

# California Small Group Enrollment Form and Declination of Coverage



Effective March 1, 2008

## ■ Instructions

### Section 1: Personal Information

Complete information requested.

### Section 2: Selected Coverage

- Select only the plans offered by your Employer.
- For each plan your Employer offers, select the individual to be covered.

### Section 3: Employee & Dependent Information

- List yourself and family members to be covered. You may attach additional sheets if necessary.
- Select a Primary Care Physician (PCP) from the *Provider Directory* for you and each of your family members by writing the PCP name and Provider number in the area provided. You may choose a different PCP for each member in your family.

PCP selection is only required if a PacifiCare SignatureValue® (HMO), PacifiCare SignatureValue® Advantage (HMO) or PacifiCare SignaturePOS® plan is selected. If you do not select a PCP when selecting one of these plans, a PCP will be automatically assigned to you.

- Verify spousal and Domestic Partner coverage eligibility with your Employer.
- Over-age (19–24 years) Dependents require proof of full-time student status or permanent disability status within 31 days of enrollment.

### Section 4: Benefit Coordination/ Other Insurance Carrier Information

Complete information requested.

### Section 5: Signature Required on Arbitration Disclosure

Read this section carefully and provide your signature(s) as required.

### Small Business Individual Health Statement

- Complete the health statement application included in this form.
- Submit the completed health statement application in a sealed envelope along with this Enrollment Form.

## ■ Employee Signature

### You can either:

Accept the health care services coverage provided through your Employer by signing the space provided on the enrollment form. Your signature indicates that you have read, understand and agree to the terms and conditions below. Affixing your signature also indicates your acceptance of payroll deductions (if necessary) to pay your share of the cost.

### OR

You can waive the health care services coverage provided through your Employer for yourself, your spouse/Domestic Partner or your Dependents by signing the DECLINATION OF COVERAGE FORM. We strongly recommend that you read through the entire form carefully before signing your name in ink and dating it.

## ■ Terms and Conditions –

### Please read carefully before signing

On behalf of myself and my eligible Dependents, I hereby apply for health care services coverage indicated in PacifiCare's Group Health Plan offered through my Employer, and agree to and understand the following:

1. To be bound by the PacifiCare Medical and Hospital Group Subscriber Agreement ("Agreement") if I have chosen the PacifiCare SignatureValue (HMO), PacifiCare SignatureValue Advantage (HMO) or PacifiCare SignaturePOS plan or the PacifiCare Life and Health Group Policy ("Policy") if I have chosen the PacifiCare SignatureElite (PPO) plan.
2. My Employer may deduct from my earnings the employee contribution required to cover my share of the premium, if any.
3. PacifiCare or a designee shall have access to and use of my medical records and the medical records of my dependents, including mental health medical records and medical records from drug and alcohol abuse treatment or prevention, for purposes of Utilization Review, Quality Assurance, surveys, processing of claims, financial audit, rating or purposes of diagnosis and treatment of patient, billing, claims management, medical data processing and administrative or health care operations of the Agreement or Policy.

Insurance coverage provided by or through United HealthCare Insurance Company, underwritten by PacificCare Life and Health Insurance Company or their affiliates. Health plan products and services are offered by PacificCare of California; PacificCare Behavioral Health of California, Inc. Administrative services provided by United HealthCare Insurance Company, United HealthCare Services, Inc., PacificCare Health Plan Administrators, Inc. or their affiliates. PacificCare® is a federally registered trademark of PacificCare Life and Health Insurance Company.

**PacificCare SignaturePOS®**  
P.O. Box 30981  
Salt Lake City, UT 84130  
1-800-913-9133  
1-800-442-8833 (TDHI)  
1-866-372-1316 (fax)

**PacificCare SignatureValue® (HMO) and PacificCare SignatureValue Advantage (HMO)**  
P.O. Box 30981  
Salt Lake City, UT 84130  
1-800-624-8822  
1-800-442-8833 (TDHI)  
1-866-372-1316 (fax)

**PacificCare SignatureElite<sup>SM</sup> (PPO)**  
P.O. Box 30981  
Salt Lake City, UT 84130  
1-866-316-9776  
1-866-816-2018 (TDHI)  
1-866-372-1316 (fax)

**PacificCare Dental and Vision Administrators**  
P.O. Box 25187  
Santa Ana, CA 92799  
1-800-228-3384  
Visit our Web site @  
[www.pacificcare.com](http://www.pacificcare.com)

- 7. My Dependents and I must live or work in PacificCare's service area if enrolling in the PacificCare SignatureValue, PacificCare SignatureValue Advantage or PacificCare SignaturePOS plan.
  - 8. If my Dependent(s) or I elect PacificCare SignatureValue, PacificCare SignatureValue Advantage or PacificCare SignaturePOS, we will select a Primary Care Physician within a 30-mile radius of our Primary Residence or Primary Workplace.
- I represent that the information supplied is true, and I hereby authorize payroll deductions from my earnings for any contributions or fees required to maintain my eligibility.

- 4. Any intentional, incomplete or incorrect material omission or misrepresentation in answering the questions on this application may result in the denial of benefits and the termination of my and/or my dependents' insurance coverage and/or health plan products and services with PacificCare.
- 5. Coverage shall not begin until acceptance of this enrollment by PacificCare. Upon acceptance of this enrollment form, PacificCare shall be bound by the terms of the Agreement or Policy, and any Amendments thereto.
- 6. I have received, read and understand the PacificCare Disclosure Form, Directory of Participating Medical Groups, and a copy of this Enrollment Form.

Detach here

# Employee Enrollment Form (Please Print) Revised 11/07

CALIFORNIA

Employer Required to Complete This Section			
Group #/Plan Code	Reason for Application: <input type="checkbox"/> QMCSO <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Group Plan <input type="checkbox"/> New Hire <input type="checkbox"/> Rehire	Employee Type: <input type="checkbox"/> Active <input type="checkbox"/> Hourly <input type="checkbox"/> Salary <input type="checkbox"/> Union <input type="checkbox"/> Non-Union <input type="checkbox"/> Other	Requested Effective Date

1. Personal Information				
Company Name		Occupation/Title		Date of Hire
Last Name		First Name	MI	Suffix
Residence Mailing Address		City	State	ZIP
Number of hours you work in a normal week:	Have you or any of your dependents ever been a PacifiCare Member? <input type="checkbox"/> Yes <input type="checkbox"/> No	Home Telephone ( ) ( )	Work Telephone ( ) ( )	
Date of Birth (mm-dd-yy)	Social Security #	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Widow <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner		
Are you currently on COBRA or Cal-COBRA? <input type="checkbox"/> Yes <input type="checkbox"/> No	Annual Salary	Would you like to receive information via e-mail? <input type="checkbox"/> Yes <input type="checkbox"/> No	E-mail	
Ethnicity (Optional) <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian, Native Hawaiian, other Pacific Islander		<input type="checkbox"/> Black or African-American <input type="checkbox"/> Not provided by employee		Preferred Language (Optional) <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other

2. Selected Coverage (Select only the plans offered by your Employer)																		
Medical Plan Options	Supplemental Plan Options																	
<b>PacifiCare SignatureValue (HMO) and PacifiCare SignatureValue Advantage (HMO)</b> <table border="0"> <tr> <td>HMO</td> <td>HMO Advantage</td> </tr> <tr> <td>10-30/100 <input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>15-30/250a <input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>10/500d <input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>20-40/500d <input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>35/600d <input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>20/1500ded <input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>40-60/2000ded <input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	HMO	HMO Advantage	10-30/100 <input type="checkbox"/>	<input type="checkbox"/>	15-30/250a <input type="checkbox"/>	<input type="checkbox"/>	10/500d <input type="checkbox"/>	<input type="checkbox"/>	20-40/500d <input type="checkbox"/>	<input type="checkbox"/>	35/600d <input type="checkbox"/>	<input type="checkbox"/>	20/1500ded <input type="checkbox"/>	<input type="checkbox"/>	40-60/2000ded <input type="checkbox"/>	<input type="checkbox"/>	<b>PacifiCare SignaturePOS (POS)</b> <input type="checkbox"/> 15/80-60  <b>PacifiCare SignatureElite (PPO)</b> <input type="checkbox"/> 15/90-50/250 <input type="checkbox"/> 20/80-60/250 <input type="checkbox"/> 30/70-50/250 <input type="checkbox"/> 35/80-60/500 <input type="checkbox"/> 35/70-50/1000 <input type="checkbox"/> 35/50-50/1000 <input type="checkbox"/> 70-50/2000 <input type="checkbox"/> 70-50/3500	<input type="checkbox"/> Life (Additional Enrollment Form required)  <b>Dental Plan Option</b> <input type="checkbox"/> PacifiCare SignatureValue (Dental HMO)  <b>Vision Plan Options</b> <input type="checkbox"/> PacifiCare SignatureOptions (Dental PPO - Full Service) <input type="checkbox"/> PacifiCare SignatureOptions (Dental PPO - Eyewear Only)
HMO	HMO Advantage																	
10-30/100 <input type="checkbox"/>	<input type="checkbox"/>																	
15-30/250a <input type="checkbox"/>	<input type="checkbox"/>																	
10/500d <input type="checkbox"/>	<input type="checkbox"/>																	
20-40/500d <input type="checkbox"/>	<input type="checkbox"/>																	
35/600d <input type="checkbox"/>	<input type="checkbox"/>																	
20/1500ded <input type="checkbox"/>	<input type="checkbox"/>																	
40-60/2000ded <input type="checkbox"/>	<input type="checkbox"/>																	

Please complete the Declination of Coverage form if declining coverage for Self and/or Eligible Dependent(s)

3. Employee & Dependent Information (List yourself and family members to be covered - attach additional sheets if necessary)				
<b>Self</b>	Primary Care Physician (PCP) Name		Provider #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dentist Name and City		Dental Provider Group #		Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Spouse/ Domestic Partner</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name	First Name	M.I.
Date of Birth (mm-dd-yy)	Social Security #	Address, if different than Employee's		
Primary Care Physician (PCP) Name		Provider #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dentist Name and City		Dental Provider Group #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Dependent 1</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name	First Name	M.I.
Relationship	Social Security #	Address, if different than Employee's		
Primary Care Physician (PCP) Name		Provider #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dentist Name and City		Dental Provider Group #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Dependent 2</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name	First Name	M.I.
Relationship	Social Security #	Address, if different than Employee's		
Primary Care Physician (PCP) Name		Provider #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dentist Name and City		Dental Provider Group #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Dependent 3</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name	First Name	M.I.
Relationship	Social Security #	Address, if different than Employee's		
Primary Care Physician (PCP) Name		Provider #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dentist Name and City		Dental Provider Group #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Check box if additional enrollment page is attached for dependents.				

Detach here

Group #

Employee Name

Social Security #

**4. Benefit Coordination/Other Insurance Carrier Information**

**Do you or any of your Dependents have any other health insurance?**  Yes  No  
If yes, will this coverage remain in effect if this application is accepted?  Yes  No If yes, complete boxes a-j:

a. Name	b. Insurance Company Name	c. Policy #	d. Effective Date	e. Other Employer Name and Address
f. Name	g. Insurance Company Name	h. Policy #	i. Effective Date	j. Other Employer Name and Address

**Is anyone listed permanently disabled?**  Yes  No If yes, complete boxes k + l:

k. Name	l. Date Disability Began
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**Is anyone listed eligible for Medicare?**  Yes  No If yes, complete boxes m + n:

m. Name	n. Medicare ID#
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**Does anyone listed have other dental insurance?**  Yes  No If yes, complete boxes o - r:

o. Name	p. Insurance Company Name	q. Policy #	r. Effective Date
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**5. Signature Required for Terms and Conditions and Arbitration Disclosure - Read Carefully**

By signing below, I acknowledge that I have read, understand and agree to the Terms and Conditions and Arbitration Disclosure on all pages of this form. A reproduction of this authorization shall be as valid as the original.

**I. I DESIRE TO PARTICIPATE IN THE COVERAGES SELECTED AND HEREBY AUTHORIZE MY EMPLOYER TO MAKE THE NECESSARY DEDUCTION(S) FROM MY WAGE/SALARY TO PAY MY PORTION OF THE PREMIUM.**

**II. ARBITRATION DISCLOSURE: I AGREE AND UNDERSTAND 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 PACIFICARE 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 A 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.**

Signature (Required)

X

Date (Required)

Detach here

# Small Business Individual Health Statement Application

Source Code	Tracking #
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■ Type or Print in Black Ink ■ Please submit in a sealed envelope along with your completed Employee Enrollment Form

Employer Name
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	First Name	Middle	Last	SS #	Date of Birth Mo./Day/Yr.	Height	Weight	Sex
Employee								
Spouse/ Domestic Partner								
Child								
Child								
Child								

**FOR ANY "YES" ANSWERS, PLEASE GIVE DETAILS IN THE SECTION PROVIDED BELOW**

- a. Is any female to be covered currently pregnant?  Yes  No

b. If you are a male listed on this application, are you expecting a child with anyone, even if the mother is not listed on the application?  Yes  No

c. If yes to "a" or "b", is there current or a history of complications or multiple gestation birth?  Yes  No
- In the last five years, have you or any eligible dependents incurred a claim in excess of \$5,000?  Yes  No
- Within the past five years, has any person to be insured been diagnosed or treated by a physician or member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?  Yes  No
- Is any person to be insured disabled, hospital confined, receiving treatment, taking medication, or been advised of a condition that will require attention or routine follow-up in the next 24 months?  Yes  No
- Within the past five years, has any person to be insured been diagnosed, had symptoms, had testing completed, had treatment, taken medications or had routine follow-up for any of the following: Cancer/Tumor, Diabetes, Heart/Blood/Vascular Disorder, Kidney Disorder, Liver Disorder, Neurological Disease, Respiratory-Lung Disorder, Stroke, Systemic Lupus/Multiple Sclerosis, Transplants, or Mental or Emotional Disorder?  Yes  No
- Are you currently on continuation coverage from a former employer?  Yes  No  
If "Yes":  Federal COBRA  Cal-COBRA

**For groups enrolling 2-10 employees or late enrollees, complete the following Additional Medical History Section below.**

Within the past five years, has any person to be insured ever had any symptoms, diagnosis, consultation, treatment, or taken any medication or received counseling for...		
A. Alcohol/Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No	G. Digestive/Eating Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	M. Muscle Disorder/Neurological Disease ... <input type="checkbox"/> Yes <input type="checkbox"/> No
B. Arthritis/Back/Joint Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	H. Ear/Eye Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	N. Skin Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
C. Asthma/Tobacco Usage <input type="checkbox"/> Yes <input type="checkbox"/> No	I. Epilepsy/Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No	O. Thyroid/Adrenal Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No
D. Blood Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	J. Genital/Urinary Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	P. Tuberculosis/Hepatitis A, B or C <input type="checkbox"/> Yes <input type="checkbox"/> No
E. Breast Disorder or Breast Implants <input type="checkbox"/> Yes <input type="checkbox"/> No	K. High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Q. Sleep Apnea <input type="checkbox"/> Yes <input type="checkbox"/> No
F. Congenital Disorder or Deformity <input type="checkbox"/> Yes <input type="checkbox"/> No	L. Infertility <input type="checkbox"/> Yes <input type="checkbox"/> No	R. Systemic Infection <input type="checkbox"/> Yes <input type="checkbox"/> No

**Detailed Answers to Questions 1-5 and the Additional Medical History Section**

- Pregnant persons and expected due dates: \_\_\_\_\_
- Provide full details to all "Yes" answers noted above. Attach a separate page if necessary.

Eligible Person	Nature of Illness/Injury	Month/Year	Medication/ Treatment	Recovered? (Yes or No)	Explanation/Comments
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Authorization**

I agree: All information on this form is correct and true, to the best of my knowledge and belief. I further authorize my employer to deduct from my earnings any contribution required to apply toward the cost of this plan. I certify that I am working at the employer's place of business in permanent employment at least 30 hours per week (or 20-29 hours per week if elected by my employer).

On behalf of myself and the eligible persons listed herein, I acknowledge that I have read and understand this form in its entirety.

Employee Signature	Date
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Employee Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
Company Name \_\_\_\_\_ Group # \_\_\_\_\_

Source Code	Tracking #
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## Declination of Coverage Form

**Complete this section if any coverage is to be declined by you or your eligible dependents.**

Unless one of the three circumstances set forth below applies to you, failure to enroll during the initial enrollment period will permit the plan to treat you as a Late Enrollee and to impose a 12-month waiting period at the time you decide to enroll.

I certify that the reason I am declining enrollment in PacifiCare's Group Health Plan is: (check, as applicable)

- I am covered under another group ( health plan  dental plan  vision plan) offered to my spouse/Domestic Partner.
- I am covered under another group ( health plan  dental plan  vision plan) offered by my EMPLOYER.
- I am covered under an Individual ( health plan  dental plan  vision plan).
- I am declining because \_\_\_\_\_
- I am declining the health plan for my spouse/Domestic Partner, name \_\_\_\_\_, because \_\_\_\_\_
- I am declining for my child/children:
  - ( health plan  dental plan  vision plan) name \_\_\_\_\_, because \_\_\_\_\_
  - ( health plan  dental plan  vision plan) name \_\_\_\_\_, because \_\_\_\_\_
  - ( health plan  dental plan  vision plan) name \_\_\_\_\_, because \_\_\_\_\_

### If I or one of my dependents have declined coverage as listed above:

I understand that in the event I and/or my eligible dependents choose to enroll in a PacifiCare plan at a later date, we may be considered "Late Enrollees" and may have to wait for coverage for a period of twelve (12) months after the date we enroll, or the next open enrollment period.

I have been informed that under the three following circumstances, I and my eligible dependents will not be considered Late Enrollees, and thus will not have to wait for a period of twelve (12) months after we enroll in PacifiCare:

1. OTHER EMPLOYER health plan COVERAGE. You and your dependents (collectively "You") shall not be considered Late Enrollees if:
  - a. You are currently covered under another employer health plan ("Plan") although You are also eligible to enroll in a PacifiCare plan;
  - b. You certify in writing on this Declination of Coverage that You are declining PacifiCare coverage because You are already covered under another group Plan;
  - c. You learn at a later date that You have lost or will lose coverage under the other Plan because of:
    - (1) the termination of your employment or the employment of the person through whom You are covered as a dependent;
    - (2) a change in your employment status or the employment status of the person through whom You are covered as a dependent;
    - (3) the termination of coverage under the other Plan;
    - (4) the termination of an employer's monetary contribution toward your coverage under the other Plan;
    - (5) the death of the person through whom You are covered as a dependent;

- (6) the legal separation or divorce; or
  - (7) loss of no share-of-cost Medi-Cal coverage from the person through whom You are covered as a dependent; and
  - (8) your declination of coverage when enrollment was previously offered and you subsequently acquired a dependent;
  - (9) the termination of coverage under the other Plan for your dependent(s); and
- d. You request enrollment no later than thirty (30) days after termination of your coverage under the other Plan due to one of the reasons stated here in subsection 1(c).

If You meet each of the requirements listed above, You will not be classified as a Late Enrollee and will not have to wait twelve (12) months after You enroll.

2. MULTIPLE PLANS. If your employer offers one or more other plans and You enrolled in one of such Plans during an open enrollment period, You will not be classified as a Late Enrollee if You enroll in PacifiCare at a later date.
3. COURT ORDER. You and your spouse/Domestic Partner and/or minor child will not be classified as Late Enrollees if a court has ordered that coverage be provided for a spouse or minor child under an employee's health plan. PacifiCare will enroll a Dependent child within thirty (30) days after receipt of a court order or request from the district attorney, either parent or the person having custody of the child as defined in Section 3751.5 of the Family Code, the employer or the group administrator. In the case of children who are eligible for Medicaid, the State Department of Health Services may also make the request.

**My signature on the inside of this form represents that I have read, understand and agree to the terms and conditions listed above.**

**Signature – I have read, understand and agree to the above Declination of Coverage**

Signature (Required)

X

Date (Required)