Landmark Healthplan of California, Inc.
1750 Howe Avenue, Suite 300
Sacramento, CA 95825
(800) 638-4557

Enrollment Form

Employer Group ______________________________
Date of Hire ____/____/____
Coverage Effective Date ____/____/____

PLEASE PRINT ALL INFORMATION

! **EMPLOYEE DATA**

Social Security Number ______ – _____ – __________

( ) Home Phone

( ) Work Phone

Last name First name M.I.

Birthdate

Street address, including apartment number

Age

City State Zip

Sex ○M ○ F

2 ! **MEMBER INFORMATION** (List spouse, then children in order of age, oldest first)

Last name	First name	M.I.	Birthdate	Age	Sex
			/ /		○ M ○ F
			/ /		○ M ○ F
			/ /		○ M ○ F
			/ /		○ M ○ F
			/ /		○ M ○ F
			/ /		○ M ○ F
			/ /		○ M ○ F

I authorize all health care providers through whom I and/or my dependents have coverage, to release to Landmark Healthplan California, Inc. information regarding my claims for coverage under current policies issued by both companies. I understand that the purpose of this release of information is to assure appropriate coordination of benefits due me under both certificates. I further understand that copies of the authorization shall be as valid as originals.

I understand that claims for money damages for bodily injury, mental disturbance or death arising out of the alleged rendition of or failure to render services by Landmark Healthplan California, Inc. practitioners or other personnel or facilities must be submitted to binding arbitration instead of a court trial.

Enrollment and membership are subject to the regulations of Landmark Healthplan California, Inc. Refer to descriptive literature or to group master contract.

In the event that this application for coverage is accepted, I authorize any health services practitioner to give Landmark Healthplan California, Inc. upon request, if permitted by law, information concerning the health condition or treatment of any person included under such coverage whenever such information is considered necessary by the Plan for the proper disposition of a claim submitted for payment or in fulfillment of obligations imposed on Landmark Healthplan California, Inc. by state or federal statutes. A photocopy of this authorization is considered as valid as the original.

Signature ____ **Today's date** ________________

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