Employee Enrollment Form

Sales Department: Tel: 415-955-8800 Fax: 415-955-8819
Member Services: Tel: 415-834-2118 Fax: 415-397-2129

CCHP will provide translation or other language assistance free of charge in completing the application. The application, together with the Disclosure Form/Evidence of Coverage ("Agreement") constitutes the plan contract, and that applicants may request a copy of the Agreement prior to enrollment to learn the terms and conditions of the plan contract

1. Employee Information

Company Name:		Group Number:	
Last Name:	First Name:	M.I.:	☐ Male ☐ Female
Residence Address, City, State, ZIP:			
Date of Birth	SSN:	Marital Status: ☐ Single ☐ Married ☐ Domestic Partner	
Home Telephone:	Work Telephone:	Email:	
Primary Care Physician (PCP):		Existing Patient? ☐ Yes ☐ No	
Are you a currently on COBRA / CAL-COBRA? ☐ Yes ☐ No If YES, qualifying event:		COBRA /CAL-COBRA Qualifying Event Effective Date:	
Preferred Language (Optional): ☐ Chinese ☐ English ☐ Spanish ☐ Others: _____		Ethnicity (Optional):	

Employer Required to Complete this Section:

Requested Effective Date

Hired Date

Source of Enrollment:

- ☐ Open Enrollment
- ☐ New Hire
- ☐ Special Enrollment
- ☐ Employee Status Change
- ☐ Add Dependent(s)
- ☐ Others: _____

2. Coverage Selection (Select only the plans offered by your Employer)

Medical Plan Options
(All Medical Plans come with a $250 Calendar Year Brand Name Drug Deductible)

☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan D ☐ Plan E
☐ Ruby 10 ☐ Ruby 20 ☐ Ruby 40
☐ Opal 25 ☐ Opal 50 ☐ Active Choice

Optional Benefits (RIDERS)

☐ SmileSaver Dental Plan 2000
☐ VSP Vision Plan C (12/12/12)
☐ Chiropractic Plan (ASH 20)

3. Dependent(s) to be covered or added:

Spouse / Domestic Partner	☐ Male ☐ Female	Last Name	First Name	M.I.
Date of Birth [mmddyyyy]	SSN:	Primary Care Physician (PCP)		Existing Patient? ☐ Yes ☐ No
Dependent # 1	☐ Male ☐ Female	Last Name	First Name	M.I.
Date of Birth [mmddyyyy]	SSN:	Primary Care Physician (PCP)		Existing Patient? ☐ Yes ☐ No
Dependent # 2	☐ Male ☐ Female	Last Name	First Name	M.I.
Date of Birth [mmddyyyy]	SSN:	Primary Care Physician (PCP)		Existing Patient? ☐ Yes ☐ No
Dependent # 3	☐ Male ☐ Female	Last Name	First Name	M.I.
Date of Birth [mmddyyyy]	SSN:	Primary Care Physician (PCP)		Existing Patient? ☐ Yes ☐ No
Dependent # 4	☐ Male ☐ Female	Last Name	First Name	M.I.
Date of Birth [mmddyyyy]	SSN:	Primary Care Physician (PCP)		Existing Patient? ☐ Yes ☐ No

4. Other Health Insurance Information

Applicant(s) applying for coverage currently has health insurance coverage or has had health insurance coverage within the past six months. Please complete this section. **Proof of coverage must accompany this application. Failure to advise and provide proof of prior coverage may subject you and/or your family member to a six month pre-existing condition clause.**

Covered Person(s) Name	Carrier Name	Coverage Begin Date	Coverage End Date	Reason for ending coverage
☐ Self				
☐ Spouse ☐ Domestic Partner				
☐ Son ☐ Daughter				
☐ Son ☐ Daughter				
☐ Son ☐ Daughter				
☐ Son ☐ Daughter				

5. Authorization to Obtain or Release Medical Information:

Chinese Community Health Plan is authorized to obtain and release medical information in compliance with the terms of the Confidentiality of Medical Information Act, effective January 1, 1980 Section 56.10 et seq. of the California Civil Code. I hereby authorize my physician, health care practitioner, hospital, clinic, or other medically related facility to furnish an agent, designee or representative of Chinese Community 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 an application or a claim. I also authorize Chinese Community Health Plan and its affiliates, or its agents, designees or representatives to disclose to a hospital, healthcare provider, government agency, or health care service plan, self-insurer, or insurer any such medical information obtained if such disclosure is necessary to allow the processing of any claim. A copy of this authorization is as valid as the original.

6. Arbitration Agreement

I understand that (except for Small Claims cases) any and all disputes, including claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), which may arise under the agreement between me and CCHP and any of this affiliates shall be determined by submission to binding arbitration as provided by California law. Any such dispute will not be resolved by a lawsuit or resort to court process except as applicable law provides for judicial review of arbitration proceedings. ALL PARTIES TO THIS CONTRACT, BY ENTERING INTO IT, ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION. For more information regarding binding arbitration, please refer to your Evidence of Coverage.

X _____

Employee Signature & Date:

X _____

Employer Signature & Date:

_____

Employee Name (please print)

_____

Employer Name (please print)