QUESTIONS?
Call or email Customer Care:
(800) 359-2002
customer.service@sharp.com
Fax: (619) 228-2444
www.SharpHealthPlan.com

ENROLLMENT APPLICATION

▼ EMPLOYER'S USE ▼

GROUP NAME	
GROUP NUMBER	EFFECTIVE DATE

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)

INDICATE COVERAGE BELOW

PLAN CHOICE

EMPLOYEE INFORMATION

SOCIAL SECURITY NO.	NAME (LAST, FIRST, MIDDLE INITIAL)	HOME PHONE NUMBER	EMAIL ADDRESS

STREET ADDRESS	CITY	STATE	ZIP CODE	BIRTHDATE

MARRIAGE STATUS	SEX	PREFERRED LANGUAGE	PRIMARY CARE PHYSICIAN (IF BLANK, PLAN WILL ASSIGN PCP)	EXISTING PATIENT?
☐ Single ☐ Registered Domestic Partnership (filed with CA Sec. of State or equivalent agency) ☐ Married ☐ Non-Registered Domestic Partnership (requires employer approval)	☐ M ☐ F			☐ YES ☐ NO

EMPLOYER'S NAME	JOB TITLE / OCCUPATION	NO. OF WORK HRS PER WEEK	ARE YOU ACTIVELY AT WORK?	PCP OFFICE LOCATION
			☐ YES ☐ NO	

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