PacificSource HEALTH PLANS

Select a Medical Plan that's the **Right Fit for You**

This form can be used to select your medical plan (if you are offered more than one) as well as select a primary care provider (PCP), if the plan you choose requires you to select one.

Please complete all sections, sign and date, and return this form before the end of your enrollment period to avoid possible enrollment delays.

Para asistirle en español, por favor llame al numero (800) 624-6052, ext. 1009, de Lunes a Viernes.

Employer Information (please print)

Employer/Group Name _____

Employer/Group Number _____ Effective Date _____

Employee Information (please print)

First Name _____ Last Name _____

Social Security or Member ID Number (see ID card) _____

Preferred Medical Plan (please choose one, if more than one plan is offered)

☐ _____

☐ _____

☐ _____

☐ _____

☐ _____

For an overview of covered services, deductible, co-payments, co-insurance, nonparticipating provider benefits, and additional details, please see the summary of benefits for each plan. While we recommend all members select a primary care provider (PCP), some plans require a PCP selection for each enrolled family member. Please provide that selection below. Use the back of the form for additional space, if needed.

Name	**Primary Care Provider**	**Current Patient?**
Employee		☐ Yes ☐ No
Spouse/ Domestic Partner		☐ Yes ☐ No
Dependent Child		☐ Yes ☐ No
Dependent Child		☐ Yes ☐ No
Dependent Child		☐ Yes ☐ No
Dependent Child		☐ Yes ☐ No

Signature and Date (please sign and date this form to confirm your choice)

Signature _____ Date _____