SHARP HEALTH PLAN
Welcome home.

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

ENROLLMENT APPLICATION

REASON FOR THIS APPLICATION

☐ **DECLINE COVERAGE (MUST Complete Section at Bottom of Form)**

☐ 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)

EMPLOYER'S USE

GROUP NAME	
GROUP NUMBER	EFFECTIVE DATE

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 ☐ 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? ☐ YES ☐ NO / PCP OFFICE LOCATION

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	NO
SPOUSE / DOMESTIC PARTNER						
CHILD						
CHILD						
CHILD						
CHILD						

OTHER MEDICAL COVERAGE

DO YOU OR YOUR DEPENDENTS INTEND TO CONTINUE OTHER MEDICAL OR MEDICARE COVERAGE IF THE APPLICATION IS APPROVED? ☐ 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

DECLINATION OF COVERAGE

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 my self and/or those individuals and acknowledge that my decision not to elect coverage permits my employer's health benefits plan (depending on carrier) to impose a 12 month exclusion from coverage following application, or until open enrollment, should I or these individuals later apply for coverage.**

I AM DECLINING COVERAGE FOR:

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 NOT have another employer health benefit plan.

#2 - The individual declining coverage DOES have another employer health benefit plan.

X SIGN HERE ONLY IF DECLINING COVERAGE
EMPLOYEE SIGNATURE _____ DATE _____

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 arbitraton in lieu of a jury or court trial if not satisfactorily resolved through Sharp Health Plan's grievance process.

X
EMPLOYEE SIGNATURE _____ DATE _____

ACKNOWLEDGMENT

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 AT THE "X" ON THE REVERSE SIDE

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 or 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 on the front and back of 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 a copy of this signed Enrollment Form and Authorization.