes, glaucoma, cataracts, detached retina, polyps, deviated nasal septum, excessive snoring, tonsillitis, sleep apnea, etc.?</p>	<p>眼、耳、鼻、喉—眼睛或視力疾病、耳朵或聽力、鼻子及呼吸、喉嚨及吞食—例如任何感染、鬥雞眼、青光眼、白內障、視網膜剝離、息肉、鼻炎、嚴重打鼾、扁桃、失眠等。</p>		<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Dep 1 家屬1 <input type="checkbox"/> Dep 2 家屬2 <input type="checkbox"/> Dep 3 家屬3
<p>13. Congenital Abnormalities, Birth Defects – cleft lip/palate, club foot, webbed fingers or toes, mental retardation, developmental delay, Down’s syndrome, heart/lung problems, skull/facial deformities, birthmark, physical handicap etc.</p>	<p>天生畸形、缺陷—兔唇／缺唇、畸形足、畸形手指／腳指、心智障礙、成長遲滯、唐氏症、心肺疾病、歪嘴斜眼、胎記等。</p>		<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Dep 1 家屬1 <input type="checkbox"/> Dep 2 家屬2 <input type="checkbox"/> Dep 3 家屬3
<p>14. Has any applicant consulted a provider for any condition or symptom(s) in the last 5 years, for which a diagnosis has not been established?</p>	<p>申請人曾否在過去五年中曾經被診療過，但病症未能確定?</p>		<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Dep 1 家屬1 <input type="checkbox"/> Dep 2 家屬2 <input type="checkbox"/> Dep 3 家屬3
<p>15. Has any applicant ever had an abnormal physical exam, laboratory results, x-rays, EKG, MRI, CT scan or been advised to undergo further testing, surgery or treatment?</p>	<p>申請人是否有不正常的報告有關身體測試、化驗、放射、心電圖、腦部掃描、身體掃描或被建議做進一步檢驗、手術或醫療?</p>		<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Dep 1 家屬1 <input type="checkbox"/> Dep 2 家屬2 <input type="checkbox"/> Dep 3 家屬3
<p>16. Are you or any applying family members presently receiving any medical treatment?</p>	<p>你或您的家人目前是否正接受任何醫藥治療?</p>		<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Dep 1 家屬1 <input type="checkbox"/> Dep 2 家屬2 <input type="checkbox"/> Dep 3 家屬3
<p>17. Have you been absent from your job due to injury or sickness more than 5 days within the past 12 months?</p>	<p>過去12個月內您曾否因生病或受傷而不能工作超過五天?</p>		<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Dep 1 家屬1 <input type="checkbox"/> Dep 2 家屬2 <input type="checkbox"/> Dep 3 家屬3
<p>18. Within the past 5 years, have you or any family member been in a hospital or institution for observation, testing, or treatment or undergone surgery or undergone surgery?</p>	<p>過去五年內，您或您的家人曾否留院或在醫療機構作觀察，檢查治療或做過手術?</p>		<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Dep 1 家屬1 <input type="checkbox"/> Dep 2 家屬2 <input type="checkbox"/> Dep 3 家屬3
<p>19. Has any applicant had any condition that is expected to require hospitalization?</p>	<p>申請人否因任何情況將會需要安排住院治療?</p>		<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Dep 1 家屬1 <input type="checkbox"/> Dep 2 家屬2 <input type="checkbox"/> Dep 3 家屬3

If answer Yes, please circle the symptoms:	如答“是”，請圈出症狀	NO 否	Yes please indicate 是
20. Has any applicant ever seen, received treatment from or consulted any doctor, or any other person providing health care services for any other condition or symptom(s) not listed on this application? If yes, complete E below.	申請人有否曾經見過或諮詢過任何醫生或其他提供醫療服務的人員有關自己的身體健康問題，而未有在以上的問題上提及到？如有請填寫E項內容。		<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Dep 1 家屬1 <input type="checkbox"/> Dep 2 家屬2 <input type="checkbox"/> Dep 3 家屬3

E. If the answer to any question in Section D is Yes, give the details below:
如果在D部份有“是”的答案，請在以下部份解釋。

Question #	Name of family member 家庭成員名字	Name of condition 狀況	Onset/ treatment date 治病日期	End date 結束日期	Still under treatment 治療中	Type of treatment 治療方法	Name of attending physician/ Hospital/Clinic Phone & Address 參與醫生、醫院名字、 電話和地址
					是 Yes <input type="checkbox"/> 否 No <input type="checkbox"/>		
					是 Yes <input type="checkbox"/> 否 No <input type="checkbox"/>		
					是 Yes <input type="checkbox"/> 否 No <input type="checkbox"/>		
					是 Yes <input type="checkbox"/> 否 No <input type="checkbox"/>		

F. PRESCRIPTION MEDICATIONS – List all medications taken within the last 12 months by any family member listed on this application. 藥物：申請人列出在過去 12 個月內食用過的藥名

Family member 家庭成員	Medication/Dosage/Frequency 藥名/用量/次數	Date prescribed (Mo/Yr) 配藥日期(月/年)	Date discontinued (Mo/Yr) 停止日期(月/年)	Name and phone # of physician or hospital 醫生/醫院名字和電話

G. How did you hear about CCHP? 您怎樣知道「華人保健計劃」?

1 <input type="checkbox"/> Radio 電台	2 <input type="checkbox"/> TV 電視	3 <input type="checkbox"/> Direct Mail 郵件	4 <input type="checkbox"/> Newspaper 報紙
5 <input type="checkbox"/> Yellow Pages 黃頁	6 <input type="checkbox"/> Agent/Broker 經紀	7 <input type="checkbox"/> Website 互聯網	8 <input type="checkbox"/> Referrals 介紹
9 <input type="checkbox"/> Dr. Office 醫生介紹:		10 <input type="checkbox"/> Events 街會/活動:	

AGENT/BROKER ATTESTATION (AB2569, Sec. 1389.8):

I, _____, assisted the applicant in submitting this application. All information in the health questionnaire was completed by the applicant. I advised the applicant that h/she should answer all questions completely and truthfully and that no information requested on the application should be withheld. I explained that withholding information could result in cancellation of coverage in the future. The applicant indicated to me that h/she understood these instructions and warnings. To the best of my knowledge, the information on the application is complete and accurate. I understand that, if any portion of this statement by me is false, I may be subject to civil penalties of up to \$10,000.

Agent/Broker Company Name:	Agent/Broker Signature:	Agent/Broker Code:	Tel:	Date
		E-mail:		

H. CONDITIONS OF APPLICATION ? please carefully read and fully understand the following:

申請規章: 請詳細閱讀和完全明白以下的內容

I hereby request (Check one) 本人現在申請(請選擇投保的項目)

Individual coverage only

個人保健

Individual plus dependent coverage

個人及家庭保健

GENERAL CONDITIONS: 申請條件

Chinese Community Health Plan reserves the right to reject any application for enrollment. This application and all medical information or examination reports shall become a part of the Plan Contract.

CCHP 『華人保健計劃』保留拒絕接受申請投保的權利。這申請表格及全部醫療資料或檢查報告將成為投保合約的一部份。

- I understand that CCHP has the right to deny my application and if so, I will be notified in writing.
本人明白『華人保健計劃』有權拒絕我的申請。如本人的申請被拒絕時，本人將會接到『華人保健計劃』的書面通知。
- I understand that I have no coverage under this application until notified by CCHP that I am accepted.
本人明白在申請期間是不會有任何醫療保障。直至收到『華人保健計劃』的投保批准通知書。
- If I am accepted, this application will become part of the agreement between CCHP and myself. Enrolled family members and I agree to be bound by the arbitration clause in the CCHP contract instead of trial by a court or jury.
如果申請被接受，這份申請表格將會成為申請人及『華人保健計劃』的投保合約的一部份。如有任何訴訟，本人及家人同意遵照和採納由仲裁人提出的方法解決，而非由陪審團或法庭裁決。
- I understand that if there is any intentional or unintentional non-disclosure or misstatement of fact in this application CCHP may terminate my coverage and my family's coverage retroactively to the effective date.
本人明白不論是有意或無意，如在此申請表格內填報的資料有不正確，不實在或有漏報等情況，一經查實，『華人保健計劃』是有權取消本人和家人的會員資格及所有保障福利，而且取消日期是追溯到最初生效日期起。
- If my coverage is terminated retroactively, the providers will bill me for all services I received through CCHP.
如果本人的保障被取消，本人需要負責所有通過『華人保健計劃』得到的醫療服務的費用，而這費用是追溯到最初生效日期起。

Acknowledgment and Agreement 同意書:

I hereby subscribe for myself and any enrolled dependents to the health plan designated here and agree to abide by all terms, conditions and provision of this Individual Membership Contract. I have read and understand the terms on this application and my signature below indicates my acceptance of these terms and that the information entered in this Application is complete, true and correct. I agree to notify Chinese Community Health Plan promptly of any facts or circumstances which arise before the effective date of coverage under CCHP which make any of the statements supplied herein incorrect. I understand that neither my family nor I will be eligible for coverage if any information is false or incomplete, and that coverage may be revoked based on such finding. I understand that any incorrect statements made in or material omissions from this application constitute the basis for termination from the Program and termination or cancellation of coverage retroactive to the effective date of enrollment.

本人及所有申請人現申請投保『華人保健計劃』，我們同意遵守及履行保健計劃契約上的守則及規定，本人經已閱讀及明白這申請表的內容，本人下面的簽字表示我們願意接受上述的條件及規定，同時本人亦保證這申請表上填寫的資料均屬完全真實及正確。本人同意如果在生效日期前，本人或家人的健康狀況有所改變而令原來填報的資料不相符，本人必需即時通知『華人保健計劃』。

本人明白在此申請表格內填報的資料如有不正確，不實在或有漏報等情況，一經查實，『華人保健計劃』是有權取消本人會員資格，及所有保障福利，而且取消日期可以追溯到最初生效日期起。

Authorization 健康資料索取及發放授權書:

I authorize any provider of health care to disclose to CCHP, or their designated agents, all medical information including any substance abuse and/or psychiatric disorders, regarding any applying family member or me. This information is collected for the purposes of evaluating my application and determining eligibility for coverage. This authorization will remain valid for 12 months from the date below. A photocopy of this authorization is as valid as the original. My authorized representative or I am entitled to receive a copy of this authorization.

本人授權凡屬“醫療服務提供者”得向『華人保健計劃』或其指定人透露有關本人及家人的所有健康資料，包括毒品濫用或精神不健全的記錄等等。這些資料是用來鑒定本人及家人的申請投保資格。這授權書有效期為12個月，由簽署日起計。影印本與正本效力相同。我或我的代理人有權獲得這份授權書的一份副本。

Arbitration Agreement 仲裁同意書:

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 or any participating medical group will be decided by neutral arbitration in lieu of a jury or court trial. I agree that if I or my family member or I am enrolled in CCHP or any participating medical group, any dispute or controversy which may arise under the agreement between myself (and or any enrolled family member) and Chinese Community Health Plan or any participating medical group will be decided by neutral arbitration in lieu of a jury or court trial. I agree that if I or my family member or I am enrolled in CCHP or any participating medical group, any dispute or controversy which may arise under the agreement between myself (and or any enrolled family member) and Chinese Community Health Plan or any participating medical group will be decided by neutral arbitration in lieu of a jury or court trial.

Applicant Signature : _____

申請人簽名

Print Your Name : _____

請用正楷填寫姓名

Date 日期 _____

Spouse Signature: _____

配偶簽名

Print Your Name: _____

請用正楷填寫姓名

Date 日期 _____