SHARP HEALTH PLAN
make life better.

Application for Health Insurance

Submit Application

Mail or fax this completed application to:

Sharp Health Plan for Individuals and Families
Attention: Underwriting
8520 Tech Way, Suite 200
San Diego, CA 92123
Fax: (858) 499-8393

Expedite this application by applying online at:

www.SharpHealthPlan.com

Application Instructions

One application is required and all enrollees must be on the same plan design. A separate application is required if any family members want a different plan design, or if a child is enrolling without a parent. If a child is enrolling without a parent, the information must be filled out in the subscriber section of the application.

Make a Payment

To pay your premium with your debit/credit card, please visit www.SharpHealthPlan.com/payment, or mail your check or money order to:

Sharp Health Plan
P.O. Box 57248
Los Angeles, CA 90074-7248

If you need assistance, we're here to help.
Customer Care: (858) 499-8300 or 1-800-359-2002

Preliminary Information

Are you currently enrolled on a Sharp Health Plan Individual or Family Plan?	☐ Yes	☐ No
If yes, please enter your subscriber identifier number (provided on renewal letter)		
Are you making any changes to your current policy?	☐ Plan Design Changes ☐ Add/Remove Dependents	☐ No Changes

Step 1a. Subscriber Information (Policy Holder) *please print*

First Name	M.I.	Last Name

Date of Birth	Social Security Number	Marital Status					
	– –	☐ Single	☐ Married	☐ Divorced	☐ Widowed	☐ Male	☐ Female
		☐ State Registered Domestic Partner		☐ Child Only Application			

Home Address (No P.O. Boxes)	City	State	Zip

Billing Address (If different from above)	City	State	Zip

Phone Number	Other Phone Number	Email Address
( )	( )	

Do you want to get information about this application by email? ☐ Yes ☐ No	Preferred spoken or written language (if not English)

Please note any communication assistance or special needs:

Do you currently have health coverage with another carrier? (If yes, please fill out the fields below) ☐ Yes ☐ No

Will you be covered by this additional health plan during your policy with Sharp Health Plan? ☐ Yes ☐ No	Is this an employer sponsored health plan? ☐ Yes ☐ No

Carrier Name	Type of Coverage (e.g. Medicare)

To find a Sharp Health Plan-affiliated doctor who meets your needs, please visit www.SharpHealthPlan.com and select "Find a Doctor," or call Customer Care at 1-800-359-2002.

Primary Care Physician (If left blank, Sharp Health Plan will assign a PCP)	Are you an existing patient with this doctor?

If this is a child under the age of 18, who is financially responsible for applicant?

Name	Signature	Date
	▶	

Dental

Please note applicants under age 19 will automatically be enrolled in a pediatric dental plan with Premier Access. To find a Premier Access dentist, please visit www.PremierLife.com, select "Find a Dentist" and choose the Individual Dental HMO plan for your area.

Primary Care Dentist Provider ID	Primary Care Dentist Office ID	Are you an existing patient with this dentist? ☐ Yes ☐ No

DHMO benefit plans are underwritten by Access Dental Plan, Inc. of CA, a Premier Access company and a specialized health care service plan licensed in the State of California under the Knox-Keene Act of 1975.

Vision

Please note applicants under age 19 will automatically be enrolled on a pediatric vision plan. Services are provided by Vision Service Plan (VSP). To search a list of available eye doctors, go to www.vsp.com/advantage.

Step 1b. Person Two

Complete the following information for each person you wish to add to this policy. Otherwise, skip to Step 2.

First Name	M.I.	Last Name

Date of Birth	Social Security Number	Relation to Subscriber	
	– –	☐ Spouse ☐ Domestic Partner ☐ Child	☐ Male ☐ Female

☐ Address is same as subscriber	Home Address (No P.O. Box)	City	State	Zip

Billing Address (If different from above)	City	State	Zip

Phone Number	Other Phone Number	Email Address
( )	( )	

Preferred spoken or written language (If not English)

Does this person currently have health coverage? (If yes, please fill out the fields below) ☐ Yes ☐ No

Will this person be covered by this health insurer during their policy with Sharp Health Plan? ☐ Yes ☐ No	Is this an employer sponsored plan? ☐ Yes ☐ No
Carrier Name	Type of Coverage (e.g. Medicare)

To find a Sharp Health Plan affiliated doctor who meets your needs, please visit www.SharpHealthPlan.com and click on "Find a Doctor" or call Customer Care at 1-800-359-2002.

Primary Care Physician Selection (If left blank, plan will assign PCP)	Is this person an existing patient with this doctor? ☐ Yes ☐ No

Is this person a child under the age of 18? ☐ Yes ☐ No

If yes, who is financially responsible for applicant?

Name	Signature ▶	Date

Dental

Please note applicants under age 19 will automatically be enrolled in a pediatric dental plan with Access Dental Plan. To find an Access Dental Plan dentist, please visit PremierLife.com, select "Find a Dentist" and choose the Individual Dental HMO plan for your area.

Primary Care Dentist Provider ID	Primary Care Dentist Office ID	Is this person an existing patient with this dentist? ☐ Yes ☐ No

DHMO benefit plans are underwritten by Access Dental Plan, Inc. of CA, a Premier Access company and a specialized health care service plan licensed in the State of California under the Knox-Keene Act of 1975.

Vision

Please note applicants under age 19 will automatically be enrolled on a pediatric vision plan. Services are provided by Vision Service Plan (VSP). To search a list of available eye doctors, go to www.vsp.com/advantage.

Step 1b. Person Three

Complete the following information for each person you wish to add to this policy. Otherwise, skip to Step 2.

First Name	M.I.	Last Name

Date of Birth	Social Security Number	Relation to Subscriber	
	– –	☐ Spouse ☐ Domestic Partner ☐ Child	☐ Male ☐ Female

☐ Address is same as subscriber	Home Address (No P.O. Box)	City	State	Zip

Billing Address (If different from above)	City	State	Zip

Phone Number	Other Phone Number	Email Address
( )	( )	

Preferred spoken or written language (If not English)

Does this person currently have health coverage? (If yes, please fill out the fields below) ☐ Yes ☐ No	
Will this person be covered by this health insurer during their policy with Sharp Health Plan? ☐ Yes ☐ No	Is this an employer sponsored plan? ☐ Yes ☐ No
Carrier Name	Type of Coverage (e.g. Medicare)

To find a Sharp Health Plan affiliated doctor who meets your needs, please visit www.SharpHealthPlan.com and click on "Find a Doctor" or call Customer Care at 1-800-359-2002.

Primary Care Physician Selection (If left blank, plan will assign PCP)	Is this person an existing patient with this doctor? ☐ Yes ☐ No

Is this person a child under the age of 18? ☐ Yes ☐ No

If yes, who is financially responsible for applicant?

Name	Signature ▶	Date

Dental

Please note applicants under age 19 will automatically be enrolled in a pediatric dental plan with Access Dental Plan. To find an Access Dental Plan dentist, please visit PremierLife.com, select "Find a Dentist" and choose the Individual Dental HMO plan for your area.

Primary Care Dentist Provider ID	Primary Care Dentist Office ID	Is this person an existing patient with this dentist? ☐ Yes ☐ No

DHMO benefit plans are underwritten by Access Dental Plan, Inc. of CA, a Premier Access company and a specialized health care service plan licensed in the State of California under the Knox-Keene Act of 1975.

Vision

Please note applicants under age 19 will automatically be enrolled on a pediatric vision plan. Services are provided by Vision Service Plan (VSP). To search a list of available eye doctors, go to www.vsp.com/advantage.

Step 1b. Person Four (Attach additional sheets if more than four dependents)

Complete the following information for each person you wish to add to this policy. Otherwise, skip to Step 2.

First Name	M.I.	Last Name

Date of Birth	Social Security Number	Relation to Subscriber	
	– –	☐ Spouse ☐ Domestic Partner ☐ Child	☐ Male ☐ Female

Home Address (No P.O. Box)	City	State	Zip

Billing Address (If different from above)	City	State	Zip

Phone Number	Other Phone Number	Email Address
( )	( )	

Preferred spoken or written language (If not English)

Does this person currently have health coverage? (If yes, please fill out the fields below) ☐ Yes ☐ No

Will this person be covered by this health insurer during their policy with Sharp Health Plan? ☐ Yes ☐ No	Is this an employer sponsored plan? ☐ Yes ☐ No
Carrier Name	Type of Coverage (e.g. Medicare)

To find a Sharp Health Plan affiliated doctor who meets your needs, please visit www.SharpHealthPlan.com and click on "Find a Doctor" or call Customer Care at 1-800-359-2002.

Primary Care Physician Selection (If left blank, plan will assign PCP)	Is this person an existing patient with this doctor? ☐ Yes ☐ No

Is this person a child under the age of 18? ☐ Yes ☐ No

If yes, who is financially responsible for applicant?

Name	Signature ▶	Date

Dental

Please note applicants under age 19 will automatically be enrolled in a pediatric dental plan with Access Dental Plan. To find an Access Dental Plan dentist, please visit PremierLife.com, select "Find a Dentist" and choose the Individual Dental HMO plan for your area.

Primary Care Dentist Provider ID	Primary Care Dentist Office ID	Is this person an existing patient with this dentist? ☐ Yes ☐ No

DHMO benefit plans are underwritten by Access Dental Plan, Inc. of CA, a Premier Access company and a specialized health care service plan licensed in the State of California under the Knox-Keene Act of 1975.

Vision

Please note applicants under age 19 will automatically be enrolled on a pediatric vision plan. Services are provided by Vision Service Plan (VSP). To search a list of available eye doctors, go to www.vsp.com/advantage.

Step 2. Plan Selection

Each plan has a specific network of physicians and hospitals associated with it. To find a Sharp Health Plan affiliated doctor who meets your needs, please visit www.SharpHealthPlan.com and select "Find a Doctor," or call Customer Care at 1-800-359-2002.

Plan Name (Select One)	Metal Tier	Network
☐ Sharp Platinum 90 HMO Network 2	Platinum	Performance
☐ Sharp Platinum 90 HMO Network 1	Platinum	Premier
☐ Sharp Gold 80 HMO Network 2	Gold	Performance
☐ Sharp Gold 80 HMO Network 1	Gold	Premier
☐ Sharp Silver 70 HMO Network 2	Silver	Performance
☐ Sharp Silver 70 HMO Network 1	Silver	Premier
☐ Sharp Bronze 60 HMO Network 2	Bronze	Performance
☐ Sharp Bronze 60 HSA Network 1	Bronze	Premier
☐ Sharp Minimum Coverage HMO Network 2	Minimum Coverage	Performance

Effective Date of Coverage
What is the requested effective date of your medical policy? _____

In most cases, if this application is completed on or before the 15th of the month, then your coverage will be effective the first day of the next month. For example, if you submit your completed application on December 10, then your effective date will be January 1. If your application is completed after the 15th day of the month, then your coverage will be effective the first day after the next month. For example, if your application is completed on of January 20, then your effective date will be March 1.

Qualifying Event for applying outside of the open enrollment period

Request for enrollment must be submitted within 60 days of a qualifying event. Attach proof of qualifying event to application.	☐ I didn't realize there is a tax penalty for being uninsured ☐ Loss of coverage ☐ Marriage ☐ Birth / Adoption ☐ Divorce ☐ Other _____

Step 3. Broker Section

Did you work with a broker? ☐ Yes. Complete information below. ☐ No. Skip to step 4.			
Broker Name: Kevin Knauss	Agency Name:		
License Number: 0H12644			
Address (no P.O. Box): 8712 Pendleton Dr.	City: Granite Bay	State: CA	Zip: 95746
Phone Number: (916) 521-7216	Email Address: kevin@insuremekevin.com		

Notice to Agent, Broker, Representative: If you have assisted the applicant in submitting this application, the law requires that you attest to this assistance. If you state any material fact you know to be false, you are subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under California Health and Safety Code section 1389.8(c) or Insurance Code section 10119.3.

Select one:

☐ I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation.

☐ I did not assist the applicant in any way in completing or submitted this application. All information was completed by the applicant with no assistance or advice from me.

Agent, Broker, Representative Signature ▶	Date

Step 4. Disclosures and Signatures

Please read the following carefully. Each applying family member age 18 and older is required to review the completed application and provide their own signature on the following page. Keep a copy of this application for your records.

Access Dental Disclosures

I understand that if I have indicated that coverage under the Plan is to be provided only for the dependent child on this form, I am responsible for payment of the required Premium and compliance with all of the provisions and conditions of the Disclosure Form/ Contract.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. Therefore, Premier Access Insurance Companies will not require that an HIV test be required as a condition of obtaining coverage. In accordance with California Health and Safety Code section 120980, Premier Access Insurance Company complies in all respects with the prohibition against the unauthorized disclosures of an HIV test.

RIGHT OF REIMBURSEMENT: I, on my behalf of my Dependent(s) listed on this Enrollment Application, hereby agree that in the event any dental services provided to me or my Dependent(s) covered by Premier are the primary financial responsibility of another party because of other dental coverage, I will fully inform Premier and will execute such assignments, liens or other documents which may be necessary to enable Premier to recover the value of services and supplies provided.

NOTICE: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud and may be subject to fines and confinement in prison. In accordance with the disclosure requirements of California Health & Safety Code, Section 1363 (h), this is to advise you that Premier Access' ratio of health care expenses to premiums received for the last calendar year with respect to the Premier Access Individual & Family Plans was 60.0%.

MANDATORY BINDING ARBITRATION: I understand that any dispute or controversy that may arise between me and Premier Access shall be submitted to binding arbitration held in accordance with the commercial arbitration rules of the American Arbitration Association in lieu of a jury or court trial, and that should any dispute arise, neither Premier Access nor I may pursue any claims as a plaintiff or class member in any purported class or representative proceeding, and instead must pursue any such claims in an individual capacity. Both Premier Access and I expressly waive any right to initiate or arbitrate a class action against one another relative to any disputes relating to or arising in any way out of my enrollment with Premier Access or its affiliates. The arbitration proceeding will take place in Sacramento, California or, if that location is prohibitive or significantly inconvenient to the parties, at an alternate location selected by the American Arbitration Association.

(**continued on next page**)

(step 4 continued)

Sharp Health Plan Disclosures

- I alone am responsible for the accuracy and completeness of the information provided on this application. I have personally reviewed all information provided on this application, even if I did not fill out the application myself. To the best of my knowledge and belief, all information on this application is accurate, true and complete. If Sharp Health Plan determines that there is fraud (by act, practice or omission) or an intentional misrepresentation of material fact in the information on this application, I understand that coverage may be rescinded as allowed by law.
- In order to determine fraud, I understand that I may be subject to an audit by Sharp Health Plan, at which time I will need to provide proof of residency, date of birth and dependent eligibility (if applicable). I further understand that I must provide Sharp Health Plan with any new information that arises after the submission of this application but before my enrollment with Sharp Health Plan begins.
- If I indicated in Step 1 that I have a language preference other than English and have completed the English version of this application (or version other than in my language preference), I confirm that I understand the questions on this application.
- I understand that California law prohibits an HIV test from being required or used by health care plans as a condition of obtaining coverage.
- Depending on your income level and family size, you may be eligible for financial assistance to help pay for your health coverage if you purchase your coverage through Covered California. Sharp Health Plan benefit plans are available through Covered California. You must apply during an open or special enrollment period. Open enrollment is from November 15, 2014 – February 15, 2015. If you have a life change such as marriage, divorce, a new child or loss of a job, you can apply at the time the life change occurs ("special enrollment period").
- **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 arbitration in lieu of a jury or court trial if not satisfactorily resolved through Sharp Health Plan's grievance process.**

Subscriber (or person financially responsible for subscriber if under 18)

Name	Signature ▶	Date

Person Two (over 18) *if applicable*

Name	Signature ▶	Date

Person Three (over 18) *if applicable*

Name	Signature ▶	Date

Person Four (over 18) *if applicable*

Name	Signature ▶	Date