SHARP HEALTH PLAN
make life better.

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

EMPLOYER'S USE

GROUP NAME

GROUP NUMBER | EFFECTIVE DATE

REASON FOR THIS APPLICATION

☐ **DECLINE COVERAGE (Complete "Declination" Section on Back)**

☐ New Hire _____ (Date of Hire) ☐ Rehire _____ (Date of Rehire) ☐ Open Enrollment

☐ Add Dependent: _____ (Marriage/DP Reg. Date (attach certificate copy)) _____ (Date of Birth) _____ (Date of Adoption)

☐ Cal-COBRA ☐ COBRA ☐ Qualifying Event (attach proof)

☐ Terminate Coverage

Termination Date _____ Employer Signature _____

☐ Address Change (List Change Below) ☐ Name Change (List Change Below) ☐ Delete Dependent (List Names Below)

INDICATE PLAN BELOW

PLAN CHOICE

INDICATE NETWORK BELOW

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
☐ Single ☐ Registered Domestic Partnership (filed with CA Sec. of State or equivalent agency)
☐ Married ☐ Non-Registered Domestic Partnership (requires employer approval)

SEX ☐ M ☐ F

PREFERRED LANGUAGE

PRIMARY CARE PHYSICIAN (IF BLANK, PLAN WILL ASSIGN PCP) *

EXISTING PATIENT? ☐ YES ☐ NO

EMPLOYER'S NAME	JOB TITLE / OCCUPATION	NO. OF WORK HRS PER WEEK	ARE YOU ACTIVELY AT WORK?	PRIMARY CARE DENTIST I.D.	PRIMARY CARE DENTIST OFFICE I.D.
			☐ YES ☐ NO	N/A	N/A

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? YES	EXISTING PATIENT? NO	If you have Dental Coverage and a Primary Care Dentist, Please Complete Below. PRIMARY CARE DENTIST I.D.	PRIMARY CARE DENTIST OFFICE I.D.
SPOUSE / DOMESTIC PARTNER					☐	☐	N/A	N/A
CHILD					☐	☐	N/A	N/A
CHILD					☐	☐	N/A	N/A
CHILD					☐	☐	N/A	N/A
CHILD					☐	☐	N/A	N/A

Do any of the dependents listed above have an address that is different from the employee? ☐ No ☐ Yes (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 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 _____ EMPLOYEE SIGNATURE _____ DATE

* To find a Sharp Health Plan affiliated doctor who meets your needs, please visit 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

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)	
NAME (LAST, FIRST, MIDDLE INITIAL)	
NAME (LAST, FIRST, MIDDLE INITIAL)	

ENTER 1 OR 2 FROM 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.

X _____ _____
EMPLOYEE SIGNATUARE DATE