Health Net®

MEMBER ENROLLMENT AND CHANGE FORM

Medical plans are provided by Health Net of California, Inc. and / or Health Net Life Insurance Company (together, 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, HMO Variable Copay, EPO, SELECT (POS), ELECT (POS) or ELECT Open Access (EOA) plan, you must select your physician group and primary care physician. Be sure to fill in the names and numbers as they appear in the HMO Directory of Providers, or call the Customer Contact Center from 8:00 a.m.–6:00 p.m., Monday through Friday for assistance.

   English 1-800-522-0088
   Spanish 1-800-331-1777

4) If you choose to enroll in 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

6009689 (7/05)

MEDICAL ENROLLMENT AND CHANGE FORM

EMPLOYER NAME

EFFECTIVE DATE | EMPLOYER GROUP NUMBER

(SECTIONS 1, 2, 3, 4 AND 6 ARE REQUIRED)
IMPORTANT: PLEASE PRINT ALL SECTIONS IN BLACK INK, USING A BALL POINT PEN.

1) PERSONAL INFORMATION

LAST NAME	FIRST NAME	M.I.	1) ☐ MALE 2) ☐ FEMALE
STREET ADDRESS	CITY	STATE	ZIP

TELEPHONE NO. ( ) –	EMPLOYER NAME	JOB TITLE

DATE OF HIRE / /	CLASS	DEPT. NO.	EMAIL ADDRESS	EMPLOYMENT STATUS ☐ SALARIED ☐ HOURLY	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DOMESTIC PARTNER

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

	LAST NAME, FIRST NAME, M.I.	RESIDENCE ADDRESS, CITY, STATE, ZIP	DATE OF BIRTH	SOCIAL SECURITY #/ MATRICULAR ID #
☐ SELF			MO DAY YR	
☐ SPOUSE ☐ M ☐ DOMESTIC PARTNER ☐ F			MO DAY YR	
☐ SON ☐ DAUGHTER			MO DAY YR	
☐ SON ☐ DAUGHTER			MO DAY YR	
☐ SON ☐ DAUGHTER			MO DAY YR	

4) DO YOU OR YOUR DEPENDENTS HAVE OTHER HEALTH CARE COVERAGE? IF YES, PLEASE COMPLETE THIS SECTION INCLUDING MEDICARE

Please fill out the following information to receive proper credit for PREVIOUS COVERAGE, if immediately prior to becoming eligible for this plan, you or your dependents were covered under any public or private health care coverage (including MediCal or individual coverage). According to federal law, your employer or FORMER CARRIER must provide you with a certificate that shows evidence of your prior coverage. We reserve the right to request a copy of this certificate.

	NAME	NAME AND ADDRESS OF OTHER INSURANCE CARRIER	PRIOR COVERAGE START DATE
☐ SELF			MO DAY YR
☐ SPOUSE ☐ M ☐ DOMESTIC PARTNER ☐ F			MO DAY YR
☐ SON ☐ DAUGHTER			MO DAY YR
☐ SON ☐ DAUGHTER			MO DAY YR
☐ SON ☐ DAUGHTER			MO DAY YR
☐ SON ☐ DAUGHTER			MO DAY YR

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

☐ Declining Medical coverage for: ☐ Self ☐ Spouse ☐ Dependent(s) ☐ Domestic Partner

Reason: ☐ Other group coverage ☐ Individual Coverage ☐ Other _____
☐ Other group coverage by another group (i.e. spouse's employer)

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.**

Note: If you decline coverage for yourself or an eligible dependent because of coverage under other health insurance, you may be eligible for special enrollment rights if you or your dependent lose eligibility for that coverage. Also, 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.

Employee Signature_____ **Date**_____
(ONLY IF DECLINING COVERAGE; If signed in error, please cross out and initial)

Health Net®

Health Net® Life Insurance Company

2) SELECTED COVERAGE

CHECK THE DESIRED PLAN AS OFFERED BY YOUR EMPLOYER:

MEDICAL PLAN (write the plan number next to the product)

☐ HMO ____________________
☐ HMO VARIABLE COPAY ____________________
☐ HMO SILVER NETWORK ____________________
☐ ELECT℠ OPEN ACCESS ____________________
☐ ELECT (POS) ____________________
☐ EPO ____________________
☐ FLEX NET (Indemnity) ____________________
☐ PPO ____________________
☐ OUT-OF-STATE PPO (OOS PPO) ____________________
☐ SALUD CON HEALTH NET ____________________
☐ SELECT (POS) ____________________
☐ SELECT 3-TIER POS ____________________
☐ OTHER ____________________

REASON FOR CHANGE:

☐ Plan change
☐ Change address/name
☐ Delete dependent (list names below)
☐ Other____________________
____
____

REASON FOR APPLICATION:

☐ New hire
☐ Open Enrollment
☐ Loss of prior coverage date__________
☐ COBRA* effective date__________
☐ Add dependent
Qualifying event __________
Qualifying event date__________

COVERAGE TYPE	MEDICARE	MEDICARE CLAIM/HICN #	OVERAGE DEPENDENT TYPE	PARTICIPATING PHYSICIAN GROUP/PPG #	HEALTH NET PRIMARY CARE PHYSICIAN/PCP #	PHYSICIAN NAME (FIRST, LAST)	IS THIS YOUR CURRENT M.D.?
☐ Medical	☐ PART A ☐ PART B		NOT APPLICABLE	| | |	| | | | |		☐ YES ☐ NO
☐ Medical	☐ PART A ☐ PART B		NOT APPLICABLE	| | |	| | | | |		☐ YES ☐ NO
☐ Medical	☐ PART A ☐ PART B		☐ Disabled ☐ Full-time Student ☐ Over 50% support	| | |	| | | | |		☐ YES ☐ NO
☐ Medical	☐ PART A ☐ PART B		☐ Disabled ☐ Full-time Student ☐ Over 50% support	| | |	| | | | |		☐ YES ☐ NO
☐ Medical	☐ PART A ☐ PART B		☐ Disabled ☐ Full-time Student ☐ Over 50% support	| | |	| | | | |		☐ YES ☐ NO

(if applicable)

PRIOR COVERAGE END DATE	REASON FOR ENDING COVERAGE	GROUP #/ POLICY ID #	IS THIS YOUR OR YOUR DEPENDENT'S PRIMARY COVERAGE?	DOES IT COVER?	MEDICARE	MEDICARE CLAIM/ HICN #	OVERAGE DEPENDENT TYPE
MO | DAY | YR			☐ YES ☐ NO	MEDICAL: ☐ YES ☐ NO	☐ PART A ☐ PART B		NOT APPLICABLE
MO | DAY | YR			☐ YES ☐ NO	MEDICAL: ☐ YES ☐ NO	☐ PART A ☐ PART B		NOT APPLICABLE
MO | DAY | YR			☐ YES ☐ NO	MEDICAL: ☐ YES ☐ NO	☐ PART A ☐ PART B		☐ DISABLED ☐ FULL-TIME STUDENT ☐ OVER 50% SUPPORT
MO | DAY | YR			☐ YES ☐ NO	MEDICAL: ☐ YES ☐ NO	☐ PART A ☐ PART B		☐ DISABLED ☐ FULL-TIME STUDENT ☐ OVER 50% SUPPORT
MO | DAY | YR			☐ YES ☐ NO	MEDICAL: ☐ YES ☐ NO	☐ PART A ☐ PART B		☐ DISABLED ☐ FULL-TIME STUDENT ☐ OVER 50% SUPPORT
MO | DAY | YR			☐ YES ☐ NO	MEDICAL: ☐ YES ☐ NO	☐ PART A ☐ PART B		☐ DISABLED ☐ FULL-TIME STUDENT ☐ OVER 50% SUPPORT

6) ACCEPTANCE OF COVERAGE (signature required)

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 Health Net Entities. Health Net Entities 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 Health Net Entities. I may also obtain a copy of this Notice on the web site 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, 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.

Arbitration Agreement: I understand and agree that any and all disputes or disagreements between Group (or enrolled members) and the Health Net Entities regarding the construction, interpretation, performance or breach of the Health Net Entities Group Policies, or regarding other matters relating to or arising out of the Health Net Entities Group Policies, whether stated in tort, contract or otherwise, 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 are giving up their constitutional rights to the extent permitted by law to have their dispute decided in a court of law before a jury. I also understand that disputes with the Health Net Entities involving claims for medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) are also subject to final and binding arbitration. A more detailed arbitration provision is included in the Health Net Entities Group Policies.

Effective July 1, 2002, members who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. § 1001 et seq., a federal law regulating benefit plans, are not required to submit disputes about certain "adverse benefit determinations" made by Health Net Entities to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by Health Net Entities to deny, reduce, terminate or not pay for all or a part of a benefit. However, I and Health Net Entities may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

X ____

EMPLOYEE SIGNATURE DATE

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	1-800-522-0088
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

To contact your doctor or other health care provider: Telephone the physician group if one is named on the other side of this form. Otherwise, if you have questions, please 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, HMO Variable Copay, Salud con Health Net HMO, SELECT, ELECT, ELECT Open Access, EPO and Dental HMO Enrollees: *Participating Physician Group (PPG) and Primary Care Physician (PCP).*

Please note, if you do not select a participating physician group or primary physician for yourself and each of your eligible dependents, a physician group or primary physician 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 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 areas where the system is established and operating)**. In all cases, contact your primary physician or 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 your primary physician or physician group 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

Preexisting 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, HMO, Salud con Health Net EPO and PPO and SELECT POS.

Health Net Life Insurance Company offers the following products: PPO, EPO and FLEX NET.

Please visit us at www.healthnet.com