PAN AMERICAN LIFE INSURANCE GROUP

GROUP EMPLOYEE ENROLLMENT FORM

SELECT YOUR PLAN

Plan Plan 1 ☑ Yes ☐ No

YOUR EMPLOYMENT INFORMATION

Employer	Location	Hired Date	Group Number
Calaveras County, IHSS Public Authority	Calaveras IHSS		98254

Current Status: ☐ Full Time ☐ Part Time _____ (Hours per week) ☒ Other IHSS Eligible

Effective Date - TPA will complete this date

PERSONAL INFORMATION

Last Name	First Name	MI	Sex ☐ M ☐ F	Social Security #

Address	City	State	Zip Code

Date of Birth	Phone Number	Email Address	Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Registered Domestic Partner

Language Preference ☐ English ☐ Spanish

OPTIONAL
Ethnic Origin: ☐ Hispanic ☐ Non-Hispanic

COVERAGE REQUESTED

☒ Member Only Member Only Coverage

AUTHORIZATION AND SIGNATURE

I hereby declare that I am an Employee of the Plan Sponsor indicated above and that I work at or from the employment location indicated. All information given by me on this form at Pan-American Life Insurance Company's request is true and complete and is offered to Pan-American Life Insurance Company as inducement to grant insurance.

I understand and agree that I will not have coverage unless I am Actively at Work on the effective date of coverage.

☐ I have been given the opportunity to apply for this insurance, but do not desire to participate.
I WAIVE coverage on: ☐ Myself

For California Residents:
☐ I also certify that by declining coverage during this initial enrollment period that I am excluded from enrolling in coverage for a period of 12 months.

"California Law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage"

For Hawaii and Maine residents: Coverage is not available.

Employee Name: _____ **Date:** _____

Signature of Employee: _____

IMPORTANT – PLEASE **Sign the Compass authorization form on the other side**

v2.16

AUTHORIZATION TO USE AND DISCLOSE PRIVATE HEALTH INFORMATION

Phone/Fax: 800.513.1667

I hereby authorize all licensed health care practitioners, my health plan, and other persons who have participated in providing or paying for any health care service to me to disclose my individually identifiable health information as described below to **Compass Professional Health Services (also doing business as Life Account LLC) and/or specific health care providers as instructed by Compass PHS**. I authorize for **Compass PHS** to act on my behalf in gathering the information necessary to analyze and resolve billing or benefit questions.

I understand that:

a) Compass PHS will acquire and maintain my personal health information solely for the purpose of my continuing medical care and analysis and resolution of billing and benefit issues. My signature to execute this Authorization is voluntary.
b) Treatment, payment, or eligibility cannot be conditioned on my signing this Authorization.
c) Information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected.
d) This Authorization will remain in effect until twelve months after the signature date below.
e) I can revoke this authorization at any time by sending written notice to Compass PHS, 3102 Oak Lawn Ave, Ste 250., Dallas, TX 75219. The revocation will not affect any actions taken before the receipt of the written revocation.

First: _____ Last: _____ MI: ____ ____/____/____ M ☐ F ☐

Legal Name ***Date of Birth*** ***Sex***

_____

Address ***City*** ***State*** ***Zip***

_____ _____

Email Address ***Phone***

First: _____ Last: _____ MI: ____ Amador County IHSS

Compass Member Name *(if different)* ***Employer***

	Insurance Company *(ex. Aetna)*	***Customer Service Phone Number*** *(back of your insurance card)*	***Group #***	***Member ID #***
Medical	**Pan American**	877-569-3075	98254	
Dental	**Pan American**	877-569-3075	98254	
Vision	**Pan American**	877-569-3075	98254	

I understand that Compass PHS:

- Provides services directly to me. My employer is in no way responsible for the actions and/or results of service from Compass PHS. **As such, Compass PHS is committed to protecting my privacy and will not share my personal information with my employer or an unauthorized third party without my express consent.**
- Is not a provider of medical or health care and does not practice medicine or give medical advice. My providers, who are not employees of Compass PHS, and I are responsible for verifying the accuracy of all information gathered, generated, and provided by Compass PHS with regards to my health.
- Compass PHS should not be used in situations requiring urgent or emergent care.

_____ ____/____/____ ☐☐☐☐

Signature OR Printed Name of Legal Representative ***Date*** ***Last 4 of Social***

_____ _____

Signature of Legal Representative (if not signed by patient) *Relationship to Patient (if not signed by patient)*

A photocopy of this document is as sufficient as the original.