Health Net

Employer Group Enrollment Form

Main subscriber ID:

Effective date: M M D D Y Y Y Y

Please contact Health Net Seniority Plus Employer (HMO) if you need information in another language or format.

To enroll in Health Net, please provide the following information

Employer or union name:

Group #:

Last name:

First name:

Middle initial:

Birth date: M M D D Y Y Y Y

Sex: ☐ M ☐ F

Home Phone Number – –

Optional field: Alternate Phone Number: – –

Permanent Residence Street Address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent address.):

☐ Experiencing homelessness

City:

Optional field: County:

State:

ZIP code:

Mailing address (only if different from your permanent residence):

Street address:

City:

State:

ZIP code:

Optional:
E-mail Address:

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): M M D D Y Y Y Y

MEDICAL (Part B): M M D D Y Y Y Y

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Please read and answer these important questions

1. Are you the retiree? ☐ Yes ☐ No

   If "Yes," retirement date: M M D D Y Y Y Y

   If "No," name of retiree:

2. Are you covering a spouse or dependent(s) under this employer or union plan? ☐ Yes ☐ No

   If "Yes," name of spouse:

   Name of dependent(s)

3. Do you or your spouse work? ☐ Yes ☐ No

4. Some individuals may have other drug coverage, including other private insurance, Workers' Compensation, VA benefits, or State pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to Health Net?

   ☐ Yes ☐ No

   If "Yes," please list your other coverage and your identification (ID) number(s) for this coverage:

   Name of other coverage:

   ID # for this coverage:

5. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

   If "Yes," please provide the following information:

   Name of institution:

   Phone number of institution: – –

   Address & Phone Number of Institution (number and street):

Please choose a Primary Care Physician (PCP):

PCP access number: **Is this your current PCP?** ☐ Yes ☐ No

Please choose a Primary Care Physician Group (PPG):

Is this your current PPG? ☐ Yes ☐ No

Please check one of the boxes below if you would prefer to receive this information in a language other than English or in an accessible format:

☐ Spanish ☐ Chinese ☐ Large print ☐ Audio CD ☐ Data CD ☐ Braille

Please contact Health Net at **1-800-275-4737** (TTY: **711**) if you need information in an accessible format or language other than what is listed above. From October 1 through March 31, our office hours are 7 days a week from 8:00 a.m. to 8:00 p.m. From April 1 through September 30, our office hours are Monday through Friday from 8:00 a.m. to 8:00 p.m. A messaging system is used after hours, on weekends, and federal holidays.

Please Read and Sign Below

By completing this enrollment application, I agree to the following:

Health Net Seniority Plus Employer (HMO) is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (Example: Annual Enrollment Period from October 15–December 7) or under certain special circumstances.

Health Net serves a specific service area. If I move out of the area that Health Net serves, I need to notify the plan so that I can disenroll and find a new plan in my new area. Once I am a member of Health Net, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverage* document from Health Net when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border. I understand that beginning on the date Health Net Seniority Plus Employer (HMO) coverage begins, I must get all of my health care from Health Net, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Health Net and other services contained in my Health Net *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HEALTH NET WILL PAY FOR THE SERVICES.** I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with Health Net, he/she may be paid based on my enrollment in Health Net.

Release of information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Health Net will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under state law to complete this enrollment, and 2) documentation of this authority is available upon request from Medicare.

Signature:

Today's date:

M M D D Y Y Y Y

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

Name:

Address:

Phone number: – –

Relationship to enrollee:

Only for individuals helping enrollee with this form

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name:

Relationship to enrollee:

Signature:

National Producer Number (Agents/Brokers only):

Please Read and Sign Below

BINDING ARBITRATION: All benefits offered under this Medicare health plan, including optional supplemental benefits, if any, are subject to the Medicare appeals procedures and are not subject to arbitration. Conversely, all other claims including, but not limited to, the following claims, regardless of how they are characterized, are subject to arbitration: Determinations on items or services purchased by my employer, over and above the Medicare approved benefit package, such as payments of premiums or beneficiary cost-sharing provided by my employer, any disputes between myself, my heirs, relatives, or other associated parties on the one hand and the health plan, any contracted health care benefit providers, administrators, or other associated parties on the other hand for alleged violation of any duty arising out of or related to membership in the health plan that is not subject to the Medicare appeals process, including any claim for medical or hospital malpractice (a claim that medical services were unauthorized or were improperly, negligently or incompetently rendered), for premises liability, or relating to the delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under State law and not by lawsuit or resort to court process. By signing below, I agree to give up our right to a jury trial and accept the use of binding arbitration for claims that are not subject to the Medicare appeals procedures. I understand that the full arbitration provision is in the health plan's coverage document, which is available for my review.

Signature:

Today's date:

M	M	D	D	Y	Y	Y	Y

Health Net has a contract with Medicare to offer HMO plans. Enrollment in a Health Net Medicare Advantage plan depends on contract renewal.

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Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

ATTENTION: If you speak a language other than English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-275-4737 (TTY: 711).

Español ATENCIÓN: Contamos con servicios de asistencia lingüística que se encuentran disponibles para usted de manera gratuita. También se encuentran disponibles de manera gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-800-275-4737 (TTY: 711).

简体中文 注意：我们为您提供免费的语言协助服务，同时也可免费提供适当的辅助设施与服务，以便提供无障碍格式的信息。请致电 1-800-275-4737（TTY：711）。

繁體中文 注意：我們爲您提供免費的語言協助服務，還免費提供適當的輔助工具和服務，以無障礙格式提供資訊。請致電 1-800-275-4737 (TTY：711)。

Tagalog ATENSYON: May mga libreng serbisyo ng tulong sa wika na available para sa inyo. Available din nang libre ang mga naaangkop na karagdagang tulong at serbisyo para makapagbigay ng impormasyon sa mga accessible na format. Tumawag sa 1-800-275-4737 (TTY: 711).

Tiếng Việt LƯU Ý: Chúng tôi có cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí. Các dịch vụ và trợ giúp bổ trợ phù hợp để cung cấp thông tin ở các định dạng có thể truy cập cũng được cung cấp miễn phí. Gọi 1-800-275-4737 (TTY: 711).

한국어 주의: 무료 언어 지원 서비스를 이용하실 수 있습니다. 정보 제공을 위해 적합한 보조 도구 및 서비스 또한 액세스 가능한 형식으로 무료 이용이 가능합니다. 1-800-275-4737 (TTY: 711)번으로 전화해 주십시오.

فارسی توجه: خدمات کمک زبانی رایگان برای شما دردسترس است. ابزارها و خدمات کمکی مناسب برای ارائه اطلاعات در قالب‌های قابل‌دسترس نیز به‌صورت رایگان ارائه می‌شوند. لطفاً با شماره 1-800-275-4737 (TTY: 711) تماس بگیرید.

دری توجه: خدمات رایگان کمک زبانی برای شما فراهم است. وسایل و خدمات کمکی مناسب برای ارائه اطلاعات به شکل قابل دسترس نیز به طور رایگان در دسترس می‌باشند. لطفاً با شماره 1-800-275-4737 (TTY: 711) تماس بگیرید.

العربية انتباه: تتوفر لك خدمات مساعدة لغوية مجانية. تتوفر كذلك مجانًا مساعِدات وخدمات إضافية ملائمة لتزويد المعلومات بتنسيقات قابلة للوصول إليها. اتصل على الرقم 1-800-275-4737 (TTY: 711).

हिंदी ध्यान दें: आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध हैं. एक्सेस करने योग्य फ़ॉर्मेट में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएं भी निःशुल्क उपलब्ध हैं. 1-800-275-4737 (TTY: 711) पर कॉल करें.

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Հայերեն ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Դուք կարող եք օգտվել անվճար լեզվական ծառայություններից: Անվճար հասանելի են նաև համապատասխան օժանդակ միջոցներ և ծառայություններ՝ մատչելի ձևաչափերով տեղեկություններ տրամադրելու համար: Զանգահարեք 1-800-275-4737 (TTY՝ 711):

Русский ВНИМАНИЕ! Вам доступны бесплатные услуги языковой поддержки. Вы также можете бесплатно получить соответствующие вспомогательные средства и услуги, направленные на предоставление информации в доступных форматах. Позвоните по номеру 1-800-275-4737 (TTY: 711).

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਉਪਲਬਧ ਹਨ। ਪਹੁੰਚਣਯੋਗ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਨ ਲਈ ਢੁਕਵੇਂ ਸਹਾਇਕ ਸਾਧਨ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਮੁਫ਼ਤ ਵਿੱਚ ਉਪਲਬਧ ਹਨ। 1-800-275-4737 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

日本語 注意：言語支援サービスを無料で提供しています。情報をアクセシビリティに対応した形式で提供する各種補助支援およびサービスも無料です。1-800-275-4737 (TTY: 711) **にお電話ください。**

Français REMARQUE : des services d'assistance linguistique gratuits sont à votre disposition. Des services et aides pour obtenir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-275-4737 (TTY : 711).

Français cadien COMMUNIQUE: Des services d'aide linguistique sans frais sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations en formats accessibles sont également proposés sans frais. Composez le 1-800-275-4737 (TTY : 711).

Iloko PALIIWEN: Adda dagiti libre a serbisio a tulong iti pagsasao. Dagiti maitutop a katulongan ken serbisio a mangipaay iti impormasion kadagiti nalaka a maawatan a pormat ket libre met a magun-odan. Tawagan ti 1-800-275-4737 (TTY: 711).

Gagana Sāmoa FA'AALIGA: O lo'o avanoa fua ia te oe auaunaga fesoasoani i le gagana. E avanoa fo'i fua fesoasoani ma meafaigaluega talafeagai e tu'uina atu ai fa'amatalaga i auala faigofie ona malamalama ai. Vala'au 1-800-275-4737 (TTY: 711).

'Ōlelo Hawai'i HO'ĀKAKA: Loa'a iā 'oe ke kōkua manuahi no ka unuhi 'ōlelo. Loa'a pū kekahi mau pono kōkua kūpono a me nā lawelawe e hā'awi ai i ka 'ike i nā 'ano 'ano hiki ke ki'i 'ia, me ka uku 'ole. Kelepona i 1-800-275-4737 (TTY: 711).

Português ATENÇÃO: estão disponíveis serviços de assistência gratuitos no seu idioma. Também estão disponíveis apoios auxiliares e serviços adequados que oferecem informações em formatos acessíveis e sem custos. Ligue para 1-800-275-4737 (TTY: 711).