



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

**ENROLLMENT APPLICATION - MULTIPLE OPTIONS**

**EMPLOYER'S USE**

GROUP NAME \_\_\_\_\_  
 GROUP NUMBER \_\_\_\_\_ EFFECTIVE DATE \_\_\_\_\_

**REASON FOR THIS APPLICATION**

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

New Hire \_\_\_\_\_  Rehire \_\_\_\_\_  Open Enrollment  
Date of Hire \_\_\_\_\_ Date of Rehire \_\_\_\_\_

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 \_\_\_\_\_ PLAN NETWORK  
 SHARP GOLD  SHARP BLUE

**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.

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

EMPLOYEE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_