

Health Net's Exclusive ID Card Express

EMPLOYER GUIDE

For groups of 101–500





You Have Our Word, Backed by \$7,500!

As a new Health Net employer group, we want to make sure your employees have access to their health care benefits right away. We guarantee we'll mail out their ID cards in ten working days, or we'll pay you \$7,500. No other California health care company offers a promise like that.



The Health Net guarantee

Our exclusive **ID Card Express** is the perfect way to ensure your employees have access to their health care benefits right away. Here's everything you need to know about who's eligible for this guarantee and how it works.

Who is Eligible?

- New California groups only;
- With 101 to 500 employees; and
- Choose from Health Net's Enhanced Choice plan options.

Here's how it works

1. Once we approve your application and enrollment package, you'll receive a welcome letter from Health Net. This letter will let you know you qualify for ID Card Express.
2. We guarantee Health Net ID cards will be mailed to your group within 10 working days from the date of the welcome letter.
3. If we don't live up to our promise, we'll pay you \$7,500!

How to Submit your Enrollment Package

Here are some tips to help you meet the guarantee rules. Your broker or Health Net sales consultant will provide you with the required enrollment spreadsheet, called the Census Robotech Member Enrollment Template or Generic 349 Layouts Medical Dental Vision Life. You will need to fill out one of these spreadsheets based on your enrollment type.

- Provide all your employee enrollment forms or the required spreadsheet to Health Net as soon as possible so they can be processed with the initial submission.
 - Late or incomplete packages may be disqualified.
- Check your spreadsheet or enrollment forms. **Make sure they are complete and contain no errors.** Enrollment Packages with more than 30 percent discrepancies will delay ID cards and are not covered by this offer.

Keeping you informed

Your broker or Health Net sales consultant will work closely with you to keep you informed about your eligibility and if your employees' enrollment materials meet the qualification requirements for this guarantee. If there are any issues with the materials, or if your eligibility changes during the process, you'll be advised right away.



Double check all the highlighted critical fields as noted in the sample shown here.

Section 7 is only critical if the member wants to decline coverage for themselves or their eligible dependent(s).

To be completed by employer

1. Health plan information (select coverage)

MEMO
 HMO HMO with PPO PPO HSA compatible PPO HSA compatible PPO HSA compatible PPO HSA compatible PPO HSA compatible PPO HSA compatible PPO

2. Reason for application

New hire Change administrator Health dependent Other

3. Employee personal information

Name: [Redacted] Title: [Redacted]
 Address: [Redacted] City: [Redacted] State: [Redacted] ZIP: [Redacted]
 Date of birth (MM/DD/YYYY): [Redacted] Social Security # (Required for all applicants): [Redacted] Job title: [Redacted]
 Telephone #: [Redacted] Work phone #: [Redacted] Email address: [Redacted]
 Marital status: [Redacted] Single [Redacted] Married [Redacted] Domestic partner [Redacted]
 Participating physician group: [Redacted] Primary care physician: [Redacted]

Employee name: [Redacted] (Use a digit of Social Security #)

4. Family information - please list all eligible family members to be enrolled (Select additional sheet if necessary)

Relationship	First name	Last name	First name	Last name	City	State	ZIP
Spouse/Commitment partner	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]
Dependent	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]
Dependent	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]

Participating physician group: [Redacted] Primary care physician: [Redacted]
 PPO/HMO enrollment ID # (24-digit PPO and 6-digit PPO numbers): [Redacted] Is this your current PPO? Yes No
 Dental HMO provider name: [Redacted] Dental HMO provider ID #: [Redacted]

Employee name: [Redacted] (Use a digit of Social Security #)

5. Do you or your dependents have other health care coverage?

Self	Spouse	Child	Other dependent
<input type="checkbox"/> Yes <input type="checkbox"/> No Name: [Redacted] Reason for ending coverage: [Redacted] Group ID or Policy ID #: [Redacted]	<input type="checkbox"/> Yes <input type="checkbox"/> No Name: [Redacted] Reason for ending coverage: [Redacted] Group ID or Policy ID #: [Redacted]	<input type="checkbox"/> Yes <input type="checkbox"/> No Name: [Redacted] Reason for ending coverage: [Redacted] Group ID or Policy ID #: [Redacted]	<input type="checkbox"/> Yes <input type="checkbox"/> No Name: [Redacted] Reason for ending coverage: [Redacted] Group ID or Policy ID #: [Redacted]

6. Group term life insurance, if applicable (attach separate sheet for additional or contingent beneficiaries.)

Life beneficiary (full name)	Relationship	%
[Redacted]	[Redacted]	[Redacted]
[Redacted]	[Redacted]	[Redacted]
[Redacted]	[Redacted]	[Redacted]

Employee name: [Redacted] (Use a digit of Social Security #)

7. Declaration of coverage (complete this section if any coverage is being declined by you or your eligible dependent(s))

Employee personal information

First name: [Redacted] Last name: [Redacted] City: [Redacted] State: [Redacted] ZIP: [Redacted]
 Social Security # (Required for all applicants): [Redacted]
 Participating physician group: [Redacted] Primary care physician: [Redacted]
 PPO/HMO enrollment ID # (24-digit PPO and 6-digit PPO numbers): [Redacted] Is this your current PPO? Yes No
 Dental HMO provider name: [Redacted] Dental HMO provider ID #: [Redacted]

IF YOU ARE DECLINING COVERAGE - STOP AND READ CAREFULLY

I have decided to decline coverage for myself and/or my dependent(s). I acknowledge that my dependents and I may lose the right to be enrolled and the coverage provided for myself and/or my dependent(s) if I do not provide a written declaration of coverage. The available coverages have been explained to me by my employer, and I have been given the chance to apply for the available coverages. Additionally, by signing below, I certify that the reason I am declining coverage is accurate as indicated by the check marks above.

Signature required: (Sign only if declining coverage. If signed in error, please cross out and initial.) Date: [Redacted]

8. Acceptance of coverage (signature required)

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

ACKNOWLEDGMENT AND AGREEMENT: I understand and agree that by enrolling with or accepting services from Health Net, and/or any other group or individual, I am obligated to understand and abide by the terms, conditions and provisions of the plan contract or insurance policy. I have read and understood the terms of this application, and my signature below indicates that the information entered in this application is complete, true and correct to the best of my information and belief, 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, except disputes concerning adverse benefit determinations as defined in 45 CFR 147.156, must be submitted to individual, final and binding arbitration instead of a jury or court trial and that I am waiving all rights to class arbitration. This agreement to arbitrate includes any disputes arising from or relating to the Evidence of Coverage or Certificate of Insurance or my Health Net membership or 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 individual, 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 Evidence of Coverage or Certificate of Insurance. 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.

Employee signature: [Redacted] Date: [Redacted]
 (Sign only if accepting coverage. If signed in error, please cross out and initial.)



Next steps

You're all set – there's nothing else for you to do. We'll make sure your group receives their ID cards promptly, as promised.

You and your employees will be able to access benefits right away. And you'll find more helpful services online at www.healthnet.com.

- **For you:** Easy-to-use online billing and enrollment.
- **For your employees:** Online tools and resources to view benefits and claims, find doctors, and access wellness programs.

Health Net – your trusted partner
for better health



Call your broker or your Health Net sales consultant today to find out more about our ID Card Express program. We look forward to partnering with you to help your employees live and work well.