

SMALL BUSINESS GROUP ACCEPTANCE/CHANGE APPLICATION

PacifiCare[®]

A UnitedHealthcare Company

Effective July 1, 2006

Source Code
Tracking #

Please indicate reason for application:

New Business: Acceptance of new coverage

Renewals: Acceptance of renewal with new renewal rates: Group # _____
 Change existing coverage: Group # _____

Important: Please Print or Type All Sections in Black Ink

Legal Name of Group/DBA	Telephone ()	Fax ()		
Address	City	County	State	ZIP

Employer Contribution (Medical Only): Employee Premium = _____ % Dependent Premium = _____ %

Total Permanent Full-Time Employees: (working 30 or more hours per week)	Total Permanent Part-Time Employees: (working 20-29 hours per week)	Do you wish to offer coverage to ALL employees working 20-29 hours per week? <input type="checkbox"/> Yes Effective Date _____ <input type="checkbox"/> No
---	--	---

Please Indicate New or Changed Coverage Below

Plan of Coverage – PacifiCare SignatureOptions[®], PacifiCare SignatureIndependence[®] and PacifiCare SignatureFreedom[®] plans are underwritten by PacifiCare Life and Health Insurance Company.

Please Select All Medical Plans for the Contract Year

Select one or more plans, up to a maximum of four. Plans indicated with an asterisk (*) are only available on a Stand-Alone basis. Groups must have at least five eligible employees with PacifiCare to purchase more than one plan. PacifiCare SignatureValue plans may not be offered alongside PacifiCare SignatureValue Advantage plans.

PacifiCare SignatureValue[®] (HMO) <input type="checkbox"/> 10-30/100 <input type="checkbox"/> 15-30/250a <input type="checkbox"/> 10/500d ¹ <input type="checkbox"/> 20-40/500d ¹ <input type="checkbox"/> 35/600d ¹ <input type="checkbox"/> 20/1500ded ¹ PacifiCare SignatureValue[®] Advantage (HMO) <input type="checkbox"/> 10/500d ¹ (Advantage) <input type="checkbox"/> 35/600d ¹ (Advantage) <input type="checkbox"/> 20/1500ded ¹ (Advantage) <input type="checkbox"/> 40-60/2000ded ¹ (Advantage) PacifiCare SignaturePOS[®] (POS) <input type="checkbox"/> 15/80-60*	PacifiCare SignatureOptions[®] (PPO) <input type="checkbox"/> 15/90-50/250 <input type="checkbox"/> 20/80-60/250 <input type="checkbox"/> 30/70-50/250 <input type="checkbox"/> 35/80-60/500 <input type="checkbox"/> 35/70-50/1000 <input type="checkbox"/> 35/50-50/1000 <input type="checkbox"/> 70-50/2000 (PPO)* <input type="checkbox"/> 70-50/3500 (PPO)*	PacifiCare SignatureOptions[®] (HSA-Compatible PPO) <input type="checkbox"/> 100-50/5000 <input type="checkbox"/> 80-50/2700 <input type="checkbox"/> 70-50/3500 (HSA-Compatible) PacifiCare SignatureIndependence[®] (Indemnity) <input type="checkbox"/> 80/1000 ² PacifiCare SignatureFreedom[®] (SDHP) <input type="checkbox"/> 80-50/2000* <input type="checkbox"/> 80-50/2000 with Dental* <input type="checkbox"/> 70-50/2000 (SDHP)* <input type="checkbox"/> 70-50/2000 with Dental* <input type="checkbox"/> 50-50/3000* <input type="checkbox"/> 50-50/3000 with Dental*
--	--	---

Please answer the following question:

Will you self-fund any portion of your employees' cost-sharing by offering a wrap-around plan, such as a Health Reimbursement Account (HRA), in addition to your PacifiCare Small Group plan? Yes No If No, and group does not disclose that they have a wrap-around plan or adds one after the initial group enrollment, the group may be subject to re-rate.

Supplemental Benefits

Other Coverage (required)

Group Term Life <input type="checkbox"/> Add ³ <input type="checkbox"/> Cancel <input type="checkbox"/> Renew <input type="checkbox"/> Change ³	Chiropractic/Acupuncture – Supplemental Chiropractic/Acupuncture through an arrangement with American Specialty Health Plans (for PacifiCare SignatureValue, PacifiCare SignatureValue Advantage and PacifiCare SignaturePOS only) <input type="checkbox"/> Add <input type="checkbox"/> Cancel <input type="checkbox"/> Renew	Domestic Partners Coverage All PacifiCare plans include Domestic Partner coverage as required by state law.
--	--	---

¹ By electing this plan, the Group has chosen not to offer Infertility Services to its employees. The Group understands that PacifiCare covers Infertility Services in other Small Business plans.

² This plan is not available on a Stand-Alone basis.

³ Separate application required.

The undersigned is authorized by the above Small Employer Group to apply for or change group coverage offered by PacifiCare of California and/or PacifiCare Life and Health Insurance Company at the attached premium rates guaranteed for 12 months effective _____ and is authorized to enter into a Medical and Hospital Group Subscriber Agreement and/or Group Master Policy.

Further, the undersigned agrees to make full monthly premium payments to PacifiCare for the benefits received in accordance with the terms of the contract.

Authorized Signature	Date
Print Name	Title

For renewals only, please fax to Account Management Team Fax # 1-800-926-2951

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH CARE SERVICE PLANS AND INSURANCE COMPANIES AS A CONDITION OF OBTAINING COVERAGE.

UNDERWRITING APPROVAL	D.P. Only
INTERNAL USE ONLY: G.C. #	