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Landmark Healthplan of California, Inc.
2629 Townsgate Rd., Suite 235, Westlake Village, CA 91361
Phone: 800-298-4875 | Fax: 916-307-5250
Submit to: https://LHP-CA.secureemailportal.com/
GroupServices@LHP-CA.com

Enrollment Form

PLEASE PRINT or TYPE

Employer/Group Information

Group Policy Information

Group Name:

Group Number:

Enrollment Action Desired

☐ Enroll New Employee ☐ Update Existing Employee

Group Eligibility & Service Contact:

Name:

Title:

Phone: Fax:

E-mail:

Employee Information

Employee Hire Date: / / (MM/DD/YYYY) Benefits Effective Date: / / (MM/DD/YYYY)

Social Security No.: - - Birth Date: / / Age: Gender: (Male/Female/X-Nonbinary)

Employee Name: First: Last: Middle Initial:

Address:

City: State: Zip Code: -

Phone: - - Work: - - E-mail:

Employee Dependent Information

First Name	Last Name	M.I.	Birth Date (MM/DD/YYYY)	Age	Relationship	Gender
			/ /		Spouse/Partner	(M/F/X)
			/ /		Dependent	(M/F/X)
			/ /		Dependent	(M/F/X)
			/ /		Dependent	(M/F/X)
			/ /		Dependent	(M/F/X)
			/ /		Dependent	(M/F/X)

Acceptance of Terms and Conditions

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.

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: MM / DD / YYYY

Ethnicity, Race & Language Survey

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 8:30 AM and 5:00 PM, Monday through Friday.

California law requires that we ask you these questions, please do your best to answer completely for yourself and your dependents. You can use an extra sheet of paper if needed.

Yourself: ____

Are you of Latino or Hispanic descent? Yes: ☐ No: ☐

Of what race are you? *You may make more than one choice.*

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

What is your preferred Language?

Spoken: ____
Written: ____

☐ Check if your answers are the same for all dependents.

Dependent: ____

Are you of Latino or Hispanic descent? Yes: ☐ No: ☐

Of what race are you? *You may make more than one choice.*

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

What is your preferred Language?

Spoken: ____
Written: ____

Complete for each enrolled dependent if different from yourself.

Dependent: ____

Are you of Latino or Hispanic descent? Yes: ☐ No: ☐

Of what race are you? *You may make more than one choice.*

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

What is your preferred Language?

Spoken: ____
Written: ____

Dependent: ____

Are you of Latino or Hispanic descent? Yes: ☐ No: ☐

Of what race are you? *You may make more than one choice.*

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

What is your preferred Language?

Spoken: ____
Written: ____

Dependent: ____

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Of what race are you? *You may make more than one choice.*

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☐ Asian ☐ Native Hawaiian/Pacific Islander
☐ Black/African American ☐ Other ☐ Decline to state

What is your preferred Language?

Spoken: ____
Written: ____

Dependent: ____

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Of what race are you? *You may make more than one choice.*

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☐ Asian ☐ Native Hawaiian/Pacific Islander
☐ Black/African American ☐ Other ☐ Decline to state

What is your preferred Language?

Spoken: ____
Written: ____

Thank you for completing the survey!