



**Benefits Administered By
PINNACLE CLAIMS MANAGEMENT, INC.
17620 Fitch Street, Irvine, CA 92614**

ENROLLMENT CARD

- New
- Name Change
- Change of Address
- Change of Beneficiary
- Add/Delete Dependents
- Other
- Effective Date _____
- Change in Type of Coverage

Employer Use Only Group # _____ Work Location # _____

* Please attach any certificates of coverage for all family members.

Please fill in all requested information. Print clearly in blue or black ink and press hard for clear copies.

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NO.	BIRTHDATE
			- -	Mo. Day Yr.
ADDRESS	CITY	STATE	ZIP	PHONE
			()	SEX <input type="checkbox"/> M <input type="checkbox"/> F
TYPE OF COVERAGE:	<input type="checkbox"/> MEDICAL <input type="checkbox"/> ADD <input type="checkbox"/> DELETE	<input type="checkbox"/> DENTAL <input type="checkbox"/> ADD <input type="checkbox"/> DELETE	<input type="checkbox"/> VISION <input type="checkbox"/> ADD <input type="checkbox"/> DELETE	<input type="checkbox"/> LIFE _____ Amount <input type="checkbox"/> ADD <input type="checkbox"/> DELETE
EMPLOYER	JOB TITLE		DATE OF HIRE	
CHECK ONE	<input type="checkbox"/> MARRIED	DATE OF MARRIAGE	<input type="checkbox"/> WIDOWED	<input type="checkbox"/> SINGLE
		Mo. Day Yr.		<input type="checkbox"/> DIVORCED

Please list all eligible family members to be enrolled. Attach additional sheets if necessary. If dependents are over the age of 19 and a full time student, or disabled, verification must be attached.

DEPENDENT INFORMATION	TYPE OF COVERAGE	LAST NAME	FIRST NAME	MI	BIRTHDATE	DISABLED?
<input type="checkbox"/> Add <input type="checkbox"/> Husband <input type="checkbox"/> Delete <input type="checkbox"/> Wife	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Add <input type="checkbox"/> Delete				Mo. Day Yr.	Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/> Add <input type="checkbox"/> Son <input type="checkbox"/> Delete <input type="checkbox"/> Daughter	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Add <input type="checkbox"/> Delete				Mo. Day Yr.	Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/> Add <input type="checkbox"/> Son <input type="checkbox"/> Delete <input type="checkbox"/> Daughter	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Add <input type="checkbox"/> Delete				Mo. Day Yr.	Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/> Add <input type="checkbox"/> Son <input type="checkbox"/> Delete <input type="checkbox"/> Daughter	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Add <input type="checkbox"/> Delete				Mo. Day Yr.	Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/> Add <input type="checkbox"/> Son <input type="checkbox"/> Delete <input type="checkbox"/> Daughter	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Add <input type="checkbox"/> Delete				Mo. Day Yr.	Yes <input type="checkbox"/> No <input type="checkbox"/>

REFUSAL OF COVERAGE WAIVER: Please check all of the appropriate boxes and sign below.)

I have been given the opportunity to participate in the Group Health Care Plan and:

- I wish **not** to enroll in the total plan of benefits
- I wish **not** to enroll my Dependent(s) in the total plan of benefits. Please indicate above as a Delete action for those dependents who you are declining coverage for.
- I wish to enroll for _____ coverage only and waive the Medical coverage for Myself and Eligible Dependents.
- I certify that at this time coverage under another employer health benefit plan is my reason for declining coverage under this Group Health Plan.

Please refer to your Plan Document for additional information on Eligibility, Rehire, and Termination provisions under your Group Health Plan.

If son or daughter is 19 years of age and older and attending school full-time, please complete the following and attach verification. Please refer to Plan Document for additional information on eligible dependents and full-time students.

Name of Child: _____ Name Of School: _____ Number Of Units: _____

Do any family members have Health coverage with another carrier? YES NO Carrier: _____

LIFE INSURANCE BENEFICIARY NAME/RELATIONSHIP		
LAST	FIRST	RELATIONSHIP

I have accurately and completely given all applicable information requested on this form. I authorize any insurance company, physician, hospital, clinic or health care provider to give PCMI or its designated agent any and all records pertaining to any medical history, services or treatment provided to anyone listed on this form for purpose of review, investigation or evaluation. I hereby authorize payroll deductions for my share of the cost, if any, of the benefits to which I may become entitled.

EMPLOYEE'S SIGNATURE _____

DATE _____

TEMPORARY ID CARD

PINNACLE CLAIMS MANAGEMENT, INC.

17620 Fitch Street, Irvine, CA 92614

Customer Service (800) 649-9121

Utilization Review (800) 777-9428

This card is for identification only and does
not guarantee eligibility.

This card is void when your permanent
plastic card is mailed to you or your employer.

PERSON CODE DETERMINATION:

00 = Cardholder

30-39 = Female spouse

40-49 = Male spouse

50-59 = Female children

60-69 = Male children

RX INFO:

Processor: 600471 RESTAT Plan 0511

RESTAT CUSTOMER SERVICE 1-800-248-1062

(Applicable if pharmacy benefits were selected)

Welcome to
Pinnacle Claims Management, Inc.



*To help speed your claims processing, please complete the attached enrollment card as accurately and completely as possible.
After enrollment is completed by PCMI, we will issue you an identification card.*

*A new enrollment card must be completed if any of the information changes; new dependents must be added within 31 days from
date of birth, marriage or adoption.*