Health Net of California, Inc. and/or
Health Net Life Insurance Company (Health Net)

2026 Large Business Application

for Group Enrollment and Change

Medical plans are provided by Health Net of California, Inc. Dental HMO and PPO plans are offered and administered by Dental Benefit Providers of California, Inc. (DBP). Vision plans are underwritten by Health Net Life Insurance Company and administered by EyeMed Vision Care, LLC ("EyeMed"). Life/AD&D insurance plans are underwritten by Health Net Life Insurance Company.

Neither DBP nor EyeMed are affiliated with Health Net. Obligations under dental plans are not the obligations of, and are not guaranteed by, Health Net.

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.

2a. **If you are *declining* coverage** for yourself and/or your dependents, section 7 is required. Do not fill out any other sections.

2b. **If you are *accepting* coverage** for yourself and/or your dependents, sections 1, 2, 3, 4 (where applicable), 5, and 8 are required.

The Affordable Care Act (ACA) requires Health Net to provide to the IRS confirmation of health care coverage for yourself, as the subscriber, and your covered dependents. The IRS uses this information to confirm each member has essential coverage. Please ensure that the Social Security number (SSN) is accurate for yourself and each dependent you are enrolling. For more information about the individual shared responsibility payment provision, go to http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision.

3. If you choose to enroll in the HMO, ExcelCare HMO, SmartCare HMO, Salud HMO y Más, Salud Mexico, Elect Open Access (EOA), Select POS, or Dental HMO plans, you must select your participating physician group (PPG), primary care physician (PCP) or dental provider. Be sure to fill in the names and numbers as they appear in Health Net's online ProviderSearch tool.

   Note: If you do not select a PPG, PCP and/or a dental provider, one will be selected for you.

4. If you choose to enroll in a PPO plan, you are not required to select a PPG or PCP to enroll.

5. Make a copy of the completed application for your records. **If a correction is needed, cross out and initial each correction. Please do not use a white-out product.**

For administrative use only:	
Existing Business/Group PO Box 9103 Van Nuys, CA 91409-9103 www.healthnet.com	**New Business/Group** Please send all completed paperwork to your designated account executive or broker.

To be completed by employer	
Employer name:	
Requested effective date: / /	Employer group number (medical):
Employee eligibility date (new hire only): ☐ Same as hire date ☐ Other: / /	

Important: Please print all sections in black ink. You are entitled to see a Summary of Benefits and Coverage (SBC) before you choose a plan. Please contact your employer if you do not have the SBC for the plan you have selected.

1. Health plan information (Select coverage.)

HMO

☐ HMO ☐ SmartCare HMO[1] ☐ ExcelCare HMO[2] ☐ Salud HMO y Más[3] ☐ EOA ☐ ExcelCare EOA[2] ☐ Select POS
☐ Other: _____

PPO

☐ PPO ☐ OOS PPO ☐ HSA-compatible PPO ☐ OOS HSA-compatible PPO ☐ Integrated HSA-compatible PPO
☐ Integrated HSA-compatible PPO (opt out) ☐ Integrated HRA-compatible PPO

Dental and Vision

☐ Dental (DHMO) ☐ Dental (DPPO) ☐ Vision (PPO)

2. Reason for application

☐ Plan change
☐ Change address/name
☐ Delete dependent
☐ Other:

_____

_____

☐ New hire ☐ Open Enrollment

Special Enrollment Period

Qualifying event date: _____/_____/_____
Add dependent: _____

COBRA

☐ Effective date: _____/_____/_____
Qualifying event: _____
Qualifying event date: _____/_____/_____

☐ Marriage
☐ Newborn/Adoption/Legal guardianship/Court order/Assumption of parent-child relationship
☐ Loss of prior coverage: _____/_____/_____
☐ Other (specify): _____

3. Employee personal information

Last name:	First name:	MI:	☐ Male ☐ Female
Residence address:	City	State:	ZIP:
Date of birth (mm/dd/yyyy): / /	Social Security #/Matricular ID # (required for all applicants):	Job title:	
Telephone #: ( )	Work phone #: ( )	Email address:	
Date of hire: / /	Dept. #:	Marital status: ☐ Single ☐ Married ☐ Domestic partner	
I would prefer to receive communication and plan information in: ☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Vietnamese			
Participating physician group:	Primary care physician:		
PPG/PCP enrollment ID # (4-digit PPG and 6-digit PCP numbers):	Is this your current PCP? ☐ Yes ☐ No		
Dental HMO provider name:	Dental HMO provider ID #:		

[1]Available in all or parts of Los Angeles, Marin, Orange, Placer, Riverside, San Bernardino, San Diego, Santa Clara, and Santa Cruz counties.
[2]Available in all or parts of Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Francisco, Santa Clara, Stanislaus, and Ventura counties.
[3]Available in Imperial and Orange County and select ZIP codes of Kern, Los Angeles, Riverside, San Diego, and San Bernardino counties.

4. Family information – please list all eligible family members to be enrolled

(Attach additional sheets if necessary.)

Spouse/Domestic partner ☐ M ☐ F	Last name:	First name:	MI:
Residence address: ☐ Check here if same as subscriber		City:	State:	ZIP:
Date of birth (mm/dd/yyyy): / /		Social Security #/Matricular ID # (required for all applicants):	
Participating physician group:		Primary care physician:	
PPG/PCP enrollment ID # (4-digit PPG and 6-digit PCP numbers):		Is this your current PCP? ☐ Yes ☐ No	
Dental HMO provider name:		Dental HMO provider ID #:	

☐ Son ☐ Daughter	Disabled: ☐ Yes ☐ No	Last name:	First name:	MI:
Residence address: ☐ Check here if same as subscriber			City:	State: ZIP:
Date of birth (mm/dd/yyyy): / /			Social Security #/Matricular ID # (required for all applicants):	
Participating physician group:			Primary care physician:	
PPG/PCP enrollment ID # (4-digit PPG and 6-digit PCP numbers):			Is this your current PCP? ☐ Yes ☐ No	
Dental HMO provider name:			Dental HMO provider ID #:	

☐ Son ☐ Daughter	Disabled: ☐ Yes ☐ No	Last name:	First name:	MI:
Residence address: ☐ Check here if same as subscriber			City:	State: ZIP:
Date of birth (mm/dd/yyyy): / /			Social Security #/Matricular ID # (required for all applicants):	
Participating physician group:			Primary care physician:	
PPG/PCP enrollment ID # (4-digit PPG and 6-digit PCP numbers):			Is this your current PCP? ☐ Yes ☐ No	
Dental HMO provider name:			Dental HMO provider ID #:	

☐ Son ☐ Daughter	Disabled: ☐ Yes ☐ No	Last name:	First name:	MI:
Residence address: ☐ Check here if same as subscriber			City:	State: ZIP:
Date of birth (mm/dd/yyyy): / /			Social Security #/Matricular ID # (required for all applicants):	
Participating physician group:			Primary care physician:	
PPG/PCP enrollment ID # (4-digit PPG and 6-digit PCP numbers):			Is this your current PCP? ☐ Yes ☐ No	
Dental HMO provider name:			Dental HMO provider ID #:	

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

☐ No ☐ Yes If "Yes," please complete this section, including Medicare.

☐ Self	Name:		Name of other insurance carrier:		Prior coverage start date (mm/dd/yy): / /	
Prior coverage end date (mm/dd/yy): / /	Reason for ending coverage:		Group #/Policy ID #:	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:

☐ Spouse ☐ Domestic partner	Name:		Name of other insurance carrier:		Prior coverage start date (mm/dd/yy): / /	
Prior coverage end date (mm/dd/yy): / /	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? ☐ Yes ☐ No	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:

☐ Son ☐ Daughter	Name:		Name of other insurance carrier:		Prior coverage start date (mm/dd/yy): / /	
Prior coverage end date (mm/dd/yy): / /	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? ☐ Yes ☐ No	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:

☐ Son ☐ Daughter	Name:		Name of other insurance carrier:		Prior coverage start date (mm/dd/yy): / /	
Prior coverage end date (mm/dd/yy): / /	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? ☐ Yes ☐ No	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:

☐ Son ☐ Daughter	Name:		Name of other insurance carrier:		Prior coverage start date (mm/dd/yy): / /	
Prior coverage end date (mm/dd/yy): / /	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? ☐ Yes ☐ No	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:

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

Life/AD&D coverage: ☐ Yes ☐ No

Life beneficiary (full name):	Relationship:	%
Life beneficiary (full name):	Relationship:	%
Life beneficiary (full name):	Relationship:	%
Life beneficiary (full name):	Relationship:	%

7. Declination of coverage (Complete this section if any coverage is being declined by you or your eligible dependents.)

Employee personal information

Last name:	First name:	MI:	Social Security #/Matricular ID #:

Declining medical coverage for:
☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent(s)
Name(s): _____

Declining dental coverage for:
☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent(s)
Name(s): _____

Declining vision coverage for:
☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent(s)
Name(s): _____

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

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

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

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 have to wait to be enrolled until the next annual Open Enrollment Period or Special Enrollment Period due to a qualifying event. 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.

Employee signature: _____ **Date:** ____/____/_____
(Sign only if declining coverage. If signed in error, please cross out and initial.)

8. Acceptance of coverage (Signature required.)

California law prohibits an HIV test 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 DBP, I and any enrolled dependents are obligated to understand and abide by the terms, conditions and provisions of the Plan Contract or Insurance Policy.[4] 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 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 147.136, 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: _____ **Date:** ____/____/_____
(Sign only if accepting coverage. If signed in error, please cross out and initial.)

[4] "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 Group Policy and Certificate of Insurance.

Please contact Health Net Member Services at one of the toll-free numbers below, if you need assistance completing this form or if you have questions about your coverage:

English	800-522-0088
Cantonese	877-891-9050
Korean	877-339-8596
Mandarin	877-891-9053
Spanish	800-331-1777
Tagalog	877-891-9051
Vietnamese	877-339-8621

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

Dental	866-249-2382
Vision	866-392-6058
Life	800-865-6288

If you have questions about your PPG or PCP, call your PPG directly, or contact Health Net Provider Services at 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.

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 urgent care center/facility.
- 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 participating physician group as soon as possible to inform them about your condition.
- Call the number on your ID card within 48 hours of being admitted or as soon as possible.

Precertification

You, the member, are responsible for obtaining certification for certain services. Please check your plan certificate for a list of services requiring precertification. **For precertification, please call 800-522-0088.**

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 occurs 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 the prior insurer.

Products/Entities

Health Net of California, Inc. offers the following products: PPO, PPO HSA, HMO, ExcelCare HMO, SmartCare HMO, Salud HMO y Más, Salud Mexico, Elect Open Access (EOA) and Select POS.

Dental Benefit Providers of California, Inc. offers the following: Dental HMO and PPO.

Health Net Life Insurance Company offers the following products: Life and AD&D insurance.

Health Net Life Insurance Company underwrites the following product administered by EyeMed Vision Care, LLC: PPO Vision.

Declination of coverage

If you decline coverage for yourself or an eligible dependent because of coverage under other health insurance and you lose that coverage, or if you acquire a new dependent due to marriage, domestic partnership, birth, adoption, placement for adoption, or assumption of parent-child relationship, 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.

English
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 call 1-800-522-0088 (TTY: 711).

Arabic
خدمات اللغة مجانية. يمكنك الحصول على مترجم فوري. ويمكنك الحصول على وثائق مقروءة لك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة الهوية، أو اتصل على مركز الاتصال التجاري (TTY: 711) 1-800-522-0088

Armenian
Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեզ համար: Օգնության համար զանգահարեք մեզ ձեր ID քարտի վրա նշված հեռախոսահամարով կամ զանգահարեք 1-800-522-0088 (TTY: 711).

Chinese
免費語言服務。您可使用口譯員。您可請人使用您的語言將文件內容唸給您聽，並請我們將有您語言版本的部分文件寄給您。如需協助，請致電您會員卡上所列的電話號碼與我們聯絡，或致電 1-800-522-0088 (TTY: 711)。

Hindi
बिना लागत की भाषा सेवाएँ। आप एक दुभाषिया प्राप्त कर सकते हैं। आपको दस्तावेज पढ़ कर सुनाए जा सकते हैं। मदद के लिए, आपके आईडी कार्ड पर दिए गए सूचीबद्ध नंबर पर हमें कॉल करें, या 1-800-522-0088 (TTY: 711)।

Hmong
Kev Pab Txhais Lus Dawb. Koj xav tau neeg txhais lus los tau. Koj xav tau neeg nyeem cov ntaub ntawv kom yog koj hom lus los tau. Xav tau kev pab, hu peb tau rau tus xov tooj ntawm koj daim npav los yog hu 1-800-522-0088 (TTY: 711).

Japanese
無料の言語サービス。通訳をご利用いただけます。文書をお読みします。援助が必要な場合は、IDカードに記載されている番号までお電話いただくか、1-800-522-0088 、(TTY: 711)。

Khmer
សេវាភាសាដោយឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ អ្នកអាចស្តាប់គេអានឯកសារឱ្យអ្នក។ សម្រាប់ជំនួយ សូមទាក់ទងយើងខ្ញុំតាមរយៈលេខទូរស័ព្ទដែលមាននៅលើកាតសម្គាល់ខ្លួនរបស់អ្នក ឬ ទាក់ទងទៅមជ្ឈមណ្ឌលទំនាក់ទំនងពាណិជ្ជកម្ម នៃក្រុមហ៊ុន 1-800-522-0088 (TTY: 711).។

Korean
무료 언어 서비스. 통역 서비스를 받을 수 있습니다. 귀하가 구사하는 언어로 문서의 낭독 서비스를 받으실 수 있습니다. 도움이 필요하시면 보험 ID 카드에 수록된 번호로 전화하시거나 1-800-522-0088 (TTY: 711).

Navajo
Saad Bee Áká E'eyeed T'áá Jíík'e. Ata' halne'ígíí hóló. T'áá hó hazaad k'ehjí naaltsoos hach'į' wóltah. Shíká a'doowoł nínízingo naaltsoos bee néího'dólzinígíí bikáa'gi béésh bee hane'í bikáá' áajį' hodíílnih éí doodaii' 1-800-522-0088 (TTY: 711).

Persian (Farsi)
خدمات زبان به طور رایگان. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید که اسناد برای شما قرائت شوند. برای دریافت راهنمایی، با ما به شماره ای که روی کارت شناسایی شما درج شده تماس بگیرید یا با مرکز تماس بازرگانی 1-800-522-0088 (TTY: 711).

Panjabi (Punjabi)

ਬਨਿਾਂ ਕਸਿੇ ਲਾਗਤ ਤੋਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਆ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਚਿ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦੱਤਿੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ ਕਰਿਪਾ ਕਰਕੇ 1-800-522-0088 (TTY: 711).

Russian

Бесплатная помощь переводчиков. Вы можете получить помощь устного переводчика. Вам могут прочитать документы. За помощью обращайтесь к нам по телефону, приведенному на вашей идентификационной карточке участника плана. Кроме того, вы можете позвонить в 1-800-522-0088 (TTY: 711).

Spanish

Servicios de idiomas sin costo. Puede solicitar un intérprete. Puede obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o comuníquese con el 1-800-522-0088 (TTY: 711).

Tagalog

Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng isang interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo. Para sa tulong, tawagan kami sa nakalistang numero sa inyong ID card o tawagan ang 1-800-522-0088 (TTY: 711).

Thai

ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังได้ สำหรับความช่วยเหลือ โทรหาเราตามหมายเลขที่ให้ไว้บนบัตรประจำตัวของคุณ หรือ โทรหาศูนย์ติดต่อเชิงพาณิชย์ของ 1-800-522-0088 (TTY: 711)

Vietnamese

Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu cầu được đọc cho nghe tài liệu. Để nhận trợ giúp, hãy gọi cho chúng tôi theo số được liệt kê trên thẻ ID của quý vị hoặc gọi 1-800-522-0088 (TTY: 711).