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.