Employer Group

Medical Coordination of Benefits

Enrollment Request Form

Employer name:	
Coverage effective date	Employer group number (Medical):

Important – Please print all sections in black ink. For the application to be valid, you must submit all applicable pages.

1. Select coverage

1a: Check the desired plan as offered by your employer: (Write the plan number next to the product.)

☐ HMO: _____	☐ PPO: _____
☐ HMO: ExcelCare _____	☐ POS: Select _____
☐ HMO: SmartCare _____	☐ Flex Net/Flex Med: _____

Reason for application:

☐ Retiree ☐ Open Enrollment ☐ Loss of prior coverage date: _____

☐ COBRA effective date: _____ Qualifying event: _____ Qualifying event date: _____

☐ Add dependent Qualifying event: _____ Qualifying event date: _____

Reason for change:

☐ Plan change ☐ Change address/name ☐ Delete dependent(s) (List names in Section 3.)

☐ Other: _____

1b: Please provide your Medicare insurance information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

OR

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

_____

Medicare number:

___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Is entitled to: Effective date:

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

You must have Medicare Part A and Part B to join a Medicare Coordination of Benefits plan.

2. Retiree personal information

Last name:	First name:	MI:	Date of birth (MM/DD/YYYY):	
Residence address:	City:		State:	ZIP:
Mailing address (if different from residence):	City:		State:	ZIP:

Retiree name:		

2. Retiree personal information (continued)

Home telephone #: ( )	Social Security #:	Email address:
☐ Male ☐ Female	Marital status: ☐ Single ☐ Married ☐ Domestic partner	
Participating physician group/PPG #:	Primary care physician/PCP #:	☐ N/A. I'm enrolling in a PPO or Flex Net/Flex Med plan.
Physician name (first, last):		Is this your current MD? ☐ Yes ☐ No

Other health coverage? If "Yes," please complete this section if you **currently** have or **previously** had coverage with any public or private health plan (including Medi-Cal or Individual coverage) immediately prior to becoming eligible for this plan. According to federal laws, if you had prior coverage, your employer or former carrier must provide you with a certificate that shows evidence of your coverage. We reserve the right to request a copy of this certificate.

Name of subscriber:	Prior coverage start date: __ __/__ __/__ __ __ __ (M M / D D / Y Y Y Y)
Name and address of other insurance carrier:	
Prior coverage start date: __ __/__ __/__ __ __ __ (M M / D D / Y Y Y Y)	Reason for ending coverage:

Group #/Policy ID #:	Is this your primary coverage? ☐ Yes ☐ No	Does it cover medical? ☐ Yes ☐ No

Are you enrolling dependents? ☐ Yes ☐ No
If "Yes," complete and submit all pages of the form. If "No," and you are declining coverage for yourself or a dependent, please complete the Declination of Coverage section at the bottom of page 4.

3. Family information (Please list all eligible family members to be enrolled. To add additional dependents, fill out the Health Net Dependent Information Form, and submit it along with this application.)

DEPENDENT 1

☐ Spouse ☐ Domestic partner	☐ Male ☐ Female	Last name:	First name:	MI:

Residence address (☐ Check here if same as employee.):	City:	State:	ZIP:
Date of birth (MM/DD/YYYY):	Social Security #/Matricula ID #:		

3. Family information (continued)

DEPENDENT 1 (CONTINUED)

Coverage type: ☐ Medical ☐ Medicare Part A ☐ Medicare Part B ☐ Medicare Part D	Medicare number:	Participating physician group/PPG #:
		Primary care physician/PCP #
Physician name (first, last):	Is this your current MD? ☐ Yes ☐ No	Dental HMO Provider ID # (Complete only if electing Health Net Dental.):

Does your dependent have other health care coverage? ☐ Yes ☐ No If "Yes," complete the following:
Name of insurance carrier: _____ Prior coverage start date: _____

DEPENDENT 2

☐ Son ☐ Daughter	Last name:	First name:	MI:

Residence address (☐ Check here if same as employee.):	City:	State:	ZIP:

Date of birth (MM/DD/YYYY):	Totally disabled? ☐ Yes ☐ No	Social Security #/Matricula ID #:

Coverage type: ☐ Medical ☐ Medicare Part A ☐ Medicare Part B ☐ Medicare Part D	Medicare number:	Participating physician group/PPG #:
		Primary care physician/PCP #
Physician name (first, last):	Is this your current MD? ☐ Yes ☐ No	Dental HMO Provider ID # (Complete only if electing Health Net Dental.):

Does your dependent have other health care coverage? ☐ Yes ☐ No If "Yes," complete the following:
Name of insurance carrier: _____ Prior coverage start date: _____

4. Acceptance of coverage (Signature required.)

The use and disclosure of protected health information:
I acknowledge and understand that health care providers may disclose health information about me or my dependents to Health Net entities. Health Net entities use and may disclose this information for purposes of treatment, payment and health plan operations, including but not limited to, utilization management, quality improvement, and disease or case management programs. Health Net's Notice of Privacy Practices is included in the *Evidence of Coverage or Certificate of Insurance* for coverage underwritten by Health Net entities. I may also obtain a copy of this notice on the website at 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.

4. Acceptance of coverage (continued)

Acknowledgement and agreement: I understand and agree that by enrolling with or accepting services from the Health Net 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 to the best of my knowledge, 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.

Retiree signature: _____

Print retiree name: _____ Date: _____

If you are the authorized representative, you must sign above and provide the following information:

Name: _____ Relationship to enrollee: _____

Address: _____ Phone number: (_____) _____ — _____

Complete this section only if any coverage is to be declined by you.

☐ Declining medical coverage

Reason: ☐ Other group coverage ☐ Individual coverage
☐ Other: _____
☐ 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 acknowlege 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. You must request special enrollment within 30 days of the loss of coverage or acquisition of a new dependent.

Employee signature: _____ Date: _____

(ONLY IF DECLINING COVERAGE: If signed in error, please cross out and initial.)

Medical Coordination of Benefits HMO health plans are offered by Health Net of California, Inc. Medical Coordination of Benefits health insurance policies are underwritten by Health Net Life Insurance Company.

Section 1557 Non-Discrimination Language

Notice of Non-Discrimination

Health Net complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Health Net:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Member Services at: **1-800-275-4737** (TTY: **711**). From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.

If you believe that Health Net has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by calling the number above and telling them you need help filing a grievance; Health Net's Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019** (TDD: **1-800-537-7697**).

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Multi-Language Insert

Multi-Language Interpreter Services

Spanish: Contamos con servicios de interpretación gratuitos para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para obtener un intérprete, llámenos al **1-800-275-4737** (TTY: **711**). Alguien que habla español puede ayudarle. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费翻译服务，以便回答您可能对我们的健康或药物计划提出的任何问题。如需翻译，请拨打电话 **1-800-275-4737**（TTY：**711**）。会说汉语普通话的人员可为您提供帮助。此项服务免费。

Chinese Cantonese: 我們提供免費口譯服務，可回答您任何關於我們健康或藥物計劃的問題。若要取得口譯服務，請致電**1-800-275-4737** (TTY：**711**)。會說粵語的人員可以幫助您。此為免費服務。

Tagalog: Mayroon kaming libreng serbisyo ng tagasalin para sagutin ang anumang mga tanong na mayroon ka tungkol sa aming health o drug plan. Para kumuha ng tagasalin, tawagin lang kami sa **1-800-275-4737** (TTY: **711**). May nagsasalita ng Tagalog na puwedeng tumulong sa iyo. Ito ay libreng serbisyo.

French: Nous disposons de services d'interprétation gratuits pour répondre à toutes les questions que vous pouvez avoir sur notre régime de santé ou de médicaments. Pour entrer en contact avec un interprète, il suffit de nous appeler au **1-800-275-4737** (TTY : **711**). Une personne qui parle français peut vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch viên miễn phí để trả lời mọi câu hỏi quý vị có thể có về chương trình thuốc hoặc chương trình sức khỏe của chúng tôi. Để yêu cầu thông dịch viên, chỉ cần gọi cho chúng tôi theo số **1-800-275-4737** (TTY: **711**). Nhân viên nói tiếng Việt sẽ hỗ trợ quý vị. Dịch vụ này được miễn phí.

German: Unser kostenloser Dolmetscherdienst beantwortet mögliche Fragen zu Ihrem Gesundheits- oder Medikamentenplan. Wenn Sie einen Dolmetscher benötigen, rufen Sie uns gerne unter der folgenden Rufnummer an: **1-800-275-4737** (TTY: **711**). Sie erhalten Hilfe in deutscher Sprache. Dieser Service ist für Sie kostenlos.

Korean: 당사의 건강 또는 의약품 플랜과 관련해서 물어볼 수 있는 모든 질문에 답변하기 위한 무료 통역 서비스가 있습니다. 통역사가 필요한 경우, **1-800-275-4737**(TTY: **711**)번으로 당사에 문의해 주십시오. 한국어를 구사하는 통역사가 도움을 드릴 수 있습니다. 통역 서비스는 무료로 제공됩니다.

Russian: Если у вас возникли какие-либо вопросы о нашем плане медицинского страхования или плане с покрытием лекарственных препаратов, для вас предусмотрены бесплатные услуги переводчика. Чтобы воспользоваться услугами переводчика, просто позвоните нам по номеру **1-800-275-4737** (TTY: **711**). Вам поможет сотрудник, владеющий русским языком. Эта услуга предоставляется бесплатно.

Arabic: نوفّر خدمات ترجمة فورية مجانية للإجابة على أي أسئلة قد تكون لديك حول خطة الصحة أو الدواء الخاصة بنا. للحصول على مترجم فوري، ما عليك سوى الاتصال بنا على الرقم **1-800-275-4737** (TTY: **711**). يمكن أن يساعدك شخص يتحدث العربية وهذه الخدمة مجانية.

Hindi: हमारे पास अपने हेल्थ या ड्रग प्लान को लेकर संभवतः आपके मन में उठने वाले सवालों के जवाब देने के लिए मुफ़्त में दुभाषिया सेवाएं हैं. दुभाषिया पाने के लिए, बस **1-800-275-4737** (TTY: **711**) पर हमें कॉल करें. हिंदी जानने वाला कोई व्यक्ति आपकी मदद करेगा. यह सेवा मुफ़्त में है.

Italian: Sono disponibili servizi di interpretariato gratuiti per rispondere a qualsiasi domanda possa avere in merito al nostro piano farmacologico o sanitario. Per usufruire di un interprete, è sufficiente contattare il numero **1-800-275-4737** (TTY: **711**). Qualcuno la assisterà in lingua italiana. È un servizio gratuito.

Portuguese: Temos serviços de intérprete gratuitos para responder a quaisquer dúvidas que possa ter sobre o nosso plano de saúde ou medicação. Para obter um intérprete, contacte-nos através do número **1-800-275-4737** (TTY: **711**). Um falante de português poderá ajudá-lo. Este serviço é gratuito.

French Creole: Nou gen sèvis entèprèt gratis pou reponn nenpòt kesyon ou ka genyen sou plan sante oswa medikaman nou an. Pou jwenn yon entèprèt, jis rele nou nan **1-800-275-4737** (TTY: **711**). Yon moun ki pale Kreyòl-Franse ka ede w. Sa a se yon sèvis gratis.

Polish: Dysponujemy bezpłatnymi usługami tłumaczeniowymi w celu odpowiedzi na dowolne pytania dotyczące naszych planów zdrowotnych i lekowych. Aby uzyskać pomoc tłumacza, zadzwoń pod numer **1-800-275-4737** (TTY: **711**). Osoba mówiąca po polsku może Ci pomóc. Ta usługa jest bezpłatna.

Japanese: 無料の通訳サービスを利用して、健康や医薬品に関するご質問にお答えします。通訳をご希望の場合は、**1-800-275-4737**（TTY: **711**）までお電話ください。日本語話者がお手伝いいたします。このサービスは無料です。