Health Net®

Health Net of Arizona, Inc. and Health Net Life Insurance Company

Individual & Family Plans
Enrollment Application

Requested effective date

Important enrollment instructions

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 and family plan.

Health Net of Arizona, Inc. and Health Net Life Insurance Company (Health Net) needs a Social Security number (SSN) for everyone enrolling for health insurance, 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.

Read all sections carefully. Answer all questions thoroughly. Omissions or incomplete responses could result in a delay in processing of this Enrollment Application.

- **Print clearly in ink** and **return within 30 calendar days** from the date of signature.
- Primary applicants **must be residents of Arizona** to be eligible to apply.
- If you need assistance to complete this form, please contact your agent/broker, or call Health Net toll-free at **1-877-609-8712.**
- The Enrollment Application **must be completed and signed by the applicant** and not by an insurance agent/broker.

The Enrollment Application must be sent with the first month's premium payable by check. Make check payable to Health Net, Inc. Do not send cash.

If your are returning the completed application by mail, send to: Health Net Individual & Family Enrollment, PO Box 1150, Rancho Cordova, CA 95741-1150, with your completed check. 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.

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

☐ **Annual open enrollment period** ☐ **Special enrollment period (see page 3)**

1. Applicant information

Last name:	First name:	MI:	☐M ☐F
Home address (List street address; PO box will not be accepted.):			
City:	State:	ZIP:	County:
Mailing address (if different than home address):			
City:	State:	ZIP:	County:

Daytime phone:	Alternate phone:	Email address:
Birth date (mm/dd/yy):	Social Security number (required for all applicants):	Primary care provider (HMO only):
Primary subscriber's Health Net ID (applicable for adding dependents and change requests only):		

2. Type of application

☐ New enrollment application.

☐ Adding newborn child.

☐ Adding dependent.

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

3. 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.

4. Type of coverage

Medical (Select one)

Health Net Life Insurance Company PPO plans

These PPO plans utilize Health Net's statewide provider network.

☐ PPO Bronze 30% / 30% / $3,000

☐ PPO Basic 0% / 0% / $6,850 – available to individuals who are under age 30. You may also be eligible for this plan if you are age 30 or older and are exempt from the federal requirement to maintain minimum essential coverage. Proof of exemption must be submitted with this application.

Health Net of Arizona, Inc. CommunityCare HMO plans

These HMO plans utilize Health Net's CommunityCare tailored provider network available in Maricopa and Pima counties only.

☐ CommunityCare HMO Gold $30 / $60 / $6,000 / $375

☐ CommunityCare HMO Silver $30 / $50 / $4,500

☐ CommunityCare HMO Bronze 40% / 40% / $5,750

This pediatric dental coverage section requires a "Yes" or "No" response and may NOT be left blank.

Purchasing pediatric dental coverage with Health Net? ☐ Yes ☐ No (If "**No,**" I confirm that I am purchasing pediatric dental coverage with another carrier as required by ACA mandate.)

Note: If a pediatric dental plan is purchased, all children will be enrolled in the pediatric plan.

Optional coverage: Health Net Life Insurance Company Dental / Vision[1] plan for adults (over age 18) – If Dental and Vision is purchased for the primary applicant, all family members over age 18 will also be enrolled in the Dental and Vision plan. Dental and Vision can only be purchased with, or added to, medical coverage during the open enrollment or special enrollment periods.

☐ Primary applicant ☐ Spouse ☐ Child #1 ☐ Child #2 ☐ Child #3 ☐ Child #4

[1]Health Net Life Insurance Company dental coverage is administered by Dental Benefit Providers, Inc. Health Net Life Insurance Company vision benefits are serviced by EyeMed Vision Care, LLC (EyeMed). Discounts on vision care services and products are made available by EyeMed.

5. Family members to be enrolled

Eligible dependents include your spouse and/or children under 26. List all individuals for whom you are requesting coverage. Please provide Social Security numbers for yourself and all dependents over one year of age. **Please print.**

Spouse	Last name:	First name:	MI:	☐M ☐F
Birth date (mm/dd/yy):	Social Security number (required for all applicants):	Primary care provider (HMO only):		
Child 1	Last name:	First name:	MI:	☐M ☐F
Birth date (mm/dd/yy):	Social Security number (required for all applicants):	Primary care provider (HMO only):		
Child 2	Last name:	First name:	MI:	☐M ☐F
Birth date (mm/dd/yy):	Social Security number (required for all applicants):	Primary care provider (HMO only):		
Child 3	Last name:	First name:	MI:	☐M ☐F
Birth date (mm/dd/yy):	Social Security number (required for all applicants):	Primary care provider (HMO only):		
Child 4	Last name:	First name:	MI:	☐M ☐F
Birth date (mm/dd/yy):	Social Security number (required for all applicants):	Primary care provider (HMO only):		

6. 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 application receipt.** For a list of special enrollment period qualifying events, please refer to page 4. The application must be received within 60 days of the qualifying event.[2] Proof of the qualifying event is required. Please write in the applicable qualifying event below and the name of the person whom it applies to. For additional dependents, please attach a separate sheet of paper.

Qualifying event # (see chart on next page)	Date of event[2]	Primary applicant	Spouse	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.

6. Special enrollment period (continued)

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 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 (other than by reason of such employee's gross misconduct), 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, dependent child or surviving spouse) 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.	
2)	The qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption, or placement for adoption.	Court documentation or discharge records.
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 HHS, or its instrumentalities as evaluated and determined by the Exchange.	Documentation would depend on circumstance.
4)	The enrollee, or his or her dependent, adequately demonstrates to Health Net that the health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.	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)	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.
7)	He or she loses medically needy coverage under Medicaid (not including voluntary termination or termination due to failure to pay premium).	Medicaid documentation.
8)	He or she loses pregnancy-related coverage under Medicaid (not including voluntary termination or termination due to failure to pay premium).	Medicaid documentation.

7. 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. This application shall become a part of the Agreement. Should you have questions or need assistance completing this application, you can call Health Net at 1-877-609-8712 for assistance.

When Health Net can rescind coverage: Health Net may rescind coverage for any fraudulent or intentional omission or misrepresentation of material facts 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 coverage is rescinded, Health Net shall have no liability for the provision of coverage under your policy. By signing this Application, you represent that all responses are true, complete and accurate, to the best of your knowledge, and that should Health Net accept your Application, the Application will become part of the policy between Health Net and you. By signing this Application, you further agree to comply with the terms of your Evidence of Coverage. 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 coverage is rescinded, Health Net will provide a written notice 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; and
3. explain that your monthly premium will be modified to reflect the number of members that remain covered under the policy.

If coverage 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 policy 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 Arizona law.

If your coverage is rescinded, you have the right to appeal Health Net's decision to rescind such coverage.

Use and disclosure of information: I acknowledge that health care providers may disclose to Health Net health information about me or my dependents, including information regarding substance abuse or mental/emotional conditions. Health Net will use and 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, as permitted by law. **The authorization shall remain valid for 30 months after the date the application is signed.**

Premium payment acknowledgement: I understand and agree that, in order to process my Enrollment Application, Health Net requires that I submit a payment of one month's premium but that Health Net will not cash my check, draft my bank account or charge my credit card unless coverage is approved by the Membership Department. I understand that, by collecting the first month's premium, Health Net will not issue coverage and is not assuming any risk for health coverage for me or any member of my family. I understand that my insurance agent/broker has no authority to approve or bind coverage or to assign effective dates for coverage. I understand that coverage does not become effective immediately. I understand that coverage is not effective until it is approved by Health Net in writing, regardless of whether Health Net has cashed my check, drafted my bank account or charged my credit card. I understand that if my Enrollment Application is approved, I will receive a refund for any applicant or dependent of applicant on this Enrollment Application who chooses not to enroll in the plan, or if I, or any one of my family members, is not approved for coverage by Health Net.

I acknowledge that if I wish to authorize another individual, including my insurance agent/broker, to have access to my personal information, I may be required to sign a separate Authorization for Disclosure of Protected Health Information form. Neither payment, enrollment or eligibility for coverage will be conditioned on my providing or refusing to provide this authorization.

(continued)

7. Conditions of enrollment (continued)

Acknowledgment and agreement: I understand and agree that by enrolling or accepting services under a health plan with Health Net of Arizona, Inc. or Health Net Life Insurance Company, I am, and any enrolled dependents are, obligated to understand and abide by all terms, conditions and provisions of the Agreement.

I have read and understand the terms of this Enrollment Application, and my signature on the signature page indicates my acceptance of these terms and acknowledge that the information entered in this Enrollment Application is complete, true and correct. A photocopy of this is as valid as the original.

In addition, I understand and agree to the following:

- There is no coverage unless an Enrollment Application is approved by Health Net's Membership Department and a Notice of Acceptance is issued to you. No other department, officer, agent, or employee of Health Net is authorized to grant enrollment.
- Health Net is not liable for bills incurred before the effective date of coverage.
- Health Net will notify me if my Enrollment Application is accepted. My effective date will also be subject to the receipt of my premium by Health Net, Inc.
- The agent/broker selling Health Net health coverage does not have the authority to approve my Enrollment Application and cannot change any terms of the Agreement or waive any requirements.
- I understand that either I am, or my personal representative is, entitled to receive a copy of my signed Enrollment Application.

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:

All applicants 18 years and older must sign application.
Please be sure all questions are answered and application is signed and dated to prevent application from being returned.

8. Agent/Broker information

Agent/Broker's name:		
Insurance agency name:	Health Net broker number:	Health Net direct sales agent ID:

Notice of Privacy Practices

Health Net knows that personal information in your medical records is private. Health Net provides members with a Notice of Privacy Practices that describes how it uses and discloses protected health information; the individual's rights to access and to request amendments, restrictions and an accounting of disclosures of protected health information; and the procedures for filing complaints. Members receive the Notice of Privacy Practices in the new member Welcome Packet. However, you may also obtain a copy of Health Net's Notice of Privacy Practices on the website at www.healthnet.com or through Health Net's Customer Contact Center at the number listed on the back of your Health Net ID card.

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. Applicants please call 1-877-609-8712 (TTY: 711). **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 deben llamar al 1-877-609-8712 (TTY: 711). **Spanish**

Mga Libreng Serbisyo sa Wika. Makakakuha ka ng tagapagsaling-wika at mapapabasa mo ang mga dokumento sa iyo sa iyong wika. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card. Mangyaring tumawag ang mga aplikante sa 1-877-609-8712 (TTY: 711). **Tagalog**

免費語言服務。您可使用口譯員並請人使用您的語言將文件唸給您聽。如需協助，請致電您會員卡上所列的電話號碼與我們聯絡。申請人請致電 1-877-609-8712（TTY：711)。 **Chinese**

Saad t'áá jiik'ehgo bee aka'a'ayeed. Naaltsoos hwízaadjí bee bik'e'éshchíígo atah halne' há choo'íihgo éí hachį' yidoołtá. Shiká adoowoł jinzóó, ninaaltsoos bee éhozínii béésh bee bich'į' hodoonihígíí bikáá'. Hada'diiláa'ígíí éí kojį' dahodóólnih, 1-877-609-8712 (TTY:711). **Navajo**

In Arizona, Health Net of Arizona, Inc. underwrites benefits for HMO plans, and Health Net Life Insurance Company underwrites benefits for indemnity plans and life insurance coverage.

Health Net Life Insurance Company's dental coverage is administered by Dental Benefit Providers, Inc. Health Net Life Insurance Company vision benefits are serviced by EyeMed Vision Care, LLC (EyeMed). Discounts on vision care services and products are made available by EyeMed.