

SMALL BUSINESS GROUP ENROLLMENT AND CHANGE FORM

Medical and Life/AD&D plans are provided by Health Net of California, Inc. and/or Health Net Life Insurance Company (together, the “Health Net Entities”). Dental plans are provided by SafeGuard Health Plans, Inc. and/ or its affiliate, SafeHealth Life Insurance Company, (together “SafeGuard Entities”). Vision plans are provided by Fidelity Security Life Insurance Company and serviced by Eyemed Vision Care LLC (together the “Fidelity Entities”).

Neither the SafeGuard Entities nor The Fidelity Entities are affiliated with the Health Net Entities. Obligations under dental and vision plans are not obligations of, and are not guaranteed by, the Health Net Entities.

Welcome to Health Net

SIMPLE STEPS FOR COMPLETING THE FORM:

- 1) Review the materials enclosed in your enrollment packet. Be sure that you understand the coverage options that are available to you by your employer.
- 2) Carefully review and select the plan option(s) that are best for you and your covered family members.
- 3) If you choose to enroll in the HMO, HMO Silver Network, HMO Salud con Health Net, SELECT (POS), ELECT Open Access (EOA) or Dental HMO (DHMO), you must select your dental provider, physician group and primary care physician. Be sure to fill in the names and numbers as they appear in the HMO Health Net Directory of Providers, or call the Customer Contact Center from 8:00 a.m.- 6:00 p.m., Monday through Friday for assistance.

Small Business Group (English): 1-800-361-3366

Small Business Group (Spanish): 1-800-331-1777

Health Net Life: 1-800-865-6288

Health Net Dental: 1-800-880-8113

Health Net Vision: 1-866-392-6058

- 4) If you choose to select PPO or Flex Net, you are not required to select a primary care physician or physician group to enroll.

Post Office Box 9103

Van Nuys, California 91409-9103

www.healthnet.com

HEALTH NET SMALL BUSINESS GROUP ENROLLMENT AND CHANGE FORM

(For enrollment, sections 1, 2, and 8 are required. For waivers, only section 7 is required.)

EMPLOYER NAME

EFFECTIVE DATE **EMPLOYER GROUP NUMBER (Medical)**

SOCIAL SECURITY NUMBER

IMPORTANT: PLEASE PRINT ALL SECTIONS IN BLACK INK.

1 SELECTED COVERAGE

PPO	HSA	HMO	HMO SILVER NETWORK	EOA	EOA SILVER NETWORK	H ^a OPTIONS	SALUD CON HEALTH NET
Standard	Standard	Standard	Standard	Standard	Standard	<input type="checkbox"/> Options PPO 250	Salud HMO y Más¹
<input type="checkbox"/> PPO 10	<input type="checkbox"/> HSA 2000	<input type="checkbox"/> HMO 10	<input type="checkbox"/> HMO 10	<input type="checkbox"/> EOA 10	<input type="checkbox"/> EOA 10	<input type="checkbox"/> Options PPO 500	<input type="checkbox"/> Salud HMO y Más 15
<input type="checkbox"/> PPO 20	<input type="checkbox"/> HSA 3000	<input type="checkbox"/> HMO 20	<input type="checkbox"/> HMO 10	<input type="checkbox"/> EOA 20	<input type="checkbox"/> EOA 20	<input type="checkbox"/> Options PPO 1500	<input type="checkbox"/> Salud HMO y Más 25
<input type="checkbox"/> PPO 30	<input type="checkbox"/> HSA 4000	<input type="checkbox"/> HMO 30	<input type="checkbox"/> HMO 20	<input type="checkbox"/> EOA 30	<input type="checkbox"/> EOA 20	<input type="checkbox"/> Options PPO 1750	
<input type="checkbox"/> PPO 40	Value	<input type="checkbox"/> HMO 40	<input type="checkbox"/> HMO 30	<input type="checkbox"/> EOA 40	<input type="checkbox"/> EOA 30	<input type="checkbox"/> Options PPO 3000	<input type="checkbox"/> Salud PPO ²
Value	<input type="checkbox"/> HSA 1500	Value	<input type="checkbox"/> HMO 40	Value	<input type="checkbox"/> EOA 40	(HSA compatible)	<input type="checkbox"/> Salud EPO ²
<input type="checkbox"/> PPO 10	<input type="checkbox"/> HSA 2500	<input type="checkbox"/> HMO 10	Value	<input type="checkbox"/> EOA 10	Value	<input type="checkbox"/> Options PPO 4000	<input type="checkbox"/> Salud Mexico ³
<input type="checkbox"/> PPO 20	<input type="checkbox"/> HSA 3500	<input type="checkbox"/> HMO 20	<input type="checkbox"/> HMO 10	<input type="checkbox"/> EOA 20	<input type="checkbox"/> EOA 10	(HSA compatible)	
<input type="checkbox"/> PPO 30	<input type="checkbox"/> HSA 4500	<input type="checkbox"/> HMO 30	<input type="checkbox"/> HMO 20	<input type="checkbox"/> EOA 30	<input type="checkbox"/> EOA 20	<input type="checkbox"/> Options EOA 25	FLEX NET
<input type="checkbox"/> PPO 40		<input type="checkbox"/> HMO 40	<input type="checkbox"/> HMO 30	<input type="checkbox"/> EOA 40	<input type="checkbox"/> EOA 30	<input type="checkbox"/> Options EOA 35	<input type="checkbox"/> Indemnity
			<input type="checkbox"/> HMO 40		<input type="checkbox"/> EOA 40	<input type="checkbox"/> Options HMO 25	(Out of service area only)
						<input type="checkbox"/> Options HMO 35	
						<input type="checkbox"/> Options HMO 25 Silver	
						<input type="checkbox"/> Options HMO 35 Silver	

DENTAL **DHMO**

HN Value Plan _____

HN Plus Plan _____

DPPO

Plus Plan _____

Preferred Value Plan _____

Value Plan _____

VISION PPO

Preferred 1025-2

Preferred 1025-3

Value 10-2

¹Available in Orange and select ZIP codes of Los Angeles, Riverside, San Bernardino and San Diego counties.

²Available in Los Angeles, Orange and Ventura counties.

³Available in select ZIP codes of San Diego and Imperial counties.

REASON FOR CHANGE:

- Plan change Change address/name
- Delete dependent (list names below)
- Other _____

REASON FOR APPLICATION:

- New hire Date of hire ____/____/____
- Open Enrollment Loss of prior coverage date ____/____/____
- COBRA⁴ effective date ____/____/____
- Add dependent: Qualifying event _____
- Qualifying event date ____/____/____

⁴Generally, employers who normally employed 20 or more employees during the previous calendar year are subject to federal COBRA. Employers who employed 2-19 employees on at least 50% of its working days the previous calendar year are subject to Cal-COBRA. Please consult your legal counsel if you need help determining which law applies to you.

2 EMPLOYEE PERSONAL INFORMATION

Last Name		First Name		M.I.	<input type="checkbox"/> Male <input type="checkbox"/> Female
Residence Address			City	State	Zip
Date of Birth Mo/Day/Yr		Social Security #/Matricular ID#		Job Title	
Telephone No. () ()		Work Phone No. () ()		Email Address	
Date of Hire / /	Class	Dept. no.	Employment Status <input type="checkbox"/> Salaried <input type="checkbox"/> Hourly	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner	
Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B		Participating Physician Group/PPG#		Health Net Primary Care Physician/PCP#	
Physician Name (First, Last)				Is this your current M.D.? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental HMO Provider ID#

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3 FAMILY INFORMATION Please list all eligible family members to be enrolled.
(Attach additional sheets if necessary)

<input type="checkbox"/> Spouse	<input type="checkbox"/> M	Last Name	First Name	M.I.
<input type="checkbox"/> Domestic Partner	<input type="checkbox"/> F			
Residence Address <input type="checkbox"/> Check here if same as subscriber		City	State	Zip
Date of Birth Mo/Day/Yr		Social Security #/Matricular ID #		
Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B		Overage Dependent Type Not Applicable		Participating Physician Group/PPG#
Health Net Primary Care Physician/PCP#		Physician Name (First, Last)	Is this your current M.D.? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental HMO Provider ID#
<input type="checkbox"/> Son		Last Name	First Name	M.I.
<input type="checkbox"/> Daughter				
Residence Address <input type="checkbox"/> Check here if same as subscriber		City	State	Zip
Date of Birth Mo/Day/Yr		Social Security #/Matricular ID #		
Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B		Overage Dependent Type <input type="checkbox"/> Disabled <input type="checkbox"/> Full-time Student <input type="checkbox"/> Over 50% support		Participating Physician Group/PPG#
Health Net Primary Care Physician/PCP#		Physician Name (First, Last)	Is this your current M.D.? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental HMO Provider ID#
<input type="checkbox"/> Son		Last Name	First Name	M.I.
<input type="checkbox"/> Daughter				
Residence Address <input type="checkbox"/> Check here if same as subscriber		City	State	Zip
Date of Birth Mo/Day/Yr		Social Security #/Matricular ID #		
Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B		Overage Dependent Type <input type="checkbox"/> Disabled <input type="checkbox"/> Full-time Student <input type="checkbox"/> Over 50% support		Participating Physician Group/PPG#
Health Net Primary Care Physician/PCP#		Physician Name (First, Last)	Is this your current M.D.? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental HMO Provider ID#
<input type="checkbox"/> Son		Last Name	First Name	M.I.
<input type="checkbox"/> Daughter				
Residence Address <input type="checkbox"/> Check here if same as subscriber		City	State	Zip
Date of Birth Mo/Day/Yr		Social Security #/Matricular ID #		
Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B		Overage Dependent Type <input type="checkbox"/> Disabled <input type="checkbox"/> Full-time Student <input type="checkbox"/> Over 50% support		Participating Physician Group/PPG#
Health Net Primary Care Physician/PCP#		Physician Name (First, Last)	Is this your current M.D.? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental HMO Provider ID#
<input type="checkbox"/> Son		Last Name	First Name	M.I.
<input type="checkbox"/> Daughter				
Residence Address <input type="checkbox"/> Check here if same as subscriber		City	State	Zip
Date of Birth Mo/Day/Yr		Social Security #/Matricular ID #		
Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B		Overage Dependent Type <input type="checkbox"/> Disabled <input type="checkbox"/> Full-time Student <input type="checkbox"/> Over 50% support		Participating Physician Group/PPG#
Health Net Primary Care Physician/PCP#		Physician Name (First, Last)	Is this your current M.D.? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental HMO Provider ID#
<input type="checkbox"/> Son		Last Name	First Name	M.I.
<input type="checkbox"/> Daughter				
Residence Address <input type="checkbox"/> Check here if same as subscriber		City	State	Zip
Date of Birth Mo/Day/Yr		Social Security #/Matricular ID #		
Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B		Overage Dependent Type <input type="checkbox"/> Disabled <input type="checkbox"/> Full-time Student <input type="checkbox"/> Over 50% support		Participating Physician Group/PPG#
Health Net Primary Care Physician/PCP#		Physician Name (First, Last)	Is this your current M.D.? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental HMO Provider ID#

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4 DO YOU OR YOUR DEPENDENTS HAVE OTHER HEALTH CARE COVERAGE?

If yes, please complete this section including Medicare.

<input type="checkbox"/> Self	Name	Name of Other Insurance Carrier			Prior Coverage Start Date Mo/ Day / Yr		
Prior Coverage End Date Mo/ Day / Yr	Reason for Ending Coverage	Group #/Policy ID #	Does it cover? Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare Claim/ HICN #	
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	Name	Name of Other Insurance Carrier			Prior Coverage Start Date Mo/ Day / Yr		
Prior Coverage End Date Mo/ Day / Yr	Reason for Ending Coverage	Group #/Policy ID #	Is this your dependent's primary coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does it cover? Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare Claim/ HICN #
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Name	Name of Other Insurance Carrier			Prior Coverage Start Date Mo/ Day / Yr		
Prior Coverage End Date Mo/ Day / Yr	Reason for Ending Coverage	Group #/Policy ID #	Is this your dependent's primary coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does it cover? Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare Claim/ HICN #
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Name	Name of Other Insurance Carrier			Prior Coverage Start Date Mo/ Day / Yr		
Prior Coverage End Date Mo/ Day / Yr	Reason for Ending Coverage	Group #/Policy ID #	Is this your dependent's primary coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does it cover? Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare Claim/ HICN #
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Name	Name of Other Insurance Carrier			Prior Coverage Start Date Mo/ Day / Yr		
Prior Coverage End Date Mo/ Day / Yr	Reason for Ending Coverage	Group #/Policy ID #	Is this your dependent's primary coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does it cover? Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare Claim/ HICN #
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Name	Name of Other Insurance Carrier			Prior Coverage Start Date Mo/ Day / Yr		
Prior Coverage End Date Mo/ Day / Yr	Reason for Ending Coverage	Group #/Policy ID #	Is this your dependent's primary coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does it cover? Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare Claim/ HICN #
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Name	Name of Other Insurance Carrier			Prior Coverage Start Date Mo/ Day / Yr		
Prior Coverage End Date Mo/ Day / Yr	Reason for Ending Coverage	Group #/Policy ID #	Is this your dependent's primary coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does it cover? Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare Claim/ HICN #

5 YOUR EMPLOYER COMPLETES THIS SECTION (if applying for Group Life/AD&D.)

Effective Date	Annual Salary	Occupation	Life Class	Life/AD&D Amount
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6 GROUP TERM LIFE INSURANCE If applicable. (Attach separate sheet for additional or contingent beneficiaries.)

Life coverage <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, I am applying for <input type="checkbox"/> Life/AD&D \$ _____ <input type="checkbox"/> Dependent Life \$ _____		
Life Beneficiary (Full Name)	Relationship	%
Life Beneficiary (Full Name)	Relationship	%
Life Beneficiary (Full Name)	Relationship	%
Life Beneficiary (Full Name)	Relationship	%

7 DECLINATION OF COVERAGE (complete this section if any coverage is to be declined by you or your eligible dependents.)

- Declining Medical coverage for:** _____ **Reason:** Other group coverage through this employer Individual Coverage
 Self Spouse Domestic Partner Dependent(s) Other group coverage by another group (*i.e. spouse's employer*) Other _____
- Declining Dental coverage for:** _____ **Reason:** Other group coverage through this employer Individual Coverage
 Self Spouse Domestic Partner Dependent(s) Other group coverage by another group (*i.e. spouse's employer*) Other _____
- Declining Vision coverage for:** _____ **Reason:** Other group coverage through this employer Individual Coverage
 Self Spouse Domestic Partner Dependent(s) Other group coverage by another group (*i.e. spouse's employer*) Other _____

STOP AND READ CAREFULLY.

The available coverages have been explained to me by my employer. I have been given the chance to apply for the available coverages. I have decided not to enroll myself and/or my dependent(s).
By declining coverage I acknowledge that my dependents and I may have to wait to be enrolled until the next Open Enrollment period or qualifying event. Additionally, by signing below I certify that the reason I am declining coverage is accurate as indicated by the check marks above.

Employee Signature _____ Date _____

(SIGN ONLY IF DECLINING COVERAGE. IF SIGNED IN ERROR, PLEASE CROSS OUT AND INITIAL.)

8 ACCEPTANCE OF COVERAGE (signature required.)

THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: I acknowledge and understand that health care providers may disclose health information about me or my dependents to the Health Net Entities, the DBP Entities and/or the Fidelity Entities. The Health Net Entities, the DBP Entities and/or the Fidelity Entities use and may disclose this information for purposes of treatment, payment and health plan operations, including but not limited to, utilization management, quality improvement, disease or case management programs. Health Net's Notice of Privacy Practices is included in the evidence of coverage or certificate of insurance for coverage underwritten by the Health Net Entities. I may also obtain a copy of this Notice on the website at www.healthnet.com or through the Health Net Customer Contact Center.

NOTICE: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

ACKNOWLEDGEMENT AND AGREEMENT: I understand and agree that by enrolling with or accepting services from the Health Net Entities, the DBP Entities and/or the Fidelity Entities, I and any enrolled dependents are obligated to understand and abide by the terms, conditions and provisions of the Plan Contract or Insurance Policy. I have read and understand the terms of this Application and my signature below indicates that the information entered

in this Application is complete, true and correct, and I accept these terms.

BINDING ARBITRATION AGREEMENT: Subject to the terms of the Plan Contract or Insurance Policy (which may prohibit mandatory arbitration of certain disputes if the Plan Contract or Insurance Policy is subject to ERISA, 29 U.S.C. section 1001, et seq.), I, the Employee, understand and agree that any and all disputes or disagreements between me (including any of my enrolled family members or heirs or personal representatives) and the Health Net Entities, the DBP Entities and/or the Fidelity Entities, regarding the construction, interpretation, performance or breach of the Plan Contract or Insurance Policy, or regarding other matters relating to or arising out of the Health Net Entities, the DBP Entities and/or the Fidelity Entities membership, whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or employees, are also involved, must be submitted to final and binding arbitration in lieu of a jury or court trial. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties, including the Health Net Entities, the DBP Entities and/or the Fidelity Entities, are giving up their constitutional right to have their dispute decided in a court of law before a jury. I also understand that disputes that I may have with the Health Net Entities, the DBP Entities and/or the Fidelity Entities involving claims for medical malpractice are also subject to final and binding arbitration. A more detailed arbitration provision is included in the Plan Contract or Insurance Policy. My signature below indicates that I agree to submit any dispute to binding arbitration.

Employee Signature _____ **Date** _____

"Plan Contract" refers to the Health Net of California, Inc. and/or Dental Benefit Providers of California, Inc. Group Service Agreement and Evidence of Coverage; "Insurance Policy" refers to Health Net Life Insurance Company, Unimerica Insurance Company, and/or Fidelity Security Life Insurance Company Group Policy and Certificate of Insurance.

Please contact the Health Net Customer Contact Center at the toll free numbers below should you need assistance in completing this form or if you have questions about your coverage:

English	1-800-361-3366
Cantonese	1-877-891-9050
Korean	1-877-339-8596
Mandarin	1-877-891-9053
Spanish	1-800-331-1777
Tagalog	1-877-891-9051
Vietnamese	1-877-339-8621

If you have questions about your dental or vision coverage, please call:

Dental	1-866-249-2382
Vision	1-866-392-6058

If you have questions about your physician or physician group, call your physician group directly or contact Health Net Provider Services at 1-800-641-7761.

You can use your copy of the Health Net enrollment form as your temporary ID card until you receive your permanent ID card.

HMO, HMO Silver Network, Salud con Health Net HMO, SELECT (POS), ELECT Open Access (EOA), EOA Silver Network, EPO, Dental HMO Enrollees:

Participating Physician Group (PPG), Primary Care Physician (PCP) and Dental Provider Selection.

Please note, if you do not select a Participating Physician Group, Primary Care Physician, or Dental Provider for yourself and each of your eligible dependents, a Participating Physician Group, Primary Care Physician, and Dental Provider will be selected for you.

Emergency and Urgently Needed Care

- **If your situation is life threatening or an emergency:** Call **911** or go to the nearest Hospital.
- If your situation is not so severe: If you cannot call your Primary Care Physician or physician group, or you need medical care right away, go to the nearest hospital or medical center.
- **If you are outside your physician group's service area:** Go to the nearest hospital, medical center or call **911**. In all cases, contact your Primary Care Physician or Participating Physician Group as soon as possible to inform them about your condition.

PPO, FLEX NET Enrollees:

Emergency and Urgently Needed Care

- **If your situation is life threatening or an emergency:** Call **911** or go to the nearest hospital. Please call the appropriate number within 48 hours of being admitted, or as soon as possible.

PRE-CERTIFICATION

You the member are responsible for obtaining certification for certain services. Please check your plan certificate for a list of services requiring pre-certification.

For pre-certification, please call 1-800-977-7282

Pre-existing Conditions and Creditable Coverage

Your coverage under the PPO, EPO and Flex Net benefit plans may be subject to pre-existing condition limitations for a maximum period of six months from the effective date of your enrollment. In accordance with state and federal law, Health Net Life Insurance Company will credit any prior coverage that you document at the time you apply to enroll in PPO, EPO or FLEX NET, provided the prior coverage qualifies as "creditable coverage" as defined under federal and state law. Creditable coverage will be applied to offset (in part or whole) the pre-existing condition limitation, which may apply to your coverage under this policy. If you're unable to provide documentation of bona fide creditable coverage at enrollment time, Health Net Life Insurance Company may provide assistance in obtaining the necessary documentation upon request. Note: Prior coverage, which is interrupted by a period of 63 days (or 180 days if your previous employer terminated the coverage) or more, does not qualify as creditable coverage.

Disabling Conditions:

If you or your family member were disabled as of the date of termination of coverage with a prior health insurer and the loss of coverage was due to the termination of the employer's insurance policy, you may be entitled to an extension of health benefits according to California Insurance Code section 10128. Under this law, the prior insurer retains responsibility until whichever of the following occur first: (a) the member is no longer totally disabled; (b) the maximum benefits of the prior insurer's coverage are paid; or (c) a period of 12 consecutive months has passed since the date coverage ended with prior insurer.

Products/Entities:

Health Net of California, Inc. offers the following products: ELECT Open Access, EOA Silver Network, HMO, Salud HMO and SELECT POS.

Health Net Life Insurance Company offers the following products: Flex Net, PPO, Salud con Health Net EPO & PPO, Life and AD&D insurance.

Dental Benefit Providers of California, Inc. offers the following products: Dental HMO (DHMO).

Unimerica Insurance Company offers the following products: Dental PPO and Dental Indemnity.

Fidelity Security Life Insurance Company offers the following products serviced by EyeMed Vision Care, LLC: PPO Vision.

Declination of Coverage:

If you decline coverage for yourself or an eligible dependent because of coverage under other health insurance and you lose that coverage, or, if you acquire a new dependent due to marriage, birth, adoption, or placement for adoption, you and your dependent may be eligible for special enrollment rights. You must request special enrollment within 30 days of the loss of coverage or acquisition of a new dependent.



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- 4) If you choose to select PPO or Flex Net, you are not required to select a primary care physician or physician group to enroll.
- 5) Make a copy of the completed application for your records.

Existing Business/Group

Post Office Box 9103

Van Nuys, California 91409-9103

www.healthnet.com

New Business/Group

Please send all completed

paperwork to your

designated Account Executive

or Broker.