PacifiCare
Small Group Underwriting
Submission Requirements

To ensure a complete case submission, please check off and enclose the following items to be forwarded to PacifiCare. Please verify that all necessary information is completed prior to submission.

_____ Checklist

_____ Completed & Signed Employer Group Application

_____ Completed & Signed Employee Enrollment Forms

_____ Completed & Signed Statement of Health Forms
ALL EMPLOYEES MUST COMPLETE THIS FORM!!

_____ Copy of Preliminary Quote

_____ Binder Check for 1st month's Premium

_____ Texas Workforce Commission (TEC) Quarterly Report

_____ Proprietor's/partner's Statement (for owners and officers that do Not appear on the TEC Report)

_____ Business License (if applicable)

_____ Waiver of Coverage Forms for All Employees and/or Dependents Waiving Coverage

_____ Group Life Insurance Application (optional)

_____ Supplemental Life Evidence of Insurability forms (if applicable)

_____ Prior Carrier Billing if purchasing PPO

_____ Market Segment Indicator Form (submitted by internal PC sales)

****ALL NEW GROUP PAPERWORK MUST BE IN THE PACIFICARE OFFICE BY THE 25TH OF EACH MONTH IN ORDER TO BE EFFECTIVE THE FIRST OF THE FOLLOWING MONTH!**

Mail or Fax to:
Beneflex Financial Group
11811 East Freeway Ste. 545

Houston, TX 77029
Wealth@beneflexfinacial.com
www.beneflexfinncial.com
Fax:
713-455-3068
800-884-2798

PacifiCare

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal law concerning the privacy of such information**. Failure to provide all information requested will invalidate this Authorization.**

USE AND DISCLOSURE OF HEALTH INFORMATION

I, (Insured's Name) _____ , (PacifiCare ID#) _____
hereby authorize the use or disclosure of my health information as follows:

Persons/Organizations authorized to *use or disclose* the information[1]: _____

Persons/Organizations authorized to *receive* the information: _____

Purpose of requested use or disclosure[2]: _____

_____

This Authorization applies to the following information (select *only one* of the following)[3]:

- ❑ All health information pertaining to any medical history or physical condition and treatment received.
- ❑ [Optional] Except: _____

Only the following records or types of health information (including any dates):

_____

EXPIRATION

This authorization will expire on (insert date or *event)[4]: _____

*A specific date or "until I terminate from PacifiCare Health Plan" can be used.

SIGNATURE

By signing below, I am indicating that, at my request, I am voluntarily agreeing to allow PacifiCare employees whose duties involve handling the insured information to disclose my confidential information to the designated person. I understand that PacifiCare may not condition (withhold) treatment, payment, enrollment, or eligibility of benefits as a result of this authorization.

_____
PRINT NAME

_____ _____
SIGNATURE DATE

When the form is completed it should be returned to **P.O. Box 6098, MS CY24-379, Cypress, CA 90630** or faxed to **(714) 226-5002.**

REVOCATION OF AUTHORIZATION: As stated in PacifiCare's Notice of Privacy Practices, you have the right to revoke this authorization except for instances that PacifiCare has already taken action based on the authorization. Your revocation must be mailed to the address above. You may also notify our Customer Service department by calling the toll-free number on your health plan identification card during normal business hours and request a form to revoke this authorization. Your revocation will be effective upon receipt, but will not be effective to the extent that the Requester or others have acted in reliance upon this authorization.

NOTICE OF RIGHTS AND OTHER INFORMATION

- If you have authorized the disclosure of your health information to someone, who is not legally required to keep it confidential, it may be re-disclosed and may no longer be protected.
- I may refuse to sign this authorization.
- I have a right to receive a copy of this authorization.[5]
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
- I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

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[1]If the Authorization is being requested by the entity holding the information, this entity is the Requester.

[2]The statement "at the request of the individual " is a sufficient description of the purpose when the individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.

[3]This form may not be used to release both psychotherapy notes and other types of health information *(see 45 CFR § 164.508(b)(3)(ii)).* If this form is being used to authorize the release of psychotherapy notes, a separate form must be used to authorize release of any other health information.

[4]If authorization is for use or disclosure of PHI for research, including the creation and maintenance of a research database or repository, the statement "end of research study," "none" or similar language is sufficient.

[5]Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures *(see 45 CFR § 164.508(d)(1), (e)(2)).*

PACIFICARE SMALL GROUP CENSUS FORM
GROUP INFORMATION (2 TO 50 EMPLOYEES)

Employer Group Name: _____
Employer Group Address: _____
Requester's Name: _____
Requester's Phone #: _____

Requester's Fax #: _____
Effective Date (must be 1st of the Month): _____
SIC Code or Nature of Business: _____

SEX	DATE OF BIRTH OR AGE	DEPENDENT STATUS (i.e. - EO, ES, EC EF, None)	ZIP CODE	MEDICAL CONDITIONS

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PLEASE COMPLETE AND FAX BACK TO 713-455-3068 (800)-884-2798