



QUESTIONS?  
 Call or email Customer Care:  
**(800) 359-2002**  
 customer.service@sharp.com  
 Fax: (858) 499-8399  
**(Fax Both Sides)**  
 www.SharpHealthPlan.com

**NOTE: Complete and sign both sides of this application.**

**ENROLLMENT APPLICATION - Page 1**

REASON FOR THIS APPLICATION									
<input type="checkbox"/> <b>DECLINE COVERAGE (Complete "Declination" Section on Back)</b>					<input type="checkbox"/> Terminate Coverage Termination Date _____ Employer Signature _____				
<input type="checkbox"/> New Hire _____ <input type="checkbox"/> Rehire _____ <input type="checkbox"/> Open Enrollment <small>Date of Hire _____ Date of Rehire _____</small>					<input type="checkbox"/> Address Change (List Change Below) <input type="checkbox"/> Name Change (List Change Below) <input type="checkbox"/> Delete Dependent (List Names Below)				
<input type="checkbox"/> Add Dependent: Marriage/DP Reg. Date _____ Date of Birth _____ Date of Adoption _____ <small>(attach certificate copy)</small>									
<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> COBRA <input type="checkbox"/> Qualifying Event (attach proof)									
INDICATE PLAN BELOW					INDICATE NETWORK BELOW				
PLAN CHOICE					PLAN NETWORK				
EMPLOYEE INFORMATION									
SOCIAL SECURITY NO.		NAME (LAST, FIRST, MIDDLE INITIAL)			HOME PHONE NUMBER			EMAIL ADDRESS	
STREET ADDRESS				CITY		STATE	ZIP CODE		BIRTHDATE
MARRIAGE STATUS <input type="checkbox"/> Single <input type="checkbox"/> Registered Domestic Partnership (filed with CA Sec. of State or equivalent agency) <input type="checkbox"/> Married <input type="checkbox"/> Non-Registered Domestic Partnership (requires employer approval)				SEX <input type="checkbox"/> M <input type="checkbox"/> F	PREFERRED LANGUAGE		PRIMARY CARE PHYSICIAN (IF BLANK, PLAN WILL ASSIGN PCP) *		EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
EMPLOYER'S NAME		JOB TITLE / OCCUPATION		NO. OF WORK HRS PER WEEK	ARE YOU ACTIVELY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	PRIMARY CARE DENTIST I.D.		PRIMARY CARE DENTIST OFFICE I.D.	
DEPENDENT INFORMATION -- IF YOU ARE COVERING YOUR DEPENDENTS, PLEASE COMPLETE THE FOLLOWING INFORMATION									
LAST NAME, FIRST, M.I.	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX M/F	PRIMARY CARE PHYSICIAN (IF BLANK, PLAN WILL ASSIGN PCP) *	EXISTING PATIENT?		If you have Dental Coverage and a Primary Care Dentist, Please Complete Below.		
					YES	NO	PRIMARY CARE DENTIST I.D.		PRIMARY CARE DENTIST OFFICE I.D.
SPOUSE / DOMESTIC PARTNER									
CHILD									
CHILD									
CHILD									
CHILD									
<b>Do any of the dependents listed above have an address that is different from the employee?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes (If "yes" complete other address below.)									
NAMES AND ADDRESSES THAT ARE DIFFERENT									
OTHER MEDICAL COVERAGE									
<b>DO YOU OR YOUR DEPENDENTS INTEND TO CONTINUE OTHER MEDICAL OR MEDICARE COVERAGE?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (If "yes" complete the following:) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent									
NAME OF INSURED					DEPENDENTS ENROLLED WITH OTHER MEDICAL COVERAGE				
NAME OF OTHER INSURANCE COMPANY					GROUP NO. / POLICY NO.			COVERAGE START DATE	

**Subscriber**

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the reverse side of this application. *Arbitration Agreement.* 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.

X \_\_\_\_\_ DATE \_\_\_\_\_  
 EMPLOYEE SIGNATURE

\* To find a Sharp Health Plan affiliated doctor who meets your needs, please visit [www.SharpHealthPlan.com](http://www.SharpHealthPlan.com) and click on "Find a Doctor" or call Customer Care at 1-800-359-2002.



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EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL)	DATE
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**ENROLLMENT APPLICATION - Page 2**

**Premier Access Dental**

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 Premier Access, 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 Premier Access provider agreements or local, state, or federal laws. The authorization is valid for the duration of the coverage.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. Therefore, Premier Access Insurance Companies will not require that an HIV test be required as a condition of obtaining coverage. In accordance with California Health and Safety Code section 120980, Premier Access Insurance Company complies in all respects with the prohibition against the unauthorized disclosures of an HIV test.

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 Premier are the primary financial responsibility of another party, because of other dental coverage, I will fully inform Premier and will execute such assignments, liens or other documents which may be necessary to enable Premier 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.

MANDATORY BINDING ARBITRATION: I understand that any dispute or contracting that may arise between me and Premier Access shall be submitted to binding arbitration held in accordance with the commercial arbitration rules of the American Arbitration Association in lieu of a jury or court trial, and that should any dispute arise, neither Premier Access or I may pursue any claims as a plaintiff or class member in any purported class or representative proceeding, and instead must pursue any such claims in an individual capacity. Both Premier Access and I expressly waive any right to initiate or arbitrate a class action against one another relative to any disputes relating to or arising in any way out of my enrollment with Premier Access or its affiliates. The arbitration proceeding will take place in Sacramento, California or, if that location is prohibitive or significantly inconvenient to the parties, at an alternate location selected by the American Arbitration Association.

**Sharp Health Plan**

ACKNOWLEDGEMENT: 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. Any misstatements or omissions may result in future claims being denied and/or the policy being rescinded. I understand that I am entitled to make a copy of this signed Enrollment Form and Authorization.

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.

NAME (LAST, FIRST, MIDDLE INITIAL)		<b>ENTER 1 OR 2 FROM BELOW:</b> #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.  <input checked="" type="checkbox"/> X EMPLOYEE SIGNATURE _____ DATE _____
NAME (LAST, FIRST, MIDDLE INITIAL)		
NAME (LAST, FIRST, MIDDLE INITIAL)		