

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, HSA 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, HSA 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, HSA PPO, EPO and FLEX NET.

Please visit us at www.healthnet.com



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, HSA 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

MEDICAL ENROLLMENT AND CHANGE FORM

(SECTIONS 1, 2, 3, 4 AND 6 ARE REQUIRED)

IMPORTANT: PLEASE PRINT ALL SECTIONS IN BLACK INK, USING A BALL POINT PEN.

EMPLOYER NAME			
EFFECTIVE DATE		EMPLOYER GROUP NUMBER	
LAST NAME		FIRST NAME	M.I. 1) <input type="checkbox"/> MALE 2) <input type="checkbox"/> FEMALE
STREET ADDRESS		CITY	STATE ZIP
TELEPHONE NO. () -	EMPLOYER NAME	JOB TITLE	
DATE OF HIRE / /	CLASS	DEPT. NO.	EMAIL ADDRESS
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	

For Salud con Health Net members: If available, I would prefer to receive communication or plan information in Spanish. YES NO

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 MO DAY YR	SOCIAL SECURITY #/ MATRICULAR ID #
<input type="checkbox"/> SELF				
<input type="checkbox"/> SPOUSE <input type="checkbox"/> M <input type="checkbox"/> DOMESTIC PARTNER <input type="checkbox"/> F				
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER				
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER				
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER				

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.

	NAME	NAME AND ADDRESS OF OTHER INSURANCE CARRIER	PRIOR COVERAGE START DATE MO DAY YR
<input type="checkbox"/> SELF			
<input type="checkbox"/> SPOUSE <input type="checkbox"/> M <input type="checkbox"/> DOMESTIC PARTNER <input type="checkbox"/> F			
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER			
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER			
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER			
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER			

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) Reason: Other group coverage Individual Coverage Other _____
 Domestic Partner 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 _____
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(ONLY IF DECLINING COVERAGE; If signed in error, please cross out and initial)



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2) SELECTED COVERAGE

<p>CHECK THE DESIRED PLAN AS OFFERED BY YOUR EMPLOYER: MEDICAL PLAN (write the plan number next to the product)</p> <p><input type="checkbox"/> HMO _____</p> <p><input type="checkbox"/> HMO VARIABLE COPAY _____</p> <p><input type="checkbox"/> HMO SILVER NETWORK _____</p> <p><input type="checkbox"/> ELECTSM OPEN ACCESS _____</p> <p><input type="checkbox"/> ELECT (POS) _____</p> <p><input type="checkbox"/> EPO _____</p> <p><input type="checkbox"/> FLEX NET (Indemnity) _____</p> <p><input type="checkbox"/> PPO _____</p>	<p><input type="checkbox"/> HSA PPO _____</p> <p><input type="checkbox"/> OUT-OF-STATE PPO (OOS PPO) _____</p> <p><input type="checkbox"/> SALUD CON HEALTH NET _____</p> <p><input type="checkbox"/> SELECT (POS) _____</p> <p><input type="checkbox"/> SELECT 3-TIER POS _____</p> <p><input type="checkbox"/> OTHER _____</p>	<p>REASON FOR CHANGE:</p> <p><input type="checkbox"/> Plan change</p> <p><input type="checkbox"/> Change address/name</p> <p><input type="checkbox"/> Delete dependent (list names below)</p> <p><input type="checkbox"/> Other _____</p>	<p>REASON FOR APPLICATION:</p> <p><input type="checkbox"/> New hire</p> <p><input type="checkbox"/> Open Enrollment</p> <p><input type="checkbox"/> Loss of prior coverage date _____</p> <p><input type="checkbox"/> COBRA* effective date _____</p> <p><input type="checkbox"/> Add dependent</p> <p>Qualifying event _____</p> <p>Qualifying event date _____</p>
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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.?
<input type="checkbox"/> Medical	<input type="checkbox"/> PART A <input type="checkbox"/> PART B <input type="checkbox"/> PART D		NOT APPLICABLE				<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> Medical	<input type="checkbox"/> PART A <input type="checkbox"/> PART B <input type="checkbox"/> PART D		NOT APPLICABLE				<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> Medical	<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				<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> Medical	<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				<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> Medical	<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				<input type="checkbox"/> YES <input type="checkbox"/> NO

PRIOR COVERAGE END DATE MO DAY YR	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
			<input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICAL: <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> PART A <input type="checkbox"/> PART B <input type="checkbox"/> PART D		NOT APPLICABLE
			<input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICAL: <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> PART A <input type="checkbox"/> PART B <input type="checkbox"/> PART D		NOT APPLICABLE
			<input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICAL: <input type="checkbox"/> YES <input type="checkbox"/> NO	<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
			<input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICAL: <input type="checkbox"/> YES <input type="checkbox"/> NO	<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
			<input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICAL: <input type="checkbox"/> YES <input type="checkbox"/> NO	<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
			<input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICAL: <input type="checkbox"/> YES <input type="checkbox"/> NO	<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

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.

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 SafeGuard 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 applicant, 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 Health Net regarding the

construction, interpretation, performance or breach of the Health Net Plan Contract or Insurance Policy, or regarding other matters relating to or arising out of my Health Net 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 Health Net, 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 Health Net 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.

x	EMPLOYEE SIGNATURE _____	DATE _____
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All references to "Health Net" herein include the affiliates and subsidiaries of Health Net which underwrite or administer the coverage to which this Enrollment Application applies. "Plan Contract" refers to the Health Net of California, Inc. Group Service Agreement and Evidence of Coverage; "Insurance Policy" refers to Health Net Life Insurance Company Group Policy and Certificate of Insurance.