



MEMBER ENROLLMENT AND CHANGE FORM

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 through 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 HRA, HMO Silver Network, HMO Variable Copay, HMO y más, ELECT Open Access (EOA), ELECT (POS), EPO, Salud con Health Net EPO or SELECT (POS) plan, you must select your physician group and primary care physician. For Dental HMO (DHMO) you must select your dental provider. Be sure to fill in the names and numbers as they appear in the online or printed 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, PPO HSA, Salud con Health Net 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.

Medical 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 Dental Benefit Providers of California, Inc. and / or Unimerica Insurance Company (together, "DBP Entities"). Vision plans are provided by Fidelity Security Life Insurance Company and serviced by Eyemed Vision Care LLC (together the "Fidelity Entities").

Neither the DBP 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.

Post Office Box 9103
Van Nuys, California 91409-9103
www.healthnet.com

MEMBER ENROLLMENT AND CHANGE FORM

(Sections 1, 2, 3, 4 and 8 are required.)

EMPLOYER NAME

COVERAGE EFFECTIVE DATE

EMPLOYER GROUP NUMBER (Medical)

SOCIAL SECURITY NUMBER

IMPORTANT: PLEASE PRINT ALL SECTIONS IN BLACK INK.

1 SELECTED COVERAGE

1a: CHECK THE DESIRED PLAN AS OFFERED BY YOUR EMPLOYER:

MEDICAL PLAN (write the plan number next to the product, if known)

- | | |
|--|---|
| <input type="checkbox"/> HMO _____ | <input type="checkbox"/> FLEX NET (Indemnity) _____ |
| <input type="checkbox"/> HMO HRA _____ | <input type="checkbox"/> PPO _____ |
| <input type="checkbox"/> HMO Silver Network _____ | <input type="checkbox"/> PPO HSA _____ |
| <input type="checkbox"/> HMO Variable Copay _____ | <input type="checkbox"/> Out-Of-State PPO (OOS PPO) _____ |
| <input type="checkbox"/> HMO y Más _____ | <input type="checkbox"/> SALUD con Health Net _____ |
| <input type="checkbox"/> ELECT SM Open Access (EOA) _____ | <input type="checkbox"/> SELECT (POS) _____ |
| <input type="checkbox"/> ELECT (POS) _____ | <input type="checkbox"/> SELECT 3-tier POS _____ |
| <input type="checkbox"/> EPO _____ | <input type="checkbox"/> Other _____ |

REASON FOR APPLICATION:

- New hire
 Open Enrollment
 Loss of prior coverage date _____
 COBRA effective date _____
 Qualifying event _____
 Qualifying event date _____
 Add dependent
 Qualifying event _____
 Qualifying event date _____

Complete sections 1b /1c only if Health Net will be your dental and/or vision provider.

1b: DENTAL PLAN (choose one)

(write the plan number next to the product)

- HMO _____
 PPO _____
 INDEMNITY _____

1c: VISION PLAN

(write the plan number next to the product)

- PPO _____

REASON FOR CHANGE:

- Plan change
 Change address/name
 Delete dependent(s)
 (list names in Section 3)
 Other _____

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 #/Matricula ID#		Job Title		
Telephone No. () ()	Work Telephone No. () ()		Email Address		
Date of Hire / /	Job 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	

NOTE: If you are choosing to decline coverage, skip to Section 5.

Coverage Type <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D	Medicare Claim/HICN #	Participating Physician Group/PPG#	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 # (complete only if electing Health Net Dental)

For HMO y más or Salud con Health Net Members: If available, I would prefer to receive communication and plan information in Spanish.
 Yes No

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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 employee	City	State	Zip
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Date of Birth Mo/Day/Yr	Social Security #/Matricula ID #
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Coverage Type	Medicare Claim/HICN#	Participating Physician Group/PPG#	Primary Care Physician/PCP#
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D		

Physician Name (First, Last)	Is this your current M.D.? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental HMO Provider ID # (complete only if electing Health Net Dental)
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<input type="checkbox"/> Son	Last Name	First Name	M.I.
<input type="checkbox"/> Daughter			

Residence Address <input type="checkbox"/> Check here if same as employee	City	State	Zip
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Date of Birth Mo/Day/Yr	Social Security #/Matricula ID #
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Coverage Type	Medicare Claim/HICN#	Overage Dependent Type	Participating Physician Group/PPG#
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D	<input type="checkbox"/> Disabled <input type="checkbox"/> Full-time Student <input type="checkbox"/> Over 50% support	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 # (complete only if electing Health Net Dental)
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<input type="checkbox"/> Son	Last Name	First Name	M.I.
<input type="checkbox"/> Daughter			

Residence Address <input type="checkbox"/> Check here if same as employee	City	State	Zip
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Date of Birth Mo/Day/Yr	Social Security #/Matricula ID #
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Coverage Type	Medicare Claim/HICN#	Overage Dependent Type	Participating Physician Group/PPG#
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D	<input type="checkbox"/> Disabled <input type="checkbox"/> Full-time Student <input type="checkbox"/> Over 50% support	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 # (complete only if electing Health Net Dental)
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<input type="checkbox"/> Son	Last Name	First Name	M.I.
<input type="checkbox"/> Daughter			

Residence Address <input type="checkbox"/> Check here if same as employee	City	State	Zip
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Date of Birth Mo/Day/Yr	Social Security #/Matricula ID #
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Coverage Type	Medicare Claim/HICN#	Overage Dependent Type	Participating Physician Group/PPG#
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D	<input type="checkbox"/> Disabled <input type="checkbox"/> Full-time Student <input type="checkbox"/> Over 50% support	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 # (complete only if electing Health Net Dental)
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<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Last Name	First Name	M.I.
Residence Address <input type="checkbox"/> Check here if same as employee		City	State Zip
Date of Birth Mo/Day/Yr		Social Security #/Matricula ID #	
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Coverage Type Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D	Medicare Claim/HICN#	Overage Dependent Type <input type="checkbox"/> Disabled <input type="checkbox"/> Full-time Student <input type="checkbox"/> Over 50% support
			Participating Physician Group/PPG# 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 # (complete only if electing Health Net Dental)			

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

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.

<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 <input type="checkbox"/> Part D
			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 <input type="checkbox"/> Part D
			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 <input type="checkbox"/> Part D
			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 <input type="checkbox"/> Part D
			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 <input type="checkbox"/> Part D
			Medicare Claim/HICN #

5 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
 Name: _____ Other group coverage by another group (*i.e. spouse's employer*) Other _____
 Self Spouse Domestic Partner Dependent(s)
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- Declining Dental coverage for:** **Reason:** Other group coverage through this employer Individual Coverage
 Name: _____ Other group coverage by another group (*i.e. spouse's employer*) Other _____
 Self Spouse Domestic Partner Dependent(s)
-
- Declining Vision coverage for:** **Reason:** Other group coverage through this employer Individual Coverage
 Name: _____ Other group coverage by another group (*i.e. spouse's employer*) Other _____
 Self Spouse Domestic Partner Dependent(s)

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.)

6 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 Health Net Entities, the DBP Entities and/or Fidelity Entities. Health Net Entities, the DBP Entities and/or 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 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 my 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	1-800-522-0088
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

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

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

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 HRA, HMO Silver Network, HMO Variable Copay, HMO y más, ELECT Open Access (EOA), ELECT (POS), EPO, Salud con Health Net EPO or SELECT (POS) Enrollees: select a Participating Physician Group (PPG) and a Primary Care Physician (PCP).

Dental HMO Enrollees: select a participating dentist.

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 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 physician group as soon as possible to inform them about your condition.

PPO, PPO HSA, Flex Net Enrollees:

Emergency and Urgently Needed Care

- **If your situation is life threatening or an emergency:** Call **911** (in areas where the system is established and operating) 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.

Preexisting Conditions and Creditable Coverage

Your coverage under the PPO, PPO HSA, 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, PPO HSA, 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: HMO, HMO HRA, HMO Silver Network, HMO Variable Copay, HMO y más, Salud con Health Net HMO, ELECT Open Access (EOA), ELECT (POS) and SELECT (POS).

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

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

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

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

PLEASE VISIT US AT WWW.HEALTHNET.COM

