Health Net®

Health Net of California, Inc.

Individual & Family Plans CommunityCare HMO Enrollment Application

Requested effective date

☐☐ / ☐☐ / ☐☐☐☐

Application must be typed or completed in blue or black ink.

Effective date of coverage: Coverage is only available for enrollment during the annual open enrollment period, which is November 1, 2015, through January 31, 2016, or during a special enrollment period. Applications must be received within 60 days of a qualifying event. Generally, for applications received between the 1st and 15th, coverage will be effective the first day of the month following submission of application. For applications received between the 16th and month's end, coverage will be effective the first day of the second month following submission of application.

If you are currently enrolled in a Medicare plan, you are ineligible to apply for an Individual & Family Plan.

Health Net of California, Inc. (Health Net) needs a Social Security number (SSN) for everyone enrolling for health coverage, including spouses and dependent children. This is necessary so that we can provide you with verification of coverage for your tax return, as required by the Affordable Care Act. Health Net will not use your SSN for other purposes or share it with anyone other than as required by law.

THE AGENT/BROKER MAY NOT SIGN THIS APPLICATION AND AGREEMENT ON BEHALF OF THE APPLICANT.

IMPORTANT: Please see Part V if the applicant does not read/write English. The Individual & Family Plan CommunityCare HMO Enrollment Application is available in Chinese and Spanish language versions. You can also have someone help you read it. For free help, please call 1-877-609-8711.

If you need assistance in completing this application, an agent/broker may assist you. An agent/broker who helped you read and complete this application must sign the application (see Part VI).

I (and my dependents if applicable) are applying during:

☐ **Annual open enrollment period** ☐ **Special enrollment period (see Part IV)**

Part I. Applicant information

Primary applicant's last name:	First name:	MI:	☐ Male ☐ Female
Billing address:			
Mailing address:			
Home address:			
City:	State:	ZIP:	County applicant resides in:
Home phone number: ( )	Work phone number: ( )	Cell phone number: ( )	Email address:
Primary applicant's birth date (mm/dd/yy): / /	Primary applicant's Social Security number (required for all applicants): – –	Primary subscriber's Health Net ID (applicable for adding dependents and change requests only):	
Primary care physician ID:	Primary group ID:	Current patient: ☐ Yes ☐ No	
Please select your language preference (optional): ☐ English ☐ Spanish ☐ Chinese			

Primary's Social Security Number

☐☐☐ - ☐☐ - ☐☐☐☐

Part II. Tell us who you are enrolling and select the product

A. Reason for application

☐ **New application (Check family type below)**

- ☐ Self
- ☐ Self and spouse
- ☐ Self and domestic partner
- ☐ Self and child
- ☐ Self and children
- ☐ Self, spouse and child(ren)
- ☐ Self, domestic partner and child(ren)
- ☐ Child-only

☐ **Adding dependent**

☐ **Change request (only available during open or special enrollment period)**

B. Payment information

First premium payment

☐ Pay by check (Amount must match monthly premium.)

Mailing application

Include completed check with completed application and mail to:

Health Net Individual & Family Enrollment
PO Box 1150
Rancho Cordova, CA 95741-1150

Faxing application

Fax completed application to: 1-800-977-4161, and mail completed check to:

Health Net Individual & Family Enrollment
PO Box 894702
Los Angeles, CA 90189-4072

Current members can go to **www.healthnet.com**, and click the *Make A Payment Now* button, for additional payment options.

C. Choice of coverage

Health Net of California, Inc. HMO plans utilize the CommunityCare provider network.

☐ **Health Net Platinum 90 HMO**
☐ **Health Net Gold 80 HMO**
☐ **Health Net Silver 70 HMO**

Optional coverage: Dental / Vision plan for Adults (over age 18) –

☐ **Dental and Vision Plus –** *If Dental and Vision Plus is purchased for the primary applicant, all family members over age 18 will also be enrolled in the Dental and Vision Plus plan. Dental and Vision Plus can only be purchased with, or added to, medical coverage during the open enrollment or special enrollment periods.*

Note: All medical plans include pediatric dental coverage.

Part III. Family member(s) to be enrolled

List all eligible family members to be enrolled other than yourself. If a listed family member's last name is different from yours, please explain on a separate sheet of paper. For additional dependents, please attach another sheet with the requested information.

☐ Check here if a supplemental page is attached. Please write the primary applicant's Social Security number on the upper right hand corner of the supplemental page.

Note: When each family member chooses a different plan, each member will be on their own contract. To specify different plans for different family members, be sure to write the plan name you are choosing for each family member in the spaces provided below.

For domestic partner coverage, all requirements for eligibility, as required by the applicable laws of the State of California, must be met, and a joint Declaration of Domestic Partnership must be filed with the California Secretary of State.

How to make different plan choices:

a. Health Net bills to only one address per subscriber. Therefore, to be processed under one subscriber, all family members must be billed to the same address.

b. You must select a physician group and primary care physician. You may choose the same or different physician group and primary care physician for each family member you are enrolling. If you do not select a primary care physician, one will be selected for you within your regional area. To find the most up-to-date list of Health Net contracted physicians, log in to www.healthnet.com > *ProviderSearch*. You'll find a complete listing of our Individual & Family Plan network physicians, and you can search by specialty, city, county, or doctor's name. You can also call 1-877-609-8711 to request provider information or contact your Health Net authorized agent/broker.

c. For Dental and Vision Plus coverage, please provide the dentist number for the HMO dentist you've chosen. You may choose a different dentist for each family member. If you do not select a dental office, one will be selected for you in your area. For names, addresses, primary dentist number, and telephone numbers of participating dental providers, or for help in selecting a provider, call Health Net at 1-866-249-2382 or log in to www.healthnet.com.

Primary's Social Security Number

☐☐☐ - ☐☐ - ☐☐☐☐

Part III. Family member(s) to be enrolled (continued)

Relation	Last name	First name	MI	Social Security number	Date of birth
☐ Spouse ☐ Domestic partner				– –	/ /

Required for CommunityCare plans: CommunityCare HMO primary care physician ID	CommunityCare HMO physician group ID

If Adult Dental and Vision Plus is purchased, please note HMO primary dentist #

Medical plan choice for each family member if different

Relation Child 1	Last name	First name	MI	Social Security number	Date of birth
☐ Son ☐ Daughter				– –	/ /

Required for CommunityCare plans: CommunityCare HMO primary care physician ID	CommunityCare HMO physician group ID

If Adult Dental and Vision Plus is purchased, please note HMO primary dentist #

Relation Child 2	Last name	First name	MI	Social Security number	Date of birth
☐ Son ☐ Daughter				– –	/ /

Required for CommunityCare plans: CommunityCare HMO primary care physician ID	CommunityCare HMO physician group ID

If Adult Dental and Vision Plus is purchased, please note HMO primary dentist #

Relation Child 3	Last name	First name	MI	Social Security number	Date of birth
☐ Son ☐ Daughter				– –	/ /

Required for CommunityCare plans: CommunityCare HMO primary care physician ID	CommunityCare HMO physician group ID

If Adult Dental and Vision Plus is purchased, please note HMO primary dentist #

Primary's Social Security Number

☐☐☐ - ☐☐ - ☐☐☐☐

Part III. Family member(s) to be enrolled (continued)

Addition of a newborn or adopted child to an existing policy

Newborn/Adopted child's last name:	First name:	MI:

Effective date[1]:	Newborn/Adopted child's date of birth (mm/dd/yy):	Date of adoption/placement for adoption (mm/dd/yy):
☐ Male ☐ Female	Social Security number:	Primary subscriber's Health Net ID:

If you are adding an eligible newborn/adopted child to a CommunityCare HMO plan, you must select a primary care physician from the CommunityCare Network.

Primary care physician ID:	Current patient: ☐ Yes ☐ No

GENERAL CONDITIONS: If your application is not received within 60 days of the birth date or date of adoption, Health Net of California, Inc. (Health Net) will require that a standard application be completed. Cashing your check does not mean your application is approved. If rejected, your money will be returned to you. No other department, officer, agent, or employee of Health Net is authorized to grant enrollment. The subscriber's broker or agent cannot grant approval, change terms or waive requirements of this application. This application shall become a part of the Plan Contract.

Please remit the first month's premium for a newborn or adopted child. You will be required to pay additional prorated premiums for the month your child is born or adopted, which will be added to your next regular premium billing.

The application and Arbitration Clause must be signed by the subscriber. The subscriber must personally sign his or her name in ink and agree to comply with the Arbitration Clause and the terms, conditions and provisions of the application and the Plan Contract in order for this application to be processed. For this application to be considered, neither broker nor any other person may sign this application and Arbitration Clause.

[1]Effective date will be the date of birth or date of adoption (or placement for the purpose of adoption if earlier) if the application is received within 60 days of the birth date or date of adoption.

Part IV. Special enrollment period

In addition to the open enrollment period, you and your dependents are eligible to enroll or change plans during a special enrollment period, which is within 60 days of certain qualifying events. Generally, for applications received between the 1st and 15th, coverage will be effective the first day of the month following submission of application. For applications received between the 16th and month's end, coverage will be effective the first day of the second month following submission of application. **Exceptions to these effective dates include birth, adoption, placement for adoption, or through a child support order or other court order, which will be effective the date of the qualifying event or court order. Marriage will be effective the first day of the month after the application receipt.** The application must be received within 60 days[2] of the qualifying event. Proof of the qualifying event is required. Please write in the applicable qualifying event below and the name of the person to whom it applies. For additional dependents, please attach a separate sheet of paper.

Qualifying event # (see chart on next page)	Date of event[2]	Primary applicant	Spouse/ Domestic partner	Dependent 1	Dependent 2	Dependent 3

(continued)

[2]If your application is received before the loss of coverage, your effective date will be the first day of the month following the loss of coverage. If the application is received during the 60-day period after the loss of coverage, the effective date will be the first day of the month after the application receipt.

Primary's Social Security Number

Qualifying events for special enrollment periods for Individual & Family Plans

	Qualifying event	Submit required proof of qualifying event
1)	The qualified individual, or his or her dependent, loses minimum essential coverage, which could be due to one of the following reasons (not including voluntary termination of your previous coverage or termination due to failure to pay premium):	
	A. The death of the covered employee.	Copy of one of the following: • Loss of coverage notice from former insurance carrier. • Loss of coverage notice from employer. • Front and back of former insurance carrier's ID card.
	B. The termination or reduction of hours, of the covered employee's employment.	
	C. The divorce or legal separation of the covered employee from the employee's spouse.	
	D. The covered employee becoming entitled to benefits under Medicare.	
	E. A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan.	
	F. A proceeding in a case under title 11 bankruptcy, commencing on or after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time. In this case, a loss of coverage includes a substantial elimination of coverage with respect to a qualified beneficiary (spouse/domestic partner, dependent child or surviving spouse/domestic partner) within one year before or after the date of commencement of the proceeding.	
	G. Is enrolled in any non-calendar year group health plan or individual health insurance coverage, even if the qualified individual or his or her dependent has the option to renew such coverage. The date of the loss of coverage is the last day of the plan or policy year.	
	H. Loss of minimum essential coverage for any reason other than failure to pay premiums or situations allowing for a rescission for fraud or intentional misrepresentation of material fact.	Documentation would depend on circumstance.
	I. Termination of employer contributions.	Notice from employer of contributions termination.
	J. Exhaustion of COBRA continuation coverage.	COBRA paperwork reflecting exhaustion of coverage.
2)	A. The qualified individual gains a dependent or becomes a dependent through marriage, domestic partnership, birth, adoption, or placement for adoption.	Court documentation or discharge records.
	B. The enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by State law in the State in which the divorce or legal separation occurs, or if the enrollee, or his or her dependent, dies.	
3)	The qualified individual's, or his or her dependent's, enrollment or non-enrollment in a health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of the Exchange or the Department of Health and Human Services, or its instrumentalities as evaluated and determined by the Exchange.	Documentation would depend on circumstance.
4)	The health plan in which the enrollee, or his or her dependent, is enrolled substantially violated a material provision of its contract.	Documentation would depend on circumstance.
5)	The qualified individual or enrollee, or his or her dependent, gains access to a new health plan as a result of a permanent move.	Copy of one of the following: • Lease. • Mortgage statement. • First utility or phone bill.
6)	He or she is mandated to be covered as a dependent pursuant to a valid state or federal court order.	Court documentation.
7)	He or she has been released from incarceration.	Probation or parole paperwork.

(continued)

Primary's Social Security Number

☐☐☐ - ☐☐ - ☐☐☐☐

Qualifying events for special enrollment periods for Individual & Family Plans (continued)

	Qualifying event	Submit required proof of qualifying event
8)	He or she was receiving services under another health benefit plan, from a contracting provider who is no longer participating in that health plan, for any of the following conditions: (a) an acute condition (a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration); (b) a serious chronic condition (a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration); (c) a terminal illness (an incurable or irreversible condition that has a high probability of causing death within one year or less); (d) a pregnancy; (e) care of a newborn between birth and 36 months; or (f) a surgery or other procedure that has been recommended and documented by the provider to occur within 180 days of the contract's termination date, or within 180 days of the effective date of coverage for a newly covered insured, and that provider is no longer participating in the health plan.	Dated letter from primary care physician (PCP).
9)	He or she demonstrates to the Exchange, with respect to health benefit plans offered through the Exchange, or to the California Department of Managed Health Care, with respect to health benefit plans offered outside the Exchange, that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period available to the individual because he or she was misinformed that he or she was covered under minimum essential coverage.	Documentation would depend on circumstance.
10)	He or she is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code.	Active duty status documentation.
11)	Newly eligible or ineligible for advance payments of the premium tax credit, or change in eligibility for cost-sharing reductions.	Advanced Premium Tax Credit (APTC) paperwork that shows the premium assistance you are eligible for.
12)	He or she loses medically needy coverage under Medicaid (not including voluntary termination of your previous coverage or termination due to failure to pay premium).	Medicaid documentation.
13)	He or she loses pregnancy-related coverage under Medicaid (not including voluntary termination of your previous coverage or termination due to failure to pay premium).	Medicaid documentation.

Part V. Individual & Family Plans Exception to Standard Enrollment – Statement of Accountability regarding language assistance

Instructions for Part V: The following process is to be used when the applicant cannot complete the application because he or she cannot read, write and/or speak the language of the application. Health Net requires that if you need assistance in completing this application, you must employ the services of a qualified interpreter. Please contact Health Net at 1-877-609-8711 for information about qualified interpreter services and how to obtain them. This form must be submitted with the Individual & Family Plan enrollment application when applicable.

Health Net qualified interpreter – Please complete the following when assisted by a Health Net qualified interpreter.

I,_____, was assisted in the completion of this application by a qualified interpreter authorized by Health Net because I:

☐ Do not read the language of this application.
☐ Do not speak the language of this application.
☐ Do not write the language of this application.
☐ Other (explain): _____

A qualified interpreter assisted me with the completion of: ☐ The entire application.
☐ Other (explain): _____

A qualified interpreter read this application to me in the following language: _____

(continued)

Primary's Social Security Number

			-			-				

Part V. Individual & Family Plans Exception to Standard Enrollment – Statement of Accountability regarding language assistance (continued)

Signatures and date (required in ink)

Signature of applicant:	Today's date:
Date application was interpreted:	Time application was interpreted:
Qualified interpreter number:	

Qualified interpreter other than a Health Net qualified interpreter – Please complete the following when assisted by a qualified interpreter other than a Health Net qualified interpreter.

If a qualified interpreter, other than a qualified interpreter provided by Health Net, assisted you in completing this application, the interpreter must complete the following:

I,_____, understand that a qualified interpreter should: (a) have the vocabulary equivalent of a native speaker that has received an advanced education (college or university equivalent) in the non-English language; (b) be able to demonstrate cultural sensitivity in their communication, taking into consideration that every language encompasses a wide range of variation; (c) have native speaker language skills (native speaker language skills are developed by growing up or functioning in a language community); and (d) have corresponding reading and writing skills in the non-English language (the reading and writing skills would be demonstrated by advanced education in the native language).

As a qualified interpreter, I personally read and completed the application for the applicant named above because:

☐ Applicant does not read the language of this application.
☐ Applicant does not speak the language of this application.
☐ Applicant does not write the language of this application.
☐ Other (explain): _____

Under the penalty of perjury, I declare that I read to the applicant:

☐ The entire application.
☐ Other (explain): _____

I read this application to the applicant in the following language: _____

Please provide the following information regarding the qualified interpreter who assisted the applicant and who is not a Health Net qualified interpreter:

Last name:		First name:	
Address of qualified interpreter:			
City:	State:	ZIP:	Phone:
Qualified interpreter signature:			Date:

Primary's Social Security Number

			-		-				

Part VI. Applicant's agent/broker information

Complete agent/broker name and address is necessary for correspondence to be sent to the agent/broker.

Health Net broker ID:	**Health Net direct sales agent ID:**
AK691	

Name (print):	Phone number:	Fax number:
Kevin Knauss	916-521-7216	

Address:	Email address:
8712 Pendleton Dr. Granite Bay, CA, 95746	kevin@insuremekevin.com

Applicant's agent/broker signature/number ***(required):***	**Date signed** ***(required):***

Agent/broker certification

I, _____ (name of agent/broker),

(NOTE: You must select the appropriate box. You may only select one box.)

(_____) did not assist the applicant(s) in any way in completing or submitting this application. All information was completed by the applicant(s) with no assistance or advice of any kind from me. I understand that, if any portion of this statement by me is false, I may be subject to civil penalties, including but not limited to a fine of up to $10,000.

OR

(_____) assisted the applicant(s) in submitting this application. I advised the applicant(s) that he or she should answer all questions completely and truthfully and that no information requested on the application should be withheld. I explained that withholding information could result in rescission or cancellation of coverage in the future. The applicant(s) indicated to me that he or she understood these instructions and warnings. To the best of my knowledge, the information on the application is complete and accurate. I understand that, if any portion of this statement by me is false, I may be subject to civil penalties, including but not limited to a fine of up to $10,000.

Please answer all questions 1 through 3:

1. **Who filled out and completed the application form?** _____

2. Did you personally witness the applicant(s) sign the application? ☐ Yes ☐ No

3. Did you review the application after the applicant(s) signed it? ☐ Yes ☐ No

Primary's Social Security Number

			-		-				

Part VII. Conditions of enrollment

GENERAL CONDITIONS: **Health Net reserves the right to reject any application for enrollment if the applicant is not eligible for coverage due to not meeting eligibility conditions.** There is no coverage unless this application is accepted by Health Net's Membership Department and a Notice of Acceptance is issued to the applicant even though you paid money to Health Net for the first month's premium. Cashing your check does not mean your application is approved. If rejected, your money will be returned to you. No other department, officer, agent, or employee of Health Net is authorized to grant enrollment. The applicant's agent or broker cannot grant approval, change terms or waive requirements of this application. This application shall become a part of the Plan Contract.

WHEN HEALTH NET CAN RESCIND A PLAN CONTRACT
Within the first 24 months of coverage, Health Net may rescind a Plan Contract for any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact in the written information submitted by you or on your behalf on or with your enrollment application.

A material fact is information which, if known to Health Net, would have caused Health Net to decline to issue coverage.

If the Plan Contract is rescinded, Health Net shall have no liability for the provision of coverage under the Plan Contract.

By signing this application, you represent that all responses are true and that the application will become part of the Plan Contract between Health Net and you. By signing this application, you further agree to comply with the terms of the Plan Contract.

If, after enrollment, Health Net investigates your application information, Health Net must notify you of this investigation, the basis of the investigation, and offer you an opportunity to respond.

If Health Net makes a decision to rescind your coverage, such decision will be first sent for review to an independent third-party auditor contracted by Health Net.

If the Plan Contract is rescinded, Health Net will provide a 30-day written notice prior to the effective date of the rescission that will:

1. explain the basis of the decision, and your appeal rights;
2. clarify that all members covered under your coverage other than the individual whose coverage is rescinded may continue to remain covered;
3. explain that your monthly premium will be modified to reflect the number of members that remain under the Plan Contract; and
4. explain your right to appeal Health Net's decision to rescind coverage.

If the Plan Contract is rescinded:

1. Health Net may revoke your coverage as if it never existed, and you will lose health benefits including coverage for treatment already received;
2. Health Net will refund all premium amounts paid by you, less any medical expenses paid by Health Net on behalf of you and may recover from you any amounts paid under the Plan Contract from the original date of coverage; and
3. Health Net reserves its right to obtain any other legal remedies arising from the rescission that are consistent with California law.

If Health Net denies your appeal, you have the right to seek assistance from the California Department of Managed Health Care.

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. Health Net uses 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 Plan Contract, and I may also obtain a copy of this Notice on the website at www.healthnet.com or through the Health Net Customer Contact Center. Authorization for use and disclosure of protected health information shall be valid for a period of 24 months from the date of my signature on the next page.

IF SOLE APPLICANT IS A MINOR: If the sole applicant under this application is under 18 years of age, the applicant's parent or legal guardian must sign as such. By signing, he or she does hereby agree to be legally responsible for the accuracy of information in this application and for payments of premiums. If such responsible party is not the natural parent of the applicant, copies of the court papers authorizing guardianship must be submitted with this application.

IF APPLICANT CANNOT READ THE LANGUAGE OF THIS APPLICATION: If an applicant does not read the language of this application and an interpreter assisted with the completion of the application, the applicant must sign and submit the Statement of Accountability (see Part V of this application, "Individual & Family Plans Exception to Standard Enrollment – Statement of Accountability regarding language assistance").

Primary's Social Security Number

			-			-				

Part VIII. Important provisions

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.

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health care services, plans or insurance companies as a condition of obtaining coverage.

ACKNOWLEDGEMENT AND AGREEMENT: I, the applicant, understand and agree that by enrolling with or accepting services from Health Net, I and any enrolled dependents shall comply with the terms, conditions and provisions of the Plan Contract. To obtain a copy of the Plan Contract, call Health Net at 1-877-609-8711. **I, the applicant, 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: I, the applicant, understand and agree that any and all disputes between me (including any of my enrolled family members or heirs or personal representatives) and Health Net must be submitted to final and binding arbitration instead of a jury or court trial. This Agreement to arbitrate includes any disputes arising from or relating to the Plan Contract or my Health Net coverage, stated under any legal theory. This agreement to arbitrate any disputes applies even if other parties, such as health care providers or their agents or employees, are involved in the dispute. 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 by a jury. I also understand that disputes that I may have with Health Net 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. I understand that a more detailed arbitration provision is included in the Plan Contract. Mandatory Arbitration may not apply to certain disputes if the Plan Contract is subject to ERISA, 29 U.S.C. §§ 1001-1461. My signature below indicates that I understand and agree with the terms of this Binding Arbitration Agreement and agree to submit any disputes to binding arbitration instead of a court of law.

Applicant or parent or legal guardian's signature if applicant is under 18 years old:	Date signed:	Signature of applicant's dependent (age 18 or older):	Date signed:
Signature of spouse/domestic partner or applicant's dependent (age 18 or older):	Date signed:	Signature of applicant's dependent (age 18 or older):	Date signed:
Signature of applicant's dependent (age 18 or older):	Date signed:	Signature of applicant's dependent (age 18 or older):	Date signed:

The application and this Arbitration Clause must be signed by the applicant(s). The applicant(s) must personally sign his or her name in ink and agree to comply with the Arbitration Clause and the terms, conditions and provisions of the application and the Plan Contract in order for this application to be processed. For this application to be considered, neither agent/broker nor any other person may sign this application and Arbitration Clause.

Make personal check payable to "Health Net." If you are returning the completed application by mail, send to: Health Net Individual & Family Enrollment, PO Box 1150, Rancho Cordova, CA 95741-1150. If you want to fax your application, please fax to 1-800-977-4161, and mail your check to: Health Net Individual & Family Enrollment, PO Box 894702, Los Angeles, CA 90189-4072.

You may submit a photocopy or facsimile of the application and authorizations. Health Net recommends that you retain a copy of this application and authorizations for your records.

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. combined Plan Contract and Evidence of Coverage.

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card, or employer group applicants please call Health Net's Commercial Contact Center at 1-800-522-0088. Individual & Family Plan (IFP) applicants please call 1-877-609-8711. For more help: If you are enrolled in a PPO or EPO insurance policy underwritten by Health Net Life Insurance Company, call the CA Dept. of Insurance at 1-800-927-4357. If you are enrolled in a HMO or HSP plan provided by Health Net of California, Inc., call the DMHC Helpline at 1-888-HMO-2219. Your ID card indicates whether your plan was issued by Health Net Life Insurance Company or Health Net of California, Inc.

English

Servicios de Idiomas Sin Costo. Usted puede solicitar un intérprete. Puede solicitar que se le lean los documentos y que algunos de ellos se le envíen en su idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación; los solicitantes de grupo de empleadores deben llamar al Centro de Comunicación Comercial de Health Net al 1-800-522-0088. Los solicitantes del Plan Individual y Familiar (por sus siglas en inglés, IFP) deben llamar al 1-877-609-8711. Para obtener más ayuda: Si está inscrito en una póliza de seguro PPO o EPO asegurada por Health Net Life Insurance Company, llame al Departamento de Seguros de CA al 1-800-927-4357. Si está inscrito en un plan HMO o HSP proporcionado por Health Net of California, Inc., llame a la Línea de Ayuda del Departamento de Cuidado Médico (por sus siglas en inglés, DMHC) de California al 1-888-HMO-2219. Su tarjeta de identificación indica si su plan fue emitido por Health Net Life Insurance Company o Health Net of California, Inc.

Spanish

免費語言服務。您可以取得口譯員服務。我們可以把文件朗讀給您聽，也可以把部分翻譯成您語言的文件寄送給您。如需協助，請撥您會員卡上所列的電話號碼與我們聯絡，雇主團體申請人請撥 Health Net 的商業聯絡中心，電話 1-800-522-0088。Individual and Family Plan (IFP) 申請人請撥 1-877-609-8711。如需其他協助：如果您投保的是 Health Net Life Insurance Company 核保的 PPO 或 EPO 保險保單，請撥 California Department of Insurance 電話 1-800-927-4357。如果您投保的是 Health Net of California, Inc. 提供的 HMO 或 HSP 計畫，請撥 DMHC 協助專線 1-888-HMO-2219。您的會員卡會註明您的計畫是由 Health Net Life Insurance Company 或 Health Net of California, Inc. 核發。

Chinese

Dịch vụ ngôn ngữ miễn phí. Quý vị có thể được cấp thông dịch viên và người đọc giúp các tài liệu bằng ngôn ngữ của quý vị cho quý vị. Để được trợ giúp, vui lòng gọi cho chúng tôi theo số điện thoại ghi trên thẻ hội viên của quý vị; người ghi danh theo nhóm của hãng sở xin gọi Trung tâm Liên lạc Thương mại của Health Net theo số 1-800-522-0088. Người ghi danh theo Chương trình bảo hiểm dành cho cá nhân và gia đình (Individual and Family Plan, IFP) xin gọi số 1-877-609-8711. Để được trợ giúp bổ túc: Nếu quý vị ghi danh trong các hợp đồng bảo hiểm PPO hoặc EPO do Health Net Life Insurance Company cam kết tài trợ, vui lòng gọi Bộ Bảo hiểm của California theo số 1-800-927-4357. Nếu quý vị ghi danh trong chương trình bảo hiểm HMO hoặc HSP do Health Net of California, Inc. cung cấp, xin gọi Đường dây trợ giúp của DMHC theo số 1-888-HMO-2219. Trên thẻ hội viên của quý vị có ghi rõ chương trình bảo hiểm của quý vị là do Health Net Life Insurance Company hay Health Net of California, Inc. cung cấp.

Vietnamese

무료 언어 지원 서비스. 무료 통역사 서비스 및 여러분에게 편한 언어로 서류 낭독 서비스를 받을 수 있습니다. 도움이 필요하신 분은 본인의 ID 카드상에 있는 안내번호로 전화해 주십시오. 고용주 그룹 가입 신청자님의 경우 Health Net의 상업 (Commercial) 고객 서비스 센터, 안내번호 1-800-522-0088번으로 전화해 주십시오. 개인 및 가족 플랜 (IFP) 가입 신청자님은 안내번호 1-877-609-8711번으로 전화해 주십시오. 더 많은 도움이 필요하시면: 만일 귀하가 Health Net Life Insurance Company가 인수한 PPO 또는 EPO 보험 폴리시에 가입하신 경우, 캘리포니아 보험국 (CA Dept. of Insurance), 안내번호 1-800-927-4357번으로 문의하십시오. 만일 귀하가 Health Net of California, Inc.에서 제공하는 HMO 또는 HSP 플랜에 가입하신 경우, 보건관리부 (DMHC) 헬프라인, 안내번호 1-888-HMO-2219번으로 문의하십시오. 귀하의 ID 카드상에 귀하의 플랜이 Health Net Life Insurance Company에서 제공되는지 또는 Health Net of California, Inc.에서 제공되는지 명시되어 있습니다.

Korean

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք բանավոր թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ Ձեր լեզվով: Օգնության համար մեզ զանգահարեք Ձեր ինքնության (ID) տոմսի վրա նշված համարով, կամ եթե գործատիրոջ խմբի դիմորդ եք, խնդրում ենք 1-800-522-0088 համարով զանգահարել Health Net-ի Հաճախորդի Կապի Կենտրոն: Անհատական և Ընտանեկան Ծրագրի (Individual and Family Plan/IFP) դիմորդներից խնդրվում է զանգահարել 1-877-609-8711 համարով: Լրացուցիչ օգնության համար՝ 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք (CA Dept. of Insurance), եթե գրանցվել եք PPO կամ EPO ապահովագրական ապահովագրի, որի կրողն է Health Net Life Insurance Company-ն: Եթե գրանցվել եք HMO կամ HSP ծրագրում, որի մատակարարն է Health Net of California, Inc.-ը, 1-888-HMO-2219 համարով զանգահարեք DMHC-ի Օգնության Գծին: Ձեր ինքնության տոմսը նշում է, թե ով է թողարկել Ձեր ծրագիրը՝ Health Net Life Insurance Company-ն, թե՞ Health Net of California, Inc.-ը:

Armenian

無料の言語サービス。日本語の通訳が書類をお読みします。サービスをご希望の方は、IDカード記載の番号までお問い合わせください。雇用者団体プランへの加入をお申込みの方は、Health Netの民間コンタクト・センター、1-800-522-0088までお電話ください。個人・家族プラン（IFP）への加入をお申込みの方は、1-877-609-8711までお電話ください。さらに援助が必要な場合、Health Net Life Insurance Companyが保険引受会社となるPPOまたはEPO保険ポリシーにご加入の方は、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Health Net of California, Inc.が提供するHMOまたはHSPプランにご加入の方は、カリフォルニア州管理医療庁（DMHC）のヘルプライン、1-888-HMO-2219までご連絡ください。お客様のプランの発行者がHealth Net Life Insurance CompanyまたはHealth Net of California, Inc.のどちらであるかは、IDカードに記載されています。

Japanese

الخدمات اللغوية المجانية: يمكنك الحصول على مترجم فوري للمساعدة في قراءة مستنداتك باللغة التي تتحدث بها. للحصول على المساعدة يُرجى الاتصال بنا على الرقم الموضح على بطاقة التعريف الخاصة بك، أو إذا كنت من مقدّمي الطلبات من الموظفين يُرجى الاتصال بمركز التواصل مع العملاء لدى Health Net على الرقم 1-800-522-0088. بالنسبة لمقدّمي طلبات خطة الفرد والأسرة (IFP)، يُرجى الاتصال على الرقم 1-877-609-8711. للحصول على المزيد من المساعدة: إذا كنت مسجلاً في سياسة التأمين بخطة PPO أو EPO التي تكتتبها شركة التأمين Health Net Life Insurance Company على الحياة، يُرجى الاتصال بـ CA Dept. of Insurance (وزارة التأمين بولاية كاليفورنيا) على الرقم 1-800-927-4357. إذا كنت مسجلاً في خطة HMO أو HSP التي توفرها شركة Health Net of California, Inc.، يُرجى الاتصال بخط المساعدة لدى DMHC على الرقم 1-888-HMO-2219. توضح بطاقة التعريف الخاصة بك ما إذا كان تم إصدار خطتك عبر شركة التأمين على الحياة Health Net Life Insurance Company أو شركة Health Net of California, Inc.

Arabic

خدمات بی هزینه مربوط به زبان. می توانید از خدمات یک مترجم شفاهی برخوردار شده و بگوئید تا نوشته ها به زبان خودتان برایتان خوانده شوند. برای دریافت کردن کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است تماس بگیرید، و یا متقاضیان گروه کارفرمایان لطفا با مرکز تجارتی تماس Health Net به شماره 1-800-522-0088 تماس بگیرند. متقاضیان "طرح افراد و خانواده ها" (IFP) لطفاً به شماره 1-877-609-8711 تلفن کنند. برای دریافت کمک بیشتر: اگر برای یک بیمه نامه PPO یا EPO که توسط Health Net Life Insurance Company تضمین شده است ثبت نام کرده اید، به اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تلفن کنید. اگر در یک طرح HMO یا HSP که توسط Health Net of California, Inc. فراهم شده است ثبت نام میکنید، به خط کمکی DMHC به شماره 1-888-HMO-2219 تلفن کنید. کارت شناسائی تان نشان میدهد که آیا طرح شما توسط Health Net Life Insurance Company صادر شده است یا Health Net of California, Inc.

Farsi

Walang Gastusin na Mga Serbisyo sa Wika. Maaari kang kumuha ng interpreter at basahin sa iyong wika ang mga dokumento. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card, o para sa mga aplikante ng pangkat ng employer, mangyaring tawagan ang Commercial Contact Center ng Health Net sa 1-800-522-0088. Para sa mga aplikante ng Individual & Family Plan (IFP), mangyaring tumawag sa 1-877-609-8711. Para sa karagdagang tulong: Kung naka-enroll ka sa isang insurance policy ng PPO o EPO na napapailalim sa Health Net Life Insurance Company, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Kung naka-enroll ka sa isang plano ng HMO o HSP na ipinagkakaloob ng Health Net of California, Inc., tawagan ang DMHC Helpline sa 1-888-HMO-2219. Isinasaad ng iyong ID card kung ang iyong plano ay ibinigay ng Health Net Life Insurance Company o Health Net of California, Inc.

Tagalog

Kev Pab Lus Tsis Muaj Nqi Them. Koj txais tau tus neeg txhais lus thiab muab tau cov ntawv los nyeem rau koj ua koj hom lus. Kom tau kev pab, hu rau peb ntawm tus xovtooj sau rau koj daim npav ID, lossis cov tib neeg yuav thov kev pab tom chaw haujlwm thov hu rau Health Net Lub Chaw Pab Cov Tib Neeg Siv Cov Kev Pab (Customer Contact Center) ntawm 1-800-522-0088. Cov neeg thov kev pab hauv pawg Tus Kheej & Tsev Neeg (Individual and Family Plan; IFP) thov hu rau 1-877-609-8711. Yog xav tau kev pab ntxiv: Yog koj muaj npe nkag nrog PPO lossis EPO cov kev tuav pov hwm los ntawm Health Net Life Insurance Company, hu rau CA Qhov Chaw Saib Xyuas Txog Kev Tuav Pov Hwm (Dept. of Insurance) ntawm 1-800-927-4357. Yog koj muaj npe nkag nrog ib qho kev npaj pab HMO lossis HSP uas los ntawm Health Net of California, Inc., hu rau DMHC Tus Xovtooj Muab Kev Pab ntawm 1-888-HMO-2219. Koj daim npav ID yuav qhia tau tias koj qhov kev npaj pab yog los ntawm Health Net Life Insurance Company lossis Health Net of California, Inc.

Hmong

Doo Bąąh ‘Alínígóó Saad Bee ‘áka’anída’awo’ígíí. ‘Ata’ halne’í dóó naaltsoos bee ‘éédahozinígíí t’áá ni nizaad bee hadadilyaago nich’į’ yídóoltah. ‘Áka’a’eyeed biniiyégo, ninaaltsoos nitł‘izí bee nééhozinígíí bine’dęę’ béésh bee haneí biká’ígíí bee nich’į’ hodíilnih, doodago ninaalishí bił hada’dil’ínígíí t’áá shǫǫdí Health Net Commercial Hane’ ‘Íił‘įh Bił Haz’ánijį’ 1-800-522-0088 hodíilnih. Ła’ Jizíh dóó Hooghan Haz’ą́ągi Naaltsoos Hadadít’éhígíí (IFP) hada’dile’ígíí t’áá shǫǫdí kohjį’ 1-877-609-8711 hodíilnih. T’áá náásgóó ‘áka’a’eyeed biniiyégo: PPO doodago EPO béeso ‘ách’ą́ąh naa’nil bibee haz’áanii Health Net Life Insurance Company, bich’į’ haidiilaaígíí bił ha’dít’éhígíí bił ha’diléehgo, CA Dept. béeso ‘áchą́ąh naa’nil bił haz’ánígíí bich’į’ kohjį’ 1-800-927-4357 hodíilnih. Health Net of California, Inc. biyaadóó HMO doodago HSP bił ha’dít’éhígíí bił ha’diléehgo, DMHC ‘Áka’aná’awo’ Bił Haz’ánígíí kohjį’1-888-HMO-2219 hodíilnih. Health Net Life Insurance Company doodago Health Net of California, Inc. bił naaltsoos bił náha’dít’éhígíí ninaaltsoos nitł‘izí bine’dęę’ bikáá’.

Navajo

ਭਾਸ਼ਾ ਦੀਆਂ ਮੁਫਤ ਸੇਵਾਵਾਂ। ਤੁਹਾਨੂੰ ਦੁਭਾਸ਼ੀਆ ਮਿਲ ਸਕਦਾ ਹੈ ਅਤੇ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈ ਡੀ ਕਾਰਡ ‘ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ, ਜਾਂ ਇੰਪਲਾਇਰ ਗਰੁੱਪ ਦੇ ਅਰਜ਼ੀਦਾਤਾ ਕਿਰਪਾ ਕਰਕੇ Health Net ਦੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ 1-800-522-0088 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਯੋਜਨਾ (IFP) ਵਾਲੇ ਅਰਜ਼ੀਦਾਤਾ ਕਿਰਪਾ ਕਰਕੇ 1-877-609-8711 ਨੰਬਰ ਤੇ ਸੰਪਰਕ ਕਰੋ। ਹੋਰ ਮਦਦ ਲਈ: ਜੇ ਤੁਸੀਂ Health Net Life Insurance Company ਵਲੋਂ ਜਾਰੀ ਕਿਸੇ PPO ਜਾਂ EPO ਬੀਮਾ ਪਾਲਿਸੀ ਲਈ ਨਾਂ ਲਿਖਵਾਇਆ ਹੈ ਤਾਂ ਕੈਲੀਫੋਰਨਿਆ ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ 1-800-927-4357 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਜੇ ਤੁਸੀਂ Health Net of California, Inc. ਵਲੋਂ ਮੁਹੱਈਆ ਕੀਤੀ ਗਈ ਕਿਸੇ HMO ਜਾਂ HSP ਯੋਜਨਾ ਲਈ ਨਾਂ ਲਿਖਵਾਇਆ ਹੈ ਤਾਂ DMHC ਦੀ ਹੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਤੁਹਾਡੇ ਆਈ ਡੀ ਕਾਰਡ ਤੇ ਦਿਖਾਇਆ ਗਿਆ ਹੈ ਕਿ ਤੁਹਾਡੀ ਯੋਜਨਾ Health Net Life Insurance Company ਵਲੋਂ ਜਾਰੀ ਕੀਤੀ ਗਈ ਸੀ ਜਾਂ Health Net of California, Inc. ਵਲੋਂ।

Punjabi

សេវាបកប្រែភាសាឥតអស់ថ្លៃ។ អ្នកអាចទទួលអ្នកបកប្រែភាសា និងឲ្យគេអានឯកសារជូនអ្នកជាភាសាខ្មែរបាន។ សំរាប់ជំនួយ សូមទូរស័ព្ទមកយើង តាមលេខមានកត់នៅលើប័ណ្ណ ID របស់អ្នក ក្រុមនិយោជកអ្នកដាក់ពាក្យសុំ សូមទូរស័ព្ទទៅមជ្ឈមណ្ឌលទំនាក់ទំនងពាណិជ្ជកម្មរបស់ Health Net តាមលេខ 1-800-522-0088។ អ្នកដាក់ពាក្យសុំគំរោងបុគ្គលម្នាក់ៗ និងគ្រួសារ (IFP) សូមទូរស័ព្ទទៅលេខ 1-877-609-8711។ សំរាប់ព័ត៌មានបន្ថែម : បើអ្នកបានចុះឈ្មោះក្នុងផ្សាប់សន្យាធានារ៉ាប់រង PPO ឬ EPO បានធានារ៉ាប់រងដោយ Health Net Life Insurance Company ទូរស័ព្ទទៅក្រសួង ធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រនីញ៉ា តាមលេខ 1-800-927-4357។ បើអ្នកបានចុះឈ្មោះក្នុងគំរោង HMO ឬ HSP ដែលបានផ្តល់ដោយ Health Net of California, Inc.។ ទូរស័ព្ទទៅខ្សែជំនួយ DMHC តាមលេខ 1-888-HMO-2219។ ប័ណ្ណ ID របស់អ្នក បង្ហាញថាតើគំរោងរបស់អ្នកបានចេញ ដោយ Health Net Life Insurance Company ឬ Health Net of California, Inc.។

Khmer

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и вам могут прочитать документы на вашем языке. Если вам требуется помощь, звоните нам по номеру телефона, указанному на вашей идентификационной карте. Участники плана группового страхования по месту работы могут обратиться в Коммерческий контактный центр компании Health Net (Commercial Contact Center) по телефону 1-800-522-0088. Участники планов индивидуального и семейного страхования (Individual and Family Plan, IFP), пожалуйста, звоните по номеру 1-877-609-8711. Для получения дополнительной помощи: если у вас страховой полис Организации с предпочтительными поставщиками услуг (Preferred Provider Organization, PPO) или Организации с обязательными поставщиками услуг (Exclusive Provider Organization, EPO), который предоставляется компанией Health Net Life Insurance Company, обращайтесь в Департамент страхования штата Калифорния (CA Dept. of Insurance) по телефону 1-800-927-4357. Если вы зарегистрированы в плане HMO или HSP, который предоставлен компанией Health Net of California, Inc., звоните на телефон Горячей линии Департамента организованного медицинского обслуживания (DMHC Helpline) по номеру 1-888-HMO-2219. На вашей идентификационной карте указано, был ли ваш план оформлен компанией Health Net Life Insurance Company или компанией Health Net of California, Inc.

Russian