



*11230 Sorrento Valley Road
Suite 105
San Diego, CA 92121
(800) 733-4487
(858) 622-5000*

Application Instructions:

- Complete all sections of the application with signature and date.
- Complete Authorization for Direct Automatic Bill Payment form.
- Enclose a voided check. (Deposit slips will not be accepted)
- Mail package to:

Pacific Financial Designs, Inc.
11230 Sorrento Valley Road
Suite 105
San Diego, CA 92121
Attn: New Benefits

- All enrollments received by the 15th of the month will be effective the 1st of the following month. Those received after the 15th will not be processed until the following month with an effective date of the following 1st of the month.
 - Example: Application received on August 14th will be effective September 1st, but an application received on August 17th will be effective October 1st.

GENERAL INFORMATION

Name (Last, First, MI)		ID #	Social Security Number		Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (MM/DD/YY)	Date of Retirement	Policy Number
Member's email address		Event <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Other:		Effective Date of Coverage		Home Phone #		
Residence Mailing Address		Apt./Uni. #	City	Zip	State			

DENTAL ENROLLMENT

Choose from the following dental plans.
(the box that applies)

	Pacific Union Dental (CA only) Imperial	HMO Dental UHC/PacifiCare (CA only)	PPO Dental UnitedHealthcare
Member Only	Monthly <input type="checkbox"/> \$30.18 <input type="checkbox"/> \$51.61 <input type="checkbox"/> \$76.95	Monthly <input type="checkbox"/> \$16.51 <input type="checkbox"/> \$31.25 <input type="checkbox"/> \$47.68	Monthly <input type="checkbox"/> \$44.94 <input type="checkbox"/> \$88.17 <input type="checkbox"/> \$147.48
Member + One	<input type="checkbox"/> 0004	<input type="checkbox"/> 0005	<input type="checkbox"/> 0003

MEMBER/DEPENDENT INFORMATION

Name (Last, First, MI)	Relationship	Gender	Date of Birth (MM/DD/YY)	Full-time Student	Dental Provider Name & City (HMO Only)	Patient Existing	Group # (HMO) Dental Provider
	Member <input type="checkbox"/> Spouse <input type="checkbox"/> Dom. Part.	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Child	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Child	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Child	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Do you or your dependents have any other dental insurance? If "Yes", complete the following information:

Benefit	Insurance Company	Policy #	Who is covered under this other policy?
<input type="checkbox"/> Dental			
<input type="checkbox"/> Dental			
<input type="checkbox"/> Dental			

Signature

I DESIRE TO PARTICIPATE IN THE COVERAGES SELECTED AND HEREBY AUTHORIZE MY ASSOCIATION TO MAKE THE NECESSARY DEDUCTION(S) FROM MY MEMBERSHIP TO PAY MY PORTION OF THE PREMIUM.
ARBITRATION DISCLOSURE: I agree that any and all disputes, including claims relating to the delivery of services under the plan and claims of medical malpractice (that is, as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for claims subject to ERISA, between myself and my dependents enrolled in the plan (including any heirs or assigns) and United HealthCare, Pacific Union Dental and PacificCare of California or any of its parents, subsidiaries or affiliates shall be determined by submission to binding arbitration. Any such dispute will not be resolved by lawsuit or resort to court process, except as the federal arbitration act provides for judicial review of arbitration proceedings. All parties to this agreement are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration. If choose not to enroll at the time I first become eligible, I and my eligible dependents will not be allowed to enroll until the next open enrollment period.

(Date)

(Signature)

