Health Net®

Health Net of California, Inc.

Individual & Family Plans CommunityCare HMO Enrollment Application

Requested effective date

☐☐ / ☐☐ / ☐☐☐☐

Application must be typed or completed in blue or black ink.

Effective date of coverage: Coverage is only available for enrollment during the annual open enrollment period, which is November 1, 2016, through January 31, 2017, 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 & Family Plan.

Health Net of California, Inc. (Health Net) **requires** a Social Security number (SSN) for everyone enrolling for health coverage, 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. For newborns, you have 6 months to provide the newborn's SSN.

THE AGENT/BROKER MAY NOT SIGN THIS APPLICATION AND AGREEMENT ON BEHALF OF THE APPLICANT.

IMPORTANT: Please see Part V if the applicant does not read/write English. The Individual & Family Plan CommunityCare HMO Enrollment Application is available in Chinese, Spanish and Korean language versions. You can also have someone help you read it. For free help, please call 1-877-609-8711.

If you need assistance in completing this application, an agent/broker may assist you. An agent/broker who helped you read and complete this application must sign the application (see Part VI).

I (and my dependents if applicable) am applying during: ☐ Annual open enrollment period ☐ Special enrollment period (see Part IV)

Part I. Applicant information

☐ **New application (Check family type below)**
☐ Self ☐ Self and spouse ☐ Self and domestic partner ☐ Self and child ☐ Self and children
☐ Self, spouse and child(ren) ☐ Self, domestic partner and child(ren) ☐ Child only ☐ **Change request**

☐ **Adding dependent (Fill in the primary subscriber's information below, then complete dependent information in Part III.)**

Primary applicant's last name:	First name:	MI:	☐ Male ☐ Female

Permanent home street address (If you provide a PO Box, you must also provide proof of residency[1] upon submission for your application to be complete.):

City:	State:	ZIP:	County applicant resides in:

Billing address:

Mailing address:

Home phone number: ( )	Work phone number: ( )	Cell phone number: ( )	Email address:

Primary applicant's birth date (mm/dd/yy): / /	Primary applicant's Social Security number (required): – –

Are you currently a Health Net member? ☐ Yes ☐ No If "Yes," please provide the primary subscriber's Health Net ID #:

Primary care physician ID:	Primary group ID:	Current patient: ☐ Yes ☐ No

Please select your language preference (optional): ☐ English ☐ Spanish ☐ Chinese ☐ Korean

[1] See page 7, Qualifying Event #5, "Examples of California documentation."

Last 4 digits of primary applicant's Social Security #: ___ ___ ___ ___

Part II. Payment information and choice of coverage

A. Payment information

First premium payment ☐ Pay by check (Amount must match monthly premium.)

Mailing application	**Faxing application**
Include completed check with completed application and mail to: Health Net Individual & Family Enrollment PO Box 1150 Rancho Cordova, CA 95741-1150	Fax completed application to 1-800-977-4161, and mail completed check to: Health Net Individual & Family Enrollment PO Box 894702 Los Angeles, CA 90189-4702

Current members can go to **www.healthnet.com**, and click the *Make A Payment Now* button for additional payment options.

Payment of subscription charges

The Subscriber is responsible for payment of Subscription Charges to Health Net. Health Net does not accept payment of Subscription Charges from any person or entity other than the Subscriber, his or her Dependents, or third party payors to the extent required by state and federal law.

Upon discovery that Subscription Charges were paid by a person or entity other than those listed above, Health Net will reject the payment and inform the Subscriber that the payment was not accepted and that the Subscription Charges remain due.

B. Choice of coverage

Health Net of California, Inc. HMO plans utilize the CommunityCare provider network.	**Optional coverage: Dental / Vision plan for Adults (over age 18) –**
☐ **Health Net Platinum 90 HMO** ☐ **Health Net Gold 80 HMO** ☐ **Health Net Silver 70 HMO**	☐ **Dental and Vision Plus –** *If Dental and Vision Plus is purchased for the primary applicant, all family members over age 18 will also be enrolled in the Dental and Vision Plus plan. Dental and Vision Plus can only be purchased with, or added to, medical coverage during the open enrollment or special enrollment periods.* **Note: All medical plans include pediatric dental and pediatric vision coverage.**

Last 4 digits of primary applicant's Social Security #: ___ ___ ___ ___

Part III. Family member(s) to be enrolled

List all eligible family members to be enrolled other than yourself. If a listed family member's last name is different from yours, please explain on a separate sheet of paper. For additional dependents, please attach another sheet with the requested information.

☐ Check here if a supplemental page is attached. Please write the primary applicant's Social Security number on the upper right hand corner of the supplemental page.

Note: When each family member chooses a different plan, each member will be on their own contract. To specify different plans for different family members, be sure to write the plan name you are choosing for each family member in the spaces provided below.

For domestic partner coverage, all requirements for eligibility, as required by the applicable laws of the State of California, must be met, and a joint Declaration of Domestic Partnership must be filed with the California Secretary of State.

How to make different plan choices:

a. Health Net bills to only one address per subscriber. Therefore, to be processed under one subscriber, all family members must be billed to the same address.

b. You must select a physician group and primary care physician. You may choose the same or different physician group and primary care physician for each family member you are enrolling. If you do not select a primary care physician, one will be selected for you within your regional area. To find the most up-to-date list of Health Net contracted physicians, log in to www.healthnet.com > *ProviderSearch*. You'll find a complete listing of our Individual & Family Plan network physicians, and you can search by specialty, city, county, or doctor's name. You can also call 1-877-609-8711 to request provider information or contact your Health Net authorized agent/broker.

c. For Dental and Vision Plus coverage, please provide the dentist number for the HMO dentist you've chosen. You may choose a different dentist for each family member. If you do not select a dental office, one will be selected for you in your area. For names, addresses, primary dentist number, and telephone numbers of participating dental providers, or for help in selecting a provider, call Health Net at 1-866-249-2382 or log in to www.healthnet.com.

Relation	Last name	First name	MI	Social Security number (required)	Date of birth
☐ Spouse ☐ Domestic partner				– –	/ /
Required for CommunityCare plans: **CommunityCare HMO primary care physician ID**		**CommunityCare HMO physician group ID**			
If Adult Dental and Vision Plus is purchased, please note HMO primary dentist #					
Medical plan choice for each family member if different					
Relation **Child 1**	**Last name**	**First name**	**MI**	**Social Security number (required)**	**Date of birth**
☐ Son ☐ Daughter				– –	/ /
Required for CommunityCare plans: **CommunityCare HMO primary care physician ID**		**CommunityCare HMO physician group ID**			
If Adult Dental and Vision Plus is purchased, please note HMO primary dentist #					

(continued)

Last 4 digits of primary applicant's Social Security #: ___ ___ ___ ___

Part III. Family member(s) to be enrolled (continued)

Relation Child 2	Last name	First name	MI	Social Security number (required)	Date of birth
☐ Son ☐ Daughter				– –	/ /

Required for CommunityCare plans: CommunityCare HMO primary care physician ID	CommunityCare HMO physician group ID

If Adult Dental and Vision Plus is purchased, please note HMO primary dentist #

Relation Child 3	Last name	First name	MI	Social Security number (required)	Date of birth
☐ Son ☐ Daughter				– –	/ /

Required for CommunityCare plans: CommunityCare HMO primary care physician ID	CommunityCare HMO physician group ID

If Adult Dental and Vision Plus is purchased, please note HMO primary dentist #

Addition of a newborn or adopted child to an existing policy

Newborn/Adopted child's last name:	First name:	MI:

Effective date[2]:	Newborn/Adopted child's date of birth (mm/dd/yy):	Date of adoption/placement for adoption (mm/dd/yy):
☐ Male ☐ Female	Social Security number:	Primary subscriber's Health Net ID:

If you are adding an eligible newborn/adopted child to a CommunityCare HMO plan, you must select a primary care physician from the CommunityCare Network.

Primary care physician ID:	Current patient: ☐ Yes ☐ No

GENERAL CONDITIONS: If your application is not received within 60 days of the birth date or date of adoption, Health Net of California, Inc. (Health Net) will require that a standard application be completed. No other department, officer, agent, or employee of Health Net is authorized to grant enrollment. The subscriber's broker or agent cannot grant approval, change terms or waive requirements of this application. This application shall become a part of the Plan Contract.

Please remit the first month's premium for a newborn or adopted child. **Please note:** If the child's coverage effective date is other than the first of the month, you will be required to pay additional prorated premiums which will be added to your next regular premium billing.

The application and Arbitration Clause must be signed by the subscriber. The subscriber must personally sign his or her name in ink and agree to comply with the Arbitration Clause and the terms, conditions and provisions of the application and the Plan Contract in order for this application to be processed. For this application to be considered, neither broker nor any other person may sign this application and Arbitration Clause.

[2]Effective date will be the date of birth or date of adoption (or placement for the purpose of adoption if earlier) if the application is received within 60 days of the birth date or date of adoption.

Last 4 digits of primary applicant's Social Security #: ___ ___ ___ ___

Part IV. 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 the application receipt.** The application must be received within 60 days[3] of the qualifying event. Proof of the qualifying event is required. Please write in the applicable qualifying event below and the name of the person to whom it applies. For additional dependents, please attach a separate sheet of paper.

Qualifying event # (see chart on next page)	Date of event[3]	Primary applicant	Spouse/ Domestic partner	Dependent 1	Dependent 2	Dependent 3

(continued)

[3]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.

Last 4 digits of primary applicant's Social Security #: ___ ___ ___ ___

Part IV. Special enrollment period (continued)

Qualifying event		Examples of California documentation
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 of your previous coverage or termination due to failure to pay premium):	
	A. The death of the covered employee.	Copy of one of the following: • Front and back of previous insurance carrier's ID card. • Proof of creditable coverage from previous insurance carrier. • Letter from previous carrier documenting loss of coverage. • Termination or hour reduction confirmation from employer (must be on employer letterhead and signed by employer management).
	B. The termination, 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/domestic partner, dependent child or surviving spouse/domestic partner) 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.	
	H. Loss of minimum essential coverage for any reason other than failure to pay premiums or situations allowing for a rescission for fraud or intentional misrepresentation of material fact.	• Letter from applicant supporting qualifying event. • Letter from previous carrier documenting loss of coverage.
	I. Termination of employer contributions.	Notice from employer of contributions termination.
	J. Exhaustion of COBRA continuation coverage.	COBRA paperwork reflecting exhaustion of coverage.
2)	A. The qualified individual gains a dependent or becomes a dependent through marriage, domestic partnership, birth, adoption, placement for adoption, or assumption of a parent-child relationship.	• Marriage certificate. • Declaration of domestic partnership. • Certificate of registered domestic partnership. • Notarized affidavit of assumption of parent-child relationship. • Birth certificate. • Discharge records. • Court order documentation for adoption. • Certificate of divorce decree. • Legal separation agreement. • Death certificate.
	B. The enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by State law in the State in which the divorce or legal separation occurs, or if the enrollee, or his or her dependent, dies.	
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 the Department of Health and Human Services, or its instrumentalities as evaluated and determined by the Exchange.	• Front and back of previous carrier ID card. • Proof of creditable coverage. • Letter from Exchange or HHS documenting qualifying event.
4)	The health plan in which the enrollee, or his or her dependent, is enrolled substantially violated a material provision of its contract.	• Resolution document from the Exchange or other plan.

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Part IV. Special enrollment period (continued)

Qualifying event		Examples of California documentation
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 acceptable proof of residency documents: • Current driver's license or identification card. • Current and valid state vehicle registration form in the applicant's name. • Evidence the applicant is employed. • Evidence the applicant has registered with a public or private employment agency. • Evidence that the applicant has enrolled his or her children in a school. • Evidence that the applicant is receiving public assistance. • Voter registration form of receipt, voter notification card or an abstract of voter registration. • Current utility bill in the applicant's name. • Current rent or mortgage payment receipt in the applicant's name. Rent receipts provided by a relative shall not be accepted. • Mortgage deed showing primary residency. • Lease agreement in the applicant's name. • Government mail in the applicant's name (SSA statement, DMV notice, etc.). • Cell phone bill. • Credit card statement. • Bank statement or canceled check with printed name and address. • US Postal Service change of address confirmation letter. • Moving company contract or receipt showing your address. • If you're living in the home of another person, like a family member, friend, or roommate, you may send a letter/statement from that person stating that you live with them and aren't just temporarily visiting. This person must prove their own residency by including one of the documents listed above. • If you're homeless or in transitional housing, you may submit a letter or statement from another resident of the same state, stating that they know where you live and can verify that you live in the area and aren't just temporarily visiting. This person must prove their own residency by including one of the documents listed above. • Letter from a local non-profit social services provider (excluding non-profit health care providers) or government entity (including a shelter) that can verify that you live in the area and aren't just visiting.

(continued)

Part IV. Special enrollment period (continued)

Qualifying event		Examples of California documentation
6)	He or she is mandated to be covered as a dependent pursuant to a valid state or federal court order.	Court documentation.
7)	He or she has been released from incarceration.	Probation or parole release paperwork showing date of event.
8)	He or she was receiving services under another health benefit plan, from a contracting provider who is no longer participating in that health plan's network, for any of the following conditions: (a) an acute condition (a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration); (b) a serious chronic condition (a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration); (c) a terminal illness (an incurable or irreversible condition that has a high probability of causing death within one year or less); (d) a pregnancy; (e) care of a newborn between birth and 36 months; or (f) a surgery or other procedure that has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered member, and that provider is no longer participating in the health plan.	• Letter from health plan that documents the provider's termination from the network. AND • Letter from provider that documents the condition of the enrollee.
9)	He or she demonstrates to the Exchange that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period available to the individual because he or she was misinformed that he or she was covered under minimum essential coverage.	• Letter from applicant supporting the qualifying event. • Copy of the plan renewal letter.
10)	He or she is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code.	• Active duty discharge documentation.
11)	Newly eligible or ineligible for advance payments of the premium tax credit or have a change in eligibility for cost-sharing reductions.	Advanced Premium Tax Credit (APTC) paperwork that shows the premium assistance you are eligible for.
12)	He or she loses medically needy coverage under Medi-Cal (not including voluntary termination of your previous coverage or termination due to failure to pay premium).	Medicaid documentation.
13)	He or she loses pregnancy-related coverage under Medi-Cal (not including voluntary termination of your previous coverage or termination due to failure to pay premium).	Medicaid documentation.

Part V. Individual & Family Plans Exception to Standard Enrollment – Statement of Accountability regarding language assistance

Instructions for Part V: The following process is to be used when the applicant cannot complete the application because he or she cannot read, write and/or speak the language of the application. Health Net requires that if you need assistance in completing this application, you must employ the services of a qualified interpreter. Please contact Health Net at 1-877-609-8711 for information about qualified interpreter services and how to obtain them. This form must be submitted with the Individual & Family Plan enrollment application when applicable.

Health Net qualified interpreter – Please complete the following when assisted by a Health Net qualified interpreter.

I,_____, was assisted in the completion of this application by a qualified interpreter authorized by Health Net because I:

☐ Do not read the language of this application.
☐ Do not speak the language of this application.
☐ Do not write the language of this application.
☐ Other (explain): _____

A qualified interpreter assisted me with the completion of: ☐ The entire application.
☐ Other (explain): _____

A qualified interpreter read this application to me in the following language: _____

Signatures and date (required in ink)

Signature of applicant:	Today's date:
Date application was interpreted:	Time application was interpreted:
Qualified interpreter number:	

Qualified interpreter other than a Health Net qualified interpreter – Please complete the following when assisted by a qualified interpreter other than a Health Net qualified interpreter.

If a qualified interpreter, other than a qualified interpreter provided by Health Net, assisted you in completing this application, the interpreter must complete the following:

I,_____, understand that a qualified interpreter should: (a) have the vocabulary equivalent of a native speaker that has received an advanced education (college or university equivalent) in the non-English language; (b) be able to demonstrate cultural sensitivity in their communication, taking into consideration that every language encompasses a wide range of variation; (c) have native speaker language skills (native speaker language skills are developed by growing up or functioning in a language community); and (d) have corresponding reading and writing skills in the non-English language (the reading and writing skills would be demonstrated by advanced education in the native language).

As a qualified interpreter, I personally read and completed the application for the applicant named above because:

☐ Applicant does not read the language of this application.
☐ Applicant does not speak the language of this application.
☐ Applicant does not write the language of this application.
☐ Other (explain): _____

Under the penalty of perjury, I declare that I read to the applicant:

☐ The entire application.
☐ Other (explain): _____

I read this application to the applicant in the following language: _____

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Last 4 digits of primary applicant's Social Security #: ___ ___ ___ ___

Part V. Individual & Family Plans Exception to Standard Enrollment – Statement of Accountability regarding language assistance (continued)

Please provide the following information regarding the qualified interpreter who assisted the applicant and who is not a Health Net qualified interpreter:

Last name:		First name:	
Address of qualified interpreter:			
City:	State:	ZIP:	Phone:
Qualified interpreter signature:			Date:

Part VI. Applicant's agent/broker information

Complete agent/broker name and address is necessary for correspondence to be sent to the agent/broker.

Health Net broker ID:		**Health Net direct sales agent ID:**	
Name (print):	Phone number:		Fax number:
Address:		Email address:	
Applicant's agent/broker signature/number *(required):*			**Date signed *(required):***

Agent/broker certification

I, _____ (name of agent/broker),

(NOTE: You must select the appropriate box. You may only select one box.)

(_____) did not assist the applicant(s) in any way in completing or submitting this application. All information was completed by the applicant(s) with no assistance or advice of any kind from me. I understand that, if any portion of this statement by me is false, I may be subject to civil penalties, including but not limited to a fine of up to $10,000.

OR

(_____) assisted the applicant(s) in submitting this application. I advised the applicant(s) that he or she should answer all questions completely and truthfully and that no information requested on the application should be withheld. I explained that withholding information could result in rescission or cancellation of coverage in the future. The applicant(s) indicated to me that he or she understood these instructions and warnings. To the best of my knowledge, the information on the application is complete and accurate. I understand that, if any portion of this statement by me is false, I may be subject to civil penalties, including but not limited to a fine of up to $10,000.

Please answer all questions 1 through 3:

1. **Who filled out and completed the application form?** _____

2. Did you personally witness the applicant(s) sign the application? ☐ Yes ☐ No

3. Did you review the application after the applicant(s) signed it? ☐ Yes ☐ No

Part VII. 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.** There is no coverage unless this application is accepted by Health Net's Membership Department and a Notice of Acceptance is issued to the applicant even though you paid money to Health Net for the first month's premium. No other department, officer, agent, or employee of Health Net is authorized to grant enrollment. The applicant's agent or broker cannot grant approval, change terms or waive requirements of this application. This application shall become a part of the Plan Contract.

WHEN HEALTH NET CAN RESCIND A PLAN CONTRACT
Within the first 24 months of coverage, Health Net may rescind a Plan Contract for any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact 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 the Plan Contract is rescinded, Health Net shall have no liability for the provision of coverage under the Plan Contract.

By signing this application, you represent that all responses are true, complete and accurate and that the application will become part of the Plan Contract between Health Net and you. By signing this application, you further agree to comply with the terms of the Plan Contract.

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 the Plan Contract is rescinded, Health Net will provide a 30-day written notice prior to the effective date of the rescission that will:

1. explain the basis of the decision;
2. provide the effective date of the rescission;
3. clarify that all members covered under your coverage other than the individual whose coverage is rescinded may continue to remain covered;
4. explain that your monthly premium will be modified to reflect the number of members that remain under the Plan Contract; and
5. explain your right and the options you have of going to both Health Net and/or the Department of Managed Health Care if you do not agree with Health Net's decision;
6. include a Right to Request Review form. You have 180 days from the date of the Notice of Cancellation, Rescission or Nonrenewal to submit the Right to Request form to Health Net and/or the Department of Managed Health Care.

If the Plan Contract 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 Plan Contract 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 California law.

If Health Net denies your appeal, you have the right to seek assistance from the California Department of Managed Health Care.

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. Health Net uses 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 Plan Contract, and I may also obtain a copy of this Notice on the website at www.healthnet.com or through the Health Net Customer Contact Center. Authorization for use and disclosure of protected health information shall be valid for a period of 24 months from the date of my signature on the next page.

IF SOLE APPLICANT IS A MINOR: If the sole applicant under this application is under 18 years of age, the applicant's parent or legal guardian must sign as such. By signing, he or she does hereby agree to be legally responsible for the accuracy of information in this application and for payments of premiums. If such responsible party is not the natural parent of the applicant, copies of the court papers authorizing guardianship must be submitted with this application.

IF APPLICANT CANNOT READ THE LANGUAGE OF THIS APPLICATION: If an applicant does not read the language of this application and an interpreter assisted with the completion of the application, the applicant must sign and submit the Statement of Accountability (see Part V of this application, "Individual & Family Plans Exception to Standard Enrollment – Statement of Accountability regarding language assistance").

Last 4 digits of primary applicant's Social Security #: ___ ___ ___ ___

Part VIII. Important provisions

NOTICE: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health care services, plans or insurance companies as a condition of obtaining coverage.

ACKNOWLEDGEMENT AND AGREEMENT: I, the applicant, understand and agree that by enrolling with or accepting services from Health Net, I and any enrolled dependents shall comply with the terms, conditions and provisions of the Plan Contract. To obtain a copy of the Plan Contract, call Health Net at 1-877-609-8711. **I, the applicant, 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, 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 must be submitted to final and binding arbitration instead of a jury or court trial. This Agreement to arbitrate includes any disputes arising from or relating to the Plan Contract or my Health Net 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 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 Plan Contract. Mandatory Arbitration may not apply to certain disputes if the Plan Contract is subject to ERISA, 29 U.S.C. §§ 1001-1461. 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.

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:

The application and this Arbitration Clause must be signed by the applicant(s). The applicant(s) must personally sign his or her name in ink and agree to comply with the Arbitration Clause and the terms, conditions and provisions of the application and the Plan Contract in order for this application to be processed. For this application to be considered, neither agent/broker nor any other person may sign this application and Arbitration Clause.

Make personal check payable to "Health Net." If you are returning the completed application by mail, send to: Health Net Individual & Family Enrollment, PO Box 1150, Rancho Cordova, CA 95741-1150. 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 90189-4702.

You may submit a photocopy or facsimile of the application and authorizations. Health Net recommends that you retain a copy of this application and authorizations for your records.

All references to "Health Net" herein include the affiliates and subsidiaries of Health Net which underwrite or administer the coverage to which this enrollment application applies. "Plan Contract" refers to the Health Net of California, Inc. combined Plan Contract and Evidence of Coverage.

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 does not exclude people or treat them differently because 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, 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 Customer Contact Center at **1-800-522-0088 (TTY: 711)**.

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 Customer Contact Center is available to help you. You can also file a grievance by mail: Health Net of California, Inc., PO Box 10348, Van Nuys, California 91410-0348, by fax: 1-877-831-6019, or online: healthnet.com.

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.

Pending state regulatory review

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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 employer group applicants please call 1-800-522-0088 (TTY: 711). Individual & Family Plan (IFP) applicants please call 1-877-609-8711 (TTY: 711). For more help: If you are enrolled in a PPO or EPO insurance policy from Health Net Life Insurance Company, call the CA Dept. of Insurance at 1-800-927-4357. If you are enrolled in an HMO or HSP plan from Health Net of California, Inc., call the DMHC Helpline at 1-888-HMO-2219.

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 يرجى من مقدمي طلبات مجموعة أصحاب العمل الاتصال بمركز الاتصال الاتصال على الرقم (IFP) يرجى من مقدمي طلبات خطة الأفراد والعائلة 1-800-522-0088 (TTY: 711).. للحصول على المساعدة: في حال كنت مسجلاً في بوليصة تأمين المنظمة المزودة المفضلة PPO 1-877-609-8711 (TTY: 711). أو المنظمة المزودة الحصرية EPO من Health Net Life Insurance Company ، اتصل على قسم التأمين في كاليفورنيا على الرقم 1-800-927-4357. في حال كنت مسجلاً في منظمة المحافظة على الصحة HMO أو خطة التوفير الصحية HSP من شركة Health Net of California, Inc. , اتصل على خط المساعدة في قسم الرعاية الصحية المدارة DMHC على الرقم 1-888-HMO-2219.

Armenian
Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեզ համար ձեր լեզվով: Օգնության համար զանգահարեք մեզ ձեր ID քարտի վրա նշված հեռախոսահամարով, իսկ գործատուի խմբի դիմորդներին խնդրում ենք զանգահարել 1-800-522-0088 (TTY: 711) հեռախոսահամարով: Անհատական և Ընտանեկան Ծրագրի անգլերեն հապավումը՝ (IFP) դիմորդներին խնդրում ենք զանգահարել 1-877-609-8711 (TTY: 711) հեռախոսահամարով: Լրացուցիչ օգնության համար. եթե անդամագրված եք Health Net Life Insurance Company-ի PPO կամ EPO ապահովագրությանը, զանգահարեք Կալիֆորնիայի Ապահովագրության բաժին՝ 1-800-927-4357 հեռախոսահամարով: Եթե անդամագրված եք Health Net of California, Inc.-ի HMO կամ HSP ծրագրին, զանգահարեք DMHC օգնության գիծ՝ 1-888-HMO-2219 հեռախոսահամարով.

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，雇主團體申請人請致電 1-800-522-0088（TTY：711）。個人與家庭計畫 (IFP) 申請人請致電 1-877-609-8711（TTY：711）。如需進一步協助：如果您透過 Health Net Life Insurance Company 投保 PPO 或 EPO 保單，請致電 1-800-927-4357 與加州保險局聯絡。如果您透過 Health Net of California, Inc. 投保 HMO 或 HSP 計畫，請致電 DMHC 協助專線 1-888-HMO-2219。

Hindi
बिना लागत की भाषा सेवाएँ। आप एक दुभाषिया प्राप्त कर सकते हैं। आपको दस्तावेज अपनी भाषा में पढ़ कर सुनाए जा सकते हैं। मदद के लिए, आपके आईडी कार्ड पर दिए गए सूचीबद्ध नंबर पर हमें कॉल करें, या नियोक्ता समूह आवेदक कृपया 1-800-522-0088 (TTY: 711) संपर्क केंद्र पर कॉल करें। कृपया व्यक्तिगत और पारिवारिक प्लैन (IFP) के आवेदक 1-877-609-8711 (TTY: 711) पर कॉल करें। अधिक मदद के लिए: यदि आप Health Net Life Insurance Company PPO या ईपीओ EPO बीमा पॉलिसी में नामांकित हैं, तो कैलिफोर्निया बीमा विभाग को 1-800-927-4357 पर कॉल करें। यदि आप Health Net of California, Inc., एचएमओ HMO या एचएसपी HSP प्लैन में नामांकित हैं, तो डीएमएचसी DMHC हेल्पलाइन के 1-888-HMO-2219 पर कॉल करें।

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 ntawm tus xov tooj nyob ntawm koj daim npav, los yog tias koj yog tus neeg tso npe xav tau kev pab kho mob los ntawm koj txoj hauj-lwm thov hu rau 1-800-522-0088 (TTY: 711). Yog koj yog tus tso npe xav tau kev pab kho mob rau Ib Tug Neeg & Tsev Neeg Individual & Family Plan (IFP) thov hu 1-877-609-8711 (TTY: 711). Xav tau kev pab ntxiv: Yog koj tau tsab ntawv tuav pov hwm PPO los yog EPO los ntawm Health Net Life Insurance Company, hu mus rau CA Dept. of Insurance ntawm 1-800-927-4357. Yog koj tau txoj kev pab kho mob HMO los yog HSP los ntawm Health Net of California, Inc., hu mus rau DMHC tus xov tooj pab Helpline ntawm 1-888-HMO-2219.

Japanese
無料の言語サービス。通訳をご利用いただけます。日本語で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、雇用主を通じた団体保険の申込者の方は、 1-800-522-0088、(TTY: 711) までお電話ください。個人および家族向けプラン (IFP) の申込者の方は、 1-877-609-8711 (TTY: 711) までお電話ください。さらに援助が必要な場合: Health Net Life Insurance CompanyのPPOまたはEP0保険ポリシーに加入されている方は、カリフォルニア州保険局 1-800-927-4357 まで電話でお問い合わせください。Health Net of California, Inc.のHMOまたはHSPに加入されている方は、DMHCヘルプライン 1-888-HMO-2219 まで電話でお問い合わせください。

Khmer
សេវាភាសាដោយឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ អ្នកអាចស្តាប់គេអានឯកសារឱ្យអ្នកនៅក្នុងភាសារបស់អ្នក។ សម្រាប់ជំនួយ សូមទាក់ទងយើងខ្ញុំតាមរយៈលេខទូរសព្ទដែលមាននៅលើកាតសម្គាល់ខ្លួនរបស់អ្នក ឬ បេក្ខជនក្រុមនិយោជក អាចទាក់ទងទៅមជ្ឈមណ្ឌលទំនាក់ទំនងពាណិជ្ជកម្មនៃក្រុមហ៊ុន 1-800-522-0088 (TTY: 711)។ បេក្ខជនផែនការគ្រួសារ និងបេក្ខជនផែនការបុគ្គល សូមទូរសព្ទទៅលេខ 1-877-609-8711 (TTY: 711)។ សម្រាប់ជំនួយបន្ថែម ៖ បើសិនអ្នកបានចុះ ឈ្មោះក្នុងគោលការណ៍ធានារ៉ាប់រង PPO ឬ EPO Health Net Life Insurance Company សូមទាក់ទងទៅនា យកដ្ឋានធានារ៉ាប់រង CA តាមរយៈទូរសព្ទលេខ 1-800-927-4357។ បើសិនអ្នកបានចុះឈ្មោះក្នុងផែនការ HMO ឬ HSP ពីក្រុមហ៊ុន Health Net នៃរដ្ឋកាលីហ្វ័រញ៉ា សូមទាក់ទងលេខទូរសព្ទជំនួយ DMHC ៖ 1-888-HMO-2219។

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 고용주 그룹 신청인의 경우 1-800-522-0088 (TTY: 711) 번으로 전화해 주십시오. Individual & Family Plan (IFP) 신청인의 경우, 1-877-609-8711 (TTY: 711) 번으로 전화해 주십시오. 추가 도움이 필요하시면, Health Net Life Insurance Company의 PPO 또는 EPO 보험에 가입되어 있으시면 캘리포니아 주 보험국에1-800-927-4357번으로 전화해 주십시오. Health Net of California, Inc.의 HMO 또는 HSP 플랜에 가입되어 있으시면 DMHC 도움라인에 1-888-HMO-2219번으로 전화해 주십시오.

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' employer groupǫjí ninaaltsoos siłtsoozgo éí 1-800-522-0088 (TTY: 711). T'áá hó dóó ha'ałchíní bił hak'é'ésti'ígíí [IFP wolyéhígííÓ éí kojį' hojilnih 1-877-609-8711 (TTY: 711).Shíká anáá'doowoł jinízingo: PPO éí doodaii' EPOǫjí Health Net Life Insurance Company wolyéhíjí béeso ách'ą́ą́h naa'nil biniiyé hwe'iina' bik'é'ésti'go éí CA Dept. of Insurance bich'į' hojilnih 1-800-927-4357. HMO éí doodaii' HSPǫjí Health Net of Californiaǫjí béeso ách'ą́ą́h naa'nil biniiyé hats'íís bik'é'ésti'go éí kojį' hojilnih DMHC Helpline 1-888-HMO-2219.

Persian (Farsi)

خدمات زبان به طور رایگان. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید که اسناد به زبان شما برایتان قرائت شوند. برای دریافت راهنمایی، با ما به شماره ای که روی کارت شناسایی شما درج شده تماس بگیرید، یا درخواست کنندگان گروه کارفرما لطفاً با مرکز تماس بازرگانی1-800-522-0088 (TTY: 711) تماس بگیرید. درخواست کنندگان برنامه انفرادی یا خانواده (IFP) لطفاً با شماره1-877-609-8711 (TTY: 711) تماس بگیرید. برای دریافت راهنمایی بیشتر: اگر در بیمه نامه PPO یا EPO از سوی Health Net Life Insurance Company عضویت دارید، با CA Dept. of Insurance به شماره 1-800-927-4357 تماس بگیرید. اگر در برنامه HMO یا HSP از سوی Health Net of California, Inc عضویت دارید، با خط راهنمایی تلفنی DMHC به شماره 1-888-HMO-2219 تماس بگیرید.

Panjabi (Punjabi)

ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਤੋਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ਿਆ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ ਕਿਰਪਾ ਕਰਕੇ 1-800-522-0088 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਾਰਿਵਾਰਕ ਪਲੈਨ (IFP) ਦੇ ਆਵੇਦਕ ਕਿਰਪਾ ਕਰਕੇ 1-877-609-8711 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਵਧੇਰੀ ਮਦਦ ਲਈ: ਜੇ Health Net Life Insurance Company ਤੋਂ ਇੱਕ ਪੀਪੀਓ PPO ਜਾਂ ਈਓਪੋ EPO ਬੀਮਾ ਪਾਲਿਸੀ ਵਿੱਚ ਨਾਮਾਂਕਿਤ ਹੋ, ਤਾਂ ਕੈਲੀਫੋਰਨੀਆਂ ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ 1-800-927-4357 'ਤੇ ਕਾਲ ਕਰੋ। ਜੇ ਤੁਸੀਂ ਹੈਲਥ ਨੈੱਟ ਆਫ਼ ਕੈਲੀਫ਼ੋਰਨੀਆਂ, ਇੰਕ ਤੋਂ ਇੱਕ ਐਚਐਮਓ HMO ਜਾਂ ਐਚਐਸਪੀ HSP ਪਲੈਨ ਵਿੱਚ ਨਾਮਾਂਕਿਤ ਹੋ ਤਾਂ ਡੀਐਮਐਚਸੀ DMHC ਹੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 'ਤੇ ਕਾਲ ਕਰੋ।

Russian

Бесплатная помощь переводчиков. Вы можете получить помощь устного переводчика. Вам могут прочитать документы в переводе на ваш родной язык. За помощью обращайтесь к нам по телефону, приведенному на вашей идентификационной карточке участника плана. Если вы хотите стать участником группового плана, предоставляемого работодателем, звоните в коммерческий контактный центр компании 1-800-522-0088 (TTY: 711). Если вы хотите стать участником плана для семей и частных лиц (IFP), звоните по телефону 1-877-609-8711 (TTY: 711). Дополнительная помощь: Если вы включены в полис PPO или EPO от страховой компании Health Net Life Insurance Company, звоните в Департамент страхования штата Калифорния CA Dept. of Insurance, телефон 1-800-927-4357. Если вы включены в план HMO или HSP от страховой компании Health Net of California, Inc., звоните по контактной линии Департамента управляемого медицинского обслуживания (DMHC), телефон 1-888-HMO-2219.

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. Los solicitantes del grupo del empleador deben llamar al 1-800-522-0088 (TTY: 711). Los solicitantes de planes individuales y familiares deben llamar al 1-877-609-8711 (TTY: 711). Para obtener más ayuda, haga lo siguiente: Si está inscrito en una póliza de seguro PPO o EPO de Health Net Life Insurance Company, llame al Departamento de Seguros de California, al 1-800-927-4357. Si está inscrito en un plan HMO o HSP de Health Net of California, Inc., llame a la línea de ayuda del Departamento de Atención Médica Administrada, al 1-888-HMO-2219.

Tagalog

Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng isang interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo sa inyong wika. Para sa tulong, tawagan kami sa nakalistang numero sa inyong ID card, o para sa grupo ng mga aplikante ng employer, mangyaring tawagan ang 1-800-522-0088 (TTY: 711). Para sa mga aplikante ng Plano para sa Indibiduwal at Pamilya Individual & Family Plan, (IFP), mangyaring tawagan ang 1-877-609-8711 (TTY: 711). Para sa higit pang tulong: Kung nakatala kayo sa insurance policy ng PPO o EPO mula sa Health Net Life Insurance Company, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Kung nakatala kayo sa HMO o HSP na plan mula sa Health Net of California, Inc., tawagan ang Helpline ng DMHC sa 1-888-HMO-2219.

Thai

ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังเป็นภาษาของคุณได้ สำหรับความช่วยเหลือโทรหาเราตามหมายเลขที่ให้ไว้บนบัตรประจำตัวของคุณ หรือ ผู้สมัครกลุ่มนายจ้าง กรุณาโทรหาศูนย์ติดต่อเชิงพาณิชย์ของ 1-800-522-0088 (TTY: 711) ผู้สมัครแผนบุคคลและครอบครัว Individual & Family Plan (IFP) กรุณาโทร 1-877-609-8711 (TTY: 711) สำหรับความช่วยเหลือเพิ่มเติม หากคุณสมัครทำกรมธรรม์ประกันภัย PPO หรือ EPO กับ Health Net Life Insurance Company โทรหากรมการประกันภัยรัฐแคลิฟอร์เนียได้ที่ 1-800-927-4357 หากคุณสมัครแผน HMO หรือ HSP กับ Health Net of California, Inc. โทรหาสายด่วนความช่วยเหลือของ DMHC ได้ที่ 1-888-HMO-2219.

Vietnamese

Các Dị ch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu c`ầu được đọc cho nghe tài liệu bằng ngôn ngữ của quý vị. Để nhận trợ giúp, hãy gọi cho chúng tôi theo số được liệt kê trên thẻ ID của quý vị, hoặc người nộp đơn vào chương trình theo nhóm của chủ sử dụng lao động vui lòng gọi 1-800-522-0088 (TTY: 711). Người nộp đơn thuộc Chương Trình Cá Nhân & Gia Đình viết tắt trong tiếng Anh là (IFP) vui lòng gọi số 1-877-609-8711 (TTY: 711). Để nhận thêm trợ giúp: Nếu quý vị đăng ký hợp đ`ồng bảo hiểm PPO hoặc EPO từ Health Net Life Insurance Company, vui lòng gọi Sở Y Tế CA theo số 1-800-927-4357. Nếu quý vị đăng ký vào chương trình HMO hoặc HSP từ Health Net of California, Inc., vui lòng gọi Đường Dây Trợ Giúp DMHC theo số 1-888-HMO-2219.