American Marketing Administrators Inc
For: American Federal Employees Group
23901 Calabasas Road, Suite 2014
Calabasas,CA,91302
info@fedvp.com
www.fedvp.com

Enrollment Form

❑ New Member

❑ Update to Existing Member

PLEASE PRINT ALL INFORMATION

Employer Group _____

Date of Hire _____

Effective Date _____

EMPLOYEE DATA

_____ - _____ - _____ (_____) _____ (_____) _____

Social Security Number **Home Phone** **Work Phone**

_____ _____ _____ ❑ Male ❑ Female

Last Name **First Name** **M.I.** **Birth date (mm / dd / yyyy)** **Age** **Gender**

_____

Street address, including apartment #

_____

City, State Zip

DEPENDENT INFORMATION *(List spouse or registered domestic partner, then children from oldest to youngest.)*

Last Name	First Name	M.I.	Birth date (mm / dd / yyyy)	Age	Gender
			_____/_____/_____		❑ Male ❑ Female
			_____/_____/_____		❑ Male ❑ Female
			_____/_____/_____		❑ Male ❑ Female
			_____/_____/_____		❑ Male ❑ Female
			_____/_____/_____		❑ Male ❑ Female
			_____/_____/_____		❑ Male ❑ Female

Terms and conditions of enrollment are described in your Landmark Healthplan of California, Inc. (the "Plan") Combined Evidence of Coverage and Disclosure Form, and the Group Agreement between the Plan and your Employer Group.

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In the event that this application for coverage is accepted, I authorize any health care practitioner, as permitted by law, to provide the Plan with information concerning the health condition or treatment of any enrollee named above, as required for the Plan to authorize or pay for covered services provided by such practitioner.

I further authorize the Plan and any other health care plan through which I and/or my dependents have coverage to release any information to one another that would be necessary to coordinate benefits between or among the plans.

With regard to the authorizations above, I agree that a copy of this form shall be as valid as the original.

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 LANDMARK HEALTHPLAN OF CALIFORNIA, INC., 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_____ **Today's Date**_____

Landmark Healthplan of California, Inc., can provide you free language assistance to help you use your chiropractic or acupuncture benefit. Just tell your chiropractor or acupuncturist you would like this assistance when you make your appointment, or call Landmark at 1-800-298-4875 between 5:30 AM and 5 PM, Monday through Friday.

We want to provide you with excellent service so are asking for your help. By answering the following questions you will help us understand what language you prefer when we speak or write to you about your chiropractic or acupuncture benefits. A new California law requires us to ask you these questions. Please do your best to answer completely. You can use an extra sheet of paper if needed.

1) ***Are you and your family of Latino or Hispanic descent? List each family member by name and mark "NO" or "YES".*** ☐ **DECLINE TO STATE.**

FULL NAME OF FAMILY MEMBER	**NO**	**YES (please tell us from where?)**
Your name:		

2) ***Of what race are you and your family? You may mark more than one box if you or your family members are of mixed race.***

Yourself: ☐American Indian/Alaska Native ☐Black/African American ☐White/Caucasian ☐Native Hawaiian/Pacific Islander ☐Asian ☐Other ☐Decline to State

Other Family Members by Name:

_____ ☐American Indian/Alaska Native ☐Black/African American ☐White/Caucasian ☐Native Hawaiian/Pacific Islander ☐Asian ☐Other ☐Decline to State

_____ ☐American Indian/Alaska Native ☐Black/African American ☐White/Caucasian ☐Native Hawaiian/Pacific Islander ☐Asian ☐Other ☐Decline to State

_____ ☐American Indian/Alaska Native ☐Black/African American ☐White/Caucasian ☐Native Hawaiian/Pacific Islander ☐Asian ☐Other ☐Decline to State

_____ ☐American Indian/Alaska Native ☐Black/African American ☐White/Caucasian ☐Native Hawaiian/Pacific Islander ☐Asian ☐Other ☐Decline to State

3) ***What language do you prefer we use to communicate with you and the other members of your family? List each family member by name, and indicate language preference.***

FULL NAME OF FAMILY MEMBER	**SPOKEN LANGUAGE**	**WRITTEN LANGUAGE**
Your name:		