SHARP HEALTH PLAN

Employee Enrollment Application

Purpose	**Submit**	**If you need assistance, we're here to help.**
Add employees to group plan.	Sign and fax both pages: 1-858-499-8399	You can email Customer Care at customer.service@sharp.com or call 1-800-359-2002.

Employer use only		
Group name:	Group number:	Effective date (MM/DD/YY):

Reason for this application

- ☐ New hire (date of hire) _____
- ☐ Rehire (date of rehire) _____
- ☐ Open enrollment
- ☐ Add dependent coverage (list names below)
- ☐ Delete dependent coverage (list name below)
- ☐ Cal-COBRA
- ☐ COBRA
- ☐ Qualifying event (attach proof)
- ☐ Name change (list change below)
- ☐ Address or phone change (list change below)
- ☐ Primary Care Physician change (list change below)
- ☐ Termination Coverage

Termination date: _____

Employer Signature: X_____

Indicate coverage below (check one coverage level)

☐ Employee only ☐ Employee and spouse / domestic partner ☐ Employee and children ☐ Employee and family

Plan and network selection

Plan:	Network: ☐ Choice ☐ Value ☐ Performance ☐ Premier

Employee information

First name:	Last name:	Middle initial:	Sex: ☐ M ☐ F

Social Security number:	Birth date (MM/DD/YY):	Marital status: ☐ Single ☐ Married ☐ Registered Domestic Partnership (filed with CA Sec. of State or equivalent agency) ☐ Non-Registered Domestic Partnership (requires employer approval)

Home phone number:	Email address:	Preferred language:

Home address (P.O. Box is not allowed):

City:	State:	ZIP code:

Employment information

Employer's name:	Job title / occupation:	Number of work hours per week:	Are you actively at work? ☐ Yes ☐ No

Primary care information

To find a Sharp Health Plan-affiliated doctor who meets your needs, and their Provider NPI, please visit **sharphealthplan.com/findadoctor** or call Customer Care at 1-800-359-2002.

Primary Care Physician name (if left blank, Sharp Health Plan will assign):	Provider NPI:	Are you an existing patient with this doctor? ☐ Yes ☐ No

Dependent information

Last name, first name, M.I.:	Social Security number:	Birth date (MM/DD/YY):	Sex: M/F	Primary Care Physician (if left blank, Sharp Health Plan will assign):	Existing patient? Yes / No
Spouse:					
Domestic partner:					
Affidavit submitted? ☐ Yes ☐ No					
Child:					
Child:					
Child:					
Child:					

Do any of the dependents listed above have an address that is different from the employee?
☐ Yes ☐ No (If "yes" complete other address below.)

Names and addresses that are different:

Other medical coverage

Do you or your dependents intend to continue other medical or Medicare coverage? ☐ Yes ☐ No
If "Yes" complete the following: ☐ Self ☐ Spouse ☐ Dependent

Name of insured:	Dependents enrolled with other medical coverage:	
Name of other Insurance Company:	Group number / Policy number:	Coverage start date (MM/DD/YY):

Disclosures and signatures

Please read the following carefully before signing.

Delta Dental of California

I understand that I am responsible for payment of the required premium and compliance with all of the provisions and conditions of the Disclosure Form / Contract.

I hereby authorize my medical or dental care institution or professional to release to a representative of Delta Dental of California, any personal, privileged or medical records information including but not limited to, my patient records, charts, X-rays, diagnosis histories, billing records, clinical abstracts, or copies of consultations. The information authorized herein may be used for determination of benefits, quality assessment, utilization review, grievance resolution, or investigation or compliance with Delta Dental of California provider agreements or local, state, or federal laws. The authorization is valid for the duration of the coverage.

RIGHT OF REIMBURSEMENT: I, on my behalf of my Dependent(s) listed on this Enrollment Application, hereby agree that in the event any dental services provided to me or my Dependent(s) covered by Delta Dental of California are the primary financial responsibility of another party, because of other dental coverage, I will fully inform Delta Dental of California and will execute such assignments, liens or other documents which may be necessary to enable Delta Dental of California to recover the value of services and supplies provided.

NOTICE: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud and may be subject to fines and confinement in prison.

Sharp Health Plan

ACKNOWLEDGMENT: I authorize my employer to deduct from my earnings the contribution (if any) required to cover my share of the premium. I certify that I am working at the employer's place of business in permanent employment. For enrollment in Sharp Health Plan, I understand that my dependents and I must live or work in the Plan's service area.

I understand that my employer's application will determine coverage and that there is no coverage unless and until this application and an application made by my employer have been accepted and approved by Sharp Health Plan.

I understand that California law prohibits an HIV test from being required or used by health care plans as a condition of obtaining coverage.

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION. PLEASE READ CAREFULLY BEFORE SIGNING BELOW. Sharp Health Plan is authorized to obtain and release medical information in compliance with the Confidentiality of Medical Information Act. Section 56 et seq. of the California Civil Code.

I hereby authorize any physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish an agent, designee or representative of Sharp 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 any application or a claim. I authorize Sharp Health Plan, or agents, designees or representatives to disclose to a hospital or health care service plan, self-insurer, any such medical information obtained if such disclosure is necessary to allow the processing of any claim. This authorization shall become effective immediately and shall remain in effect for 30 months to permit evaluation of this application, or for the term of coverage to allow the processing of claims. A photocopy of this authorization shall be as valid as the original.

MISREPRESENTATION: I have read and understood the provisions outlined within this form. All information I have provided on this form is true and correct. I understand that it is the basis on which coverage may be issued under the plan.

Arbitration Agreement

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment of this application. I understand that any dispute or controversy that may arise regarding the performance, interpretation or breach of the agreement between myself (and/or any enrolled dependent) and Sharp Health Plan, whether arising in contract, tort or otherwise, must be submitted to arbitration in lieu of a jury or court trial if not satisfactorily resolved through Sharp Health Plan's grievance process.

Employee name (please print):	Employee signature: X	Date (MM/DD/YY):

Declination of coverage

I have been notified that I, and/or my eligible dependents, are eligible for enrollment in my employer's health benefits plan. By listing individuals for whom I am declining coverage and signing below, I voluntarily decline to enroll myself and / or those individuals and acknowledge that my decision not elect coverage permits my employer's health benefits plan to impose an exclusion from coverage until open enrollment, should I or these individuals later apply for coverage.

ENTER 1 OR 2 BELOW:
#1 - The individual declining coverage DOES have another employer health benefit plan, Medicare, Medi-Cal, Military,or cross-border coverage.
#2 - The individual declining coverage DOES NOT have one of the coverages listed in #1.

#	Name (Last, First, M.I.):
#	Name (Last, First, M.I.):
#	Name (Last, First, M.I.):

Employee signature: X	Date (MM/DD/YY):