

Application must be typed or completed in blue or black ink.
 Please note that applicants under 1 year of age on the policy effective date cannot be enrolled as the primary subscriber.

Please request your effective date (*cannot precede the postmark date of this application*).

Requested effective date: ____/____/____

NEITHER BROKER NOR ANY OTHER PERSON MAY COMPLETE THE STATEMENT OF HEALTH OR SIGN THIS APPLICATION AND AGREEMENT ON BEHALF OF THE APPLICANT. The Statement of Health can be completed by the applicant for minor dependents.

IMPORTANT: Can you read this form? If not, we can have somebody help you read it. You may also be able to get this form written in your language. For free help, please call right away at 800-909-3447, option 2.

IMPORTANTE: ¿Puede leer este formulario? De no ser así, podemos hacer que alguien le ayude a leerlo. También puede obtener este formulario escrito en su idioma. Para obtener ayuda sin costo, llame inmediatamente al 800-909-3447, opción 2.

重要資訊: 您是否能閱讀此文件?如果您無法閱讀,我們將請專人協助您。我們也能以您使用的語言翻譯此份文件。請立即致電 800-909-3447, 再按 2, 洽詢免費服務。

Applicant's last name		First name		MI	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Applicant's birth date (mo/day/year) □□/□□/□□□□		
Home address			City		State	ZIP	Height	Weight
County	Home phone number ()	Work phone number ()	Email address		Applicant's Social Security Number □□□-□□-□□□□			

List all eligible dependents to be enrolled. Dependents must be at least 30 days old or less than 65 years of age on the policy's effective date in order to qualify as an eligible dependent. If the last name of the dependent is different from the subscriber, please explain on a separate sheet of paper. 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. All applicants must reside at the same address.

For additional dependents, please attach another sheet with the requested information.

Last name	First name	MI	Social Security Number	Sex	Date of birth	Height	Weight (lbs.)
Spouse/Domestic Partner				<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /		
Child 1				<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /		
Child 2				<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /		

PLAN CHOICE

Please designate your plan choice:

Quick Net Select 750 **Quick Net Select 1,000** **Quick Net Select 2,000** **Quick Net Select 4,500**

Please designate your plan type: **Daily Plan**¹ **Monthly Plan**

Note: If you have applied for both a short-term and a standard Individual & Family health plan and have been simultaneously approved for each, you will *automatically be enrolled in the standard Individual & Family health plan* and this application for Quick Net coverage will be cancelled. Should you wish to not be enrolled in the standard Individual & Family health plan, please check this box. **NO, do not enroll me in the standard health plan.**

¹Please complete the Daily Policy Only section.

DAILY POLICY ONLY² (Do not complete this section for the monthly plan)

Benefit Coverage Period: Please choose the number of days for your Benefit Period: _____ days (30 – 180 Days)

Once enrolled, there are no changes permitted and the policy cannot be renewed.

Calculate your total premium due:

\$ _____ daily rate² (please see rates) × _____ # of coverage days = \$ _____ Total Premium Due

Please remit a check payable to "Health Net" for the full amount owed for the Policy Benefit period.

²Daily Rate is based on the number of days selected.

MEDICAL QUESTIONS 1 – 13

Genetic Information Non-discrimination Act of 2008 (GINA) Compliance Statement: This is not a request for genetic information. In answering these Medical Questions you should not include any genetic information. That is, please do not include any family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which you believe you may be at risk.

1. In the past 6 months, have you been a US resident? Yes No If no, are applicants U.S. citizens or permanent residents? Yes No
If no, applicant(s) is(are) not eligible for this policy.
2. Are you, your spouse/domestic partner, female dependent or companion currently pregnant or have you, your spouse/domestic partner, female dependent or companion performed a home pregnancy test during the previous 90 days which has reacted positive? Yes No
3. Are you in the process of adoption or surrogate pregnancy? Yes No
4. During the past 12 months, have you or any applying family member experienced symptom(s) for which a health care practitioner has not been consulted? Yes No
5. During the benefit coverage period, will you or any applying family member train for or participate in: 1) a team or individual sports activity as a professional; 2) national or international competition as an amateur or 3) a collegiate sports activity? Yes No
6. Within the last 5 years, have you or any applying family member ever received any medical or surgical consultation, advice, or treatment including medication for: heart or circulatory system disorder including heart attack or chest pain; stroke; diabetes; cancer or tumor; alcoholism or alcohol abuse; drug abuse or chemical dependency; or liver, kidney disorder? Yes No
7. Have you or any person applying enrolled in training for or engaged in an occupation involving unusual hazards, and are not covered by Workers' Compensation Insurance? Yes No
8. In the past 12 months, have you or any applying family member consulted a health care practitioner and have been recommended to have or been scheduled for diagnostic testing, treatment or surgery that has not been completed? Yes No
9. In the last 30 days have you or any applying family member been confined to a hospital? Yes No
10. Have you or any applying family member been diagnosed as having or been treated for AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS-Related Complex)? Yes No
11. Do you or any applying family member have any hospital, major medical, group health or medical insurance coverage in force that will NOT terminate prior to the effective date of this policy? Yes No If yes, when will existing coverage expire? ____/____/____
12. If you answered "Yes" to questions 2 – 11, please complete the lines below. **Please note, these persons are excluded from coverage.**
 Question # _____ family member's name _____
 Question # _____ family member's name _____
13. During the previous 62 days, have you or any person applying for coverage been covered by other health insurance? **If yes, please complete the prior coverage information below for all periods in the last 12 months. For additional dependents, please attach additional sheets.**
 Yes No
 Insured's name _____ Current carrier _____
 Effective date _____ Expected termination date _____

APPLICANT'S AGENT/BROKER INFORMATION – Complete agent/broker name and address is necessary for correspondence to be sent to the agent/broker. The following form is to be completed by the applicant's broker (if applicable).

Health Net Broker ID: _____	
_____ Name (Print)	_____ Phone number
_____ Address	_____ Fax number
_____ 	_____ Email address
_____ Applicant's Broker Signature/Number (Required)	_____ Date signed (Required)

Broker Certification

I _____
 (Name of 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. All information in the health questionnaire(s) was completed by the applicant(s). 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 4:

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
4. Are you aware of any information, including but not limited to medical history, not disclosed in this application that might have a bearing on the risk? Yes No

If "Yes," please explain: _____

IMPORTANT INFORMATION (Please read carefully)

I UNDERSTAND THAT:

- The minimum coverage time under the Health Net Life Insurance Quick Net **Daily Policy is 30 Days** and for the **Monthly Policy it is one calendar month**. The maximum length of coverage time is **180 Days for the Daily Policy** and **6 months for the Monthly Policy**.
- There are no changes to this policy once it goes into force. Under no circumstances will I, or my dependents, be allowed to make changes or request a refund beyond the 10-day free look period. No exceptions will be made.
- No benefits are payable for any expenses incurred as a result of a pre-existing condition. Pre-existing condition means an illness, injury or condition which existed during the twelve-month period, when this Policy insures one or two Covered Persons, or six-month period when this Policy insures three or more Covered Persons, immediately prior to the Member's Effective Date. An illness, injury, or condition is considered to have existed when the Member: (1) sought or received professional advice for that illness, injury, or condition; or (2) received medical care or treatment for that illness, injury or condition.
- If I am approved under a Health Net permanent plan I must exhaust my coverage under Quick Net.
- My check will be held in trust while my application is reviewed by Health Net Life Insurance Company. Applications **submitted without payment** or with **partial payment** will be **pended** until payment is received. If my payment is not received within 2 weeks of the application signature date, my application will be withdrawn.

Additional information for Monthly Policies only:

- If my Monthly policy is terminated due to lack of payment, my policy will **not** be reinstated. I may terminate my policy at any time, effective the first of the following month following Health Net's receipt of my notice to cancel.

RESCISSION OF MEMBERSHIP FOR HEALTH NET LIFE INSURANCE COMPANY INDIVIDUAL PPO PLANS: Health Net Life Insurance Company ("HNL") is an Insurance Company licensed and regulated under the California Insurance Code. HNL underwrites Individual PPO health insurance plans. HNL will undertake reasonable steps to complete medical underwriting and resolve all reasonable questions arising from the written information you have submitted on or with your Application before issuing an Insurance Policy. However, intentional or unintentional nondisclosure or misstatement of material facts in written information you have submitted on or with your Application materials may be cause for disenrollment and rescission of the Insurance Policy and HNL may recoup from the Policyholder (or from You or from the applicant) any amounts paid under the Insurance Policy obtained as a result of such nondisclosure or misstatement of material facts. In addition, if a Policyholder makes an intentional or unintentional nondisclosure, misstatement or omission of material facts in written information submitted on or with the Application as to the Policyholder's or Family Member's health status or history, HNL shall have no liability for the provision of coverage under the Insurance Policy. By signing this Application, you represent that all responses to the Statement of health are true, complete and accurate and that should your Application be accepted by HNL, the Application will become part of the contract between HNL and yourself. By signing this Application you further represent and agree to abide by the terms of the contract. Should the contract be rescinded, HNL will provide a written notice that will explain the basis of the decision and your appeals rights. HNL will refund all amounts paid by you, less any medical expenses that HNL paid.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: I acknowledge and understand that health care providers may disclose health information about me or my dependents, including information regarding substance abuse, mental/emotional conditions, AIDS (Acquired Immune Deficiency Syndrome), or ARC (AIDS-Related Complex) 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, disease or case management programs. Health Net's Notice of Privacy Practices is included in the Insurance Policy, and I may also obtain a copy of this Notice on the website at www.healthnet.com or through Health Net's Customer Contact Center. Authorization for use and disclosure of potential health information shall be valid for a period of 24 months from the date of my signature below.

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.

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. **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 are obligated to understand and abide by the terms, conditions and provisions of the Insurance Policy. 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.

Acceptance of a short-term policy will impact eligibility for individual guaranteed issue health insurance according to the requirements within the Health Insurance Portability and Accountability Act of 1996.

BINDING ARBITRATION:

I, the applicant, agree that any and all disputes or disagreements between me (including any of my enrolled family members or heirs or personal representatives) and Health Net regarding the construction, interpretation, performance or breach of the Health Net Plan Contract or Insurance Policy, or regarding other matters relating to or arising out of my Health Net membership, whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or employees, are also involved, must be submitted to final and binding arbitration in lieu of a jury or court trial. 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 the extent permitted by law to have their dispute decided in a court of law before a jury. I also understand that disputes that I may have with Health Net involving claims or 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. A more detailed arbitration provision is included in the Plan Contract or Insurance Policy. My signature below indicates that I understand the terms of this Binding Arbitration Clause and agree to submit disputes to binding arbitration.

Applicant or Parent or Legal Guardian's signature if Applicant is under 18 years old:	Date signed:
Spouse/Domestic partner's signature:	Date signed:
Signature of applicant's dependent (age 18 and older):	Date signed:
Signature of applicant's dependent (age 18 and older):	Date signed:

The Application and this Arbitration Clause must be signed by the Applicant. The applicant must personally sign his/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 or Insurance Policy 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.

CREDIT CARD PAYMENT INFORMATION (Optional)

Premium charge can be charged directly to your credit card account. The premium will be charged to your credit card account approximately ten days in advance of the due date.

First payment (daily and monthly policies) **Monthly payment** (monthly policies)

First name (as appears on card):	Middle name (as appears on card):	Last name (as appears on card):	Card type: <input type="checkbox"/> Visa <input type="checkbox"/> Mastercard	
Account number:		Expiration date (mm/yyyy):	Cardholder's email address:	
Billing address:		City:	State:	ZIP code:¹

¹The zip code must match the Cardholder's address otherwise the credit card cannot be processed.

As a convenience, I request and authorize Health Net Life Insurance Company ("Health Net") to charge my credit card account identified above for the payment of my initial premium and/or my monthly premium. This authority is to remain in effect until revoked by me in writing and until Health Net actually receives such notice, I agree that Health Net shall be fully protected in honoring any such charge. *(Note: A 30-day notice is required to discontinue this service due to the time required to initiate this change with your credit card company.)*

SIGNATURE OF CREDIT CARD ACCOUNT HOLDER:	DATE:
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Fax your completed application and payment to 1-800-977-4161 (toll free) or mail your completed application and payment to Health Net Individual & Family Enrollment, PO Box 1150, Rancho Cordova, CA 95741-1150



AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION FOR ENROLLMENT

Please detach and keep this copy for your records.

Information regarding your insurability will be treated as confidential. Health Net or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Health Net, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.



AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION FOR ENROLLMENT

This authorization for use or disclosure of personal health information is being requested by Health Net to comply with the terms of federal HIPAA regulations, 45 C.F.R. § 164.508. A copy of this form is as valid as the original.

THIS AUTHORIZATION FORM MUST BE COMPLETED IN ORDER TO ENABLE HEALTH NET TO UNDERWRITE YOUR COVERAGE. THE ENROLLMENT PROCESS CANNOT BE COMPLETED WITHOUT YOUR EXPRESS AUTHORIZATION WHICH IS MORE FULLY DESCRIBED BELOW. THIS FORM MUST BE SIGNED BY THE APPLICANT AND EACH ADULT FAMILY MEMBER APPLYING FOR COVERAGE (including dependents age 18 and over).

APPLICANT AND FAMILY MEMBERS REQUESTING ENROLLMENT:

Applicant Name	Social Security Number
Spouse Name	Social Security Number
Dependent (age 18 or older)	Social Security Number
Dependent (age 18 or older)	Social Security Number

I, _____, _____
 applicant (print name) spouse (print name)

_____, _____
 adult dependent (print name) adult dependent (print name)

hereby authorize the use or disclosure of personal health information as described below.

Additional adult dependents may be listed below.

As the (applicant) parent, I, (print name) _____, authorize the use or disclosure of personal health information about my minor dependent(s), age 17 and under, as described below:

_____, _____, _____
 (print dependent[s] name[s])

_____, _____, _____

1. Person(s) or group of persons authorized to disclose the information to Health Net include:
 - Any medical professional, hospital, or other health care facility, clinic, pharmacy, insurer or health benefit plan administrator, Medicare or Medicaid, MIB, Inc., (“MIB”), or any other health care provider or health plan that has medical information about me or my dependent(s);
 - Health care providers or health plans indicated in my application for coverage or on my dependents’ applications for coverage, or identified by me during a health history interview in regard to myself or my dependent(s), or identified by me or my dependent(s) to my agent, or any other healthcare provider or health plan referred to in my medical records or my dependent’s(s’) medical records.

Information regarding your insurability will be treated as confidential. Health Net or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866 692-6901 (TTY 866 346-3642). If you question the accuracy of the information in MIB’s file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB’s information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Health Net, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

2. I authorize the following person(s) or group of persons to receive the information disclosed by one of the persons or organizations listed in paragraph 1 above, and to use that information and the information included on my application for coverage to underwrite and rate the health plan coverage for which I have applied:
 - Health Net and its affiliates including, but not limited to, its agents, underwriting operations, including independent contractors who have executed Business Associates contracts to conduct underwriting activities on behalf of Health Net or do post enrollment review of any information for determination whether policy should be rescinded for misrepresentation, who have agreed to safeguard protected health information from unauthorized disclosure, claims operations, legal representatives, its Medical Director or his/her designees, and its sales and

marketing operations. I understand that Health Net may condition my or my dependent's(s') enrollment in the health plan on my signing this Authorization and initialing this paragraph 2.

Applicant _____ Spouse _____ Dependent _____ Dependent _____

3. Description of the information that may be used or disclosed includes: All health information pertaining to me or my minor dependent(s), if applicable, related to the diagnosis, treatment or prognosis with respect to any physical, accident, illness, medical or mental condition, including but not limited to, alcohol abuse, substance abuse, mental or emotional disorders, AIDS (Acquired Immune Deficiency Syndrome), or ARC (AIDS-Related Complex), except psychotherapy notes, and any other related information, including but not limited to, the information provided on my application.
4. I understand that if this Authorization is for disclosures to someone other than Health Net, personal health information disclosed may be subject to re-disclosure by the recipient, in which case it would no longer be protected by federal Privacy Rules. However, Health Net is subject to federal Privacy Rules and any information Health Net receives is protected by these Rules.
5. I understand that my enrollment in Health Net's health plan may be conditioned on my signing this Authorization and initialing paragraph 2. I understand that I may refuse to initial paragraph 2 of this Authorization, and that such refusal could affect my enrollment in the health plan or eligibility for benefits under the health plan.
6. If the person completing this Authorization is the personal representative of the applicant or dependent, describe your authority to act on this person's behalf.

7. As described in the "Notice of Privacy Practices," I understand that I may revoke this Authorization in writing at any time, except to the extent that action has been taken by Health Net and its subsidiaries and affiliates in reliance on this Authorization. I may send a written and dated revocation to Health Net to: Health Net Privacy Office, 21650 Oxnard Street, Ste. 2211, Woodland Hills, CA 91367. Health Net's "Notice of Privacy Practices" is available on the Health Net website at www.healthnet.com or will be provided to me in writing upon request.
8. I understand that either I am, or my personal representative is, entitled to receive a copy of my signed Authorization and by my signature below, I acknowledge that I have been provided with a copy.
9. This authorization will become effective immediately and shall remain valid for thirty (30) months from the date the authorization form is signed as to Health Net's determination on enrollment.

SIGNATURES (REQUIRED IN INK)

Applicant's Signature	Date Signed
Spouse's Signature	Date Signed
Signature of Applicant's Dependent (age 18 or older)	Date Signed
Signature of Applicant's Dependent (age 18 or older)	Date Signed
Personal Representative's Name, if applicable (Print)	Date Signed
Personal Representative's Signature	Date Signed

PLEASE RETURN THIS FORM TO:

Health Net Individual & Family Plans
P.O. Box 1150
Rancho Cordova, CA 95741-1150



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. Individual and Family Plan (IFP) applicants please call 800-909-3447, option 2. For more help call the CA Dept. of Insurance at 1-800-927-4357 if you are enrolling in a PPO plan. If you are enrolling in a HMO plan, call the DMHC Helpline at 1-888-HMO-2219.

English

Servicios de Idiomas Sin Costo. Usted puede solicitar un intérprete. Puede solicitar que una persona le lea los documentos y que algunos se le envíen en su idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación. Los solicitantes de Plan Individual y Familiar (IFP, por sus siglas en inglés), deben llamar al 800-909-3447, opción 2. Para obtener ayuda adicional llame al Departamento de Seguros de California al 1-800-927-4357, si desea inscribirse en un plan PPO. Si usted se inscribe en un plan HMO, llame a la Línea de ayuda de DMHC, al 1-888-HMO-2219.

Spanish

免費語言服務。您可以取得口譯員服務。我們可以把文件朗讀給您聽，部分文件可將您的語言版本寄送給您。如需協助，請撥打您會員卡上所列的電話號碼。個人和家庭計畫 (IFP) 申請人請撥打 800-909-3447，按 2。投保首選醫師 / 醫療組織 (PPO) 計畫者，請致電 1-800-927-4357 與加州保險部聯絡，詢求額外協助。投保管理式醫療組織 (HMO) 計畫者，請撥打加州醫療保健計畫管理局 (DMHC) 協助專線，電話 1-888-HMO-2219。

Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch và được người khác đọc giúp các tài liệu bằng ngôn ngữ của quý vị. Để được giúp đỡ, xin gọi chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị. Những người muốn xin bảo hiểm của Chương Trình Bảo Hiểm Cá Nhân và Gia Đình (IFP), xin gọi số 800-909-3447, bấm số 2. Để được giúp đỡ thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357 nếu quý vị muốn tham gia một chương trình PPO. Nếu quý vị đang tham gia một chương trình HMO, xin gọi Đường Dây Trợ Giúp của DMHC tại số 1-888-HMO-2219.

Vietnamese

무료 언어 지원 서비스. 무료 통역사 서비스 및 여러분에게 편한 언어로 서류 낭독 서비스를 받을 수 있습니다. 도움이 필요하신 분은 본인의 ID 카드상에 적힌 안내 번호로 전화해 주십시오. 개인 및 가족 플랜 (IFP) 가입 신청자님은 안내번호 800-909-3447번, 옵션 2를 이용해 주십시오. PPO 플랜에 가입하신 경우, 더 많은 도움이 필요하신 분은 캘리포니아 보험 담당국 안내번호 1-800-927-4357번으로 문의하십시오. HMO 플랜에 가입하신 경우, DMHC (보건관리부) 헬프라인, 안내번호 1-888-HMO-2219번으로 문의하십시오.

Korean

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար ձեր լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնուրույն (ID) տոմսի վրա նշված համարով: Անհատական և Ընտանեկան Օրագրի (Individual and Family Plan/IFP) դիմորդներից խնդրվում է զանգահարել 800-909-3447 համարով, ընտրանք 2: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք, եթե գրանցվում եք PPO ծրագրում: Եթե գրանցվում եք HMO ծրագրում, 1-888-HMO-2219 համարով զանգահարեք DMHC-ի Օգնության գծին:

Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и вам могут прочесть документы на вашем языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте. Участники планов индивидуального или семейного страхования (Individual and Family Plan, IFP): пожалуйста, звоните по номеру 800-909-3447, добавочный 2. Если вы участвуете в плане системы предпочтительного выбора (Preferred Provider Organization, PPO), для получения дополнительной помощи звоните в Департамент страхования штата Калифорния по телефону 1-800-927-4357. Если вы состоите в плане организаций медицинского обслуживания (Health Maintenance Organizations, HMO), пожалуйста, звоните в горячую линию Департамента организованного медицинского обслуживания (DMHC) по телефону 1-888-HMO-2219.

Russian

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa iyong wika ang mga dokumento. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card. Para sa Individual and Family Plan (IFP) applicants, mangyaring tumawag sa 800-909-3447, opsyon 2. Para sa karagdagang tulong, tumawag sa CA Dept. of Insurance sa 1-800-927-4357 kung ikaw ay nag-enroll sa isang PPO plan. Kung ikaw ay nag-enroll sa isang HMO plan, tawagan ang DMHC Helpline sa 1-888-HMO-2219. Tagalog

無料の言語サービス。日本語で通訳をご提供し、書類をお読みします。また、お手元にお届けできる翻訳書類もあります。サービスをご希望の方は、IDカード記載の番号までお問い合わせください。個人・家族プラン（IFP）への加入申込の方は、800-909-3447（ダイアル後 2 を選択）までお問い合わせください。更なるお問い合わせ事項がある場合、PPO プランにご加入の方は、カリフォルニア州保険庁、1-800-927-4357 までご連絡ください。HMOプランにご加入の方は、カリフォルニア州管理医療庁（DMHC）の相談窓口、1-888-466-2219 までご連絡ください。

Japanese

خدمات مجاني مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی برخوردار شده و بگوئید مدارک به زبان خودتان برایتان خوانده شوند. برای دریافت کمک. با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است تماس بگیرید. متقاضیان « طرح افراد و خانواده ها » (IFP) لطفاً به شماره 800-909-3447 گزینه 2 تلفن کنند. برای دریافت کمک بیشتر. به اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تلفن کنید اگر در یک طرح PPO ثبت نام میکنید. اگر در یک طرح HMO ثبت نام میکنید. به خط کمکی DMHC به شماره 1-888-HMO-2219 تلفن کنید.

Farsi

ਮੁਫਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ। ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਪਲਾਨ (IFP) ਅਰਜ਼ੀਦਾਤਾ ਕਿਰਪਾ ਕਰਕੇ 800-909-3447, ਆਪਸ਼ਨ 2 ਤੇ ਫੋਨ ਕਰੋ। ਜੇ ਤੁਸੀਂ ਕਿਸੇ PPO ਪਲਾਨ ਲਈ ਨਾਂ ਲਿਖਵਾ ਰਹੇ ਹੋ ਤਾਂ ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸੂਰੈਂਸ ਨੂੰ 1-800-927-4357 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਜੇ ਤੁਸੀਂ ਕਿਸੇ HMO ਪਲਾਨ ਲਈ ਨਾਂ ਲਿਖਵਾ ਰਹੇ ਹੋ ਤਾਂ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਮੈਨੇਜਡ ਹੈਲਥ ਕੇਅਰ (DMHC) ਦੀ ਹੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ।

Punjabi

ការបកប្រែភាសាដោយឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានការបកប្រែភាសា និងឲ្យគេអានឯកសារជូនអ្នកជាភាសាខ្មែរបាន ។ សំរាប់ព័ន្ធយ សូមទូរស័ព្ទមកលើក តាមលេខមានកត់នៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក ។ គំរោងបុគ្គលម្នាក់ៗ និងគ្រួសារ (IFP) សូមទូរស័ព្ទទៅលេខ 800-909-3447 ចុចលើជំរើសទី 2។ សំរាប់ព័ន្ធយថែមទៀត សូមទូរស័ព្ទទៅ ក្រសួងពាណិជ្ជកម្មកាលីហ្វ័រនីញ៉ា តាមលេខ 1-800-927-4357 លើសិនជាអ្នកកំពុងតែចុះឈ្មោះក្នុងគំរោង PPO ។ លើសិនជាអ្នកកំពុងតែចុះឈ្មោះក្នុងគំរោង HMO សូមទូរស័ព្ទទៅខ្សែព័ន្ធយ DMHC តាមលេខ 1-888-HMO-2219 ។

Khmer

Cov Kev Pab Txhais Lus Uas Tsis Tau Them Nqi. Koj yuav thov tau kom muaj ib tug neeg txhais lus rau koj. Koj yuav thov tau kom muaj ib tug neeg nyeem cov ntawv thiab xa ib co ntaub ntawv ua koj hom lus tuaj rau koj. Yog xav tau kev pab, hu rau pab ntawm tus xov tooj nyob hauv koj daim yuaj ID. Cov neeg thov kev pab hauv pawg Tus Kheej thiab Tsev Neeg (Individual and Family Plan [IFP]) thov hu rau 800-909-3447, xav nqe 2. Yog xav tau kev pab ntxiv hu rau CA Lub Caj Meem Fai Saib Xyuas Txog Kev Tswj Txoj Kev Kho Mob (Dept. of Insurance) ntawm 1-800-927-4357 yog hais tias koj koom rau hauv ib qho kev pab los ntawm PPO. Yog hais tias koj koom rau hauv ib qho kev pab los ntawm HMO, hu rau DMHC Tus Xov Tooj Muab Kev Pab ntawm 1-888-HMO-2219.

Hmong

خدمات لغوية بدون تكلفة. يمكنك الاستعانة بمترجم وطلب قراءة الوثائق لك بلغتك. للحصول على المساعدة. اتصل بنا على الرقم المبين على بطاقة عضويتك (ID). المتقدمين بطلبات الحصول على تأمين لشخص واحد أو لعائلة (IFP) رجاء الاتصال بالرقم 800-909-3447. خيار 2. للحصول على المزيد من المساعدة. اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357 إذا كنت مشتركاً في برنامج PPO. وإذا كنت مشتركاً في برنامج HMO اتصل بالخط الساخن لـ DMHC على الرقم 1-888-HMO-2219.

Arabic

ບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າ. ທ່ານສາມາດໄດ້ຮັບບໍລິການແປພາສາແລະມີຜູ້ອ່ານເອກກະສານໃຫ້ທ່ານຟັງເປັນພາສາຂອງທ່ານເອງ. ເພື່ອຈະໄດ້ຮັບຄວາມຊ່ວຍເຫລືອ, ໃຫ້ໂທຫາພວກເຮົາຕາມໝາຍເລກທີ່ລະບຸໄວ້ໃນບັດປະກັນໄພຂອງທ່ານ. ຜູ້ຂໍເອົາແຜນການ Individual and Family Plan (IFP) ຂໍໃຫ້ໂທຕາມໝາຍເລກ 800-909-3447 ແລະເລືອກ ຂໍ້ທີ 2. ຖ້າຫາກທ່ານກຳລັງຈະລົງທະບຽນແຜນການ PPO, ໃຫ້ໂທໄປຫາກົມປະກັນໄພແຫ່ງລັດຄາລິຟໍເນຍຕາມ ໝາຍເລກ 1-800-927-4357 ເພື່ອຈະໄດ້ຮັບຄວາມຊ່ວຍເຫລືອເພີ່ມຕື່ມ. ຖ້າຫາກທ່ານກຳລັງຈະລົງທະບຽນແຜນການ HMO, ໃຫ້ໂທຕາມສາຍດວນ DMHC ຕາມໝາຍເລກ 1-888-HMO-2219.

Laotian



LANGUAGE PREFERENCE FORM FORMULARIO DE PREFERENCIA DE IDIOMA 慣用語言資料表

TALK TO US – WE SPEAK YOUR LANGUAGE

Is English your second language? Is it easier to read and speak in a language other than English?

If yes, please complete this form and return it with your Enrollment Application. If you are accepted for enrollment, our records will be updated with this information. This information will help:

- Allow those whose preferred language is one of the two most prevalent non-English languages in Health Net's enrollment to receive certain plan documents in your preferred language.
- Provide you with interpreter assistance for health services in your preferred language.

Health Net is required to collect written and spoken language information in order to comply with California Department of Managed Health Care and California Department of Insurance language assistance regulations, however, you are not required to provide this information. Health Net will protect your information, including race, ethnicity, and your language choices.

HABLE CON NOSOTROS, HABLAMOS SU IDIOMA

¿Es el inglés su segundo idioma? ¿Le resulta más fácil leer y hablar en un idioma distinto del inglés?

Si la respuesta es sí, llene este formulario y devuélvalo junto con su Formulario de Inscripción. Si su solicitud de inscripción es aceptada, actualizaremos nuestros registros con esta información, la que nos servirá para:

- Permitir que aquellas personas cuyo idioma preferido es uno de los dos idiomas extranjeros más comunes entre todos los que se inscriben en Health Net, reciban ciertos documentos del plan en su idioma preferido.
- Brindarle la asistencia de un intérprete para servicios de salud en su idioma preferido.

A Health Net se le exige recopilar información sobre el idioma escrito y hablado para cumplir con los reglamentos sobre asistencia del idioma del Departamento de Cuidado Médico de California y el Departamento de Seguros de California, sin embargo, no es obligación que usted proporcione esta información. Health Net protegerá su información, incluidos su raza, origen étnico y sus alternativas de idioma.

請與我們交談 — 我們會說您的語言

英語是您的第二語言嗎？您是否覺得用英語以外的另一種語言來閱讀和溝通比較容易？

如果是的話，請您填寫這份表格，並連同您的投保申請書一併繳回。如果您的投保申請獲准，我們會把本表的資料更新到紀錄中。這些資料能幫助：

- 慣用語言為康寧保健投保時最通用的兩種非英文語言者，得以收到其慣用語言版本的部分計畫文件。
- 在您取得保健服務時以您慣用的語言提供您口譯員協助。

按加州醫療保健計畫管理局和加州保險局的語言協助法令規定，康寧保健必須收集書寫和口語使用語言的資訊，但是您無須提供這些資訊。康寧保健會保護您所提供的資訊，包括種族、族裔和您的語言選擇。

Name/ Nombre/ 姓名：_____

Social Security Number/ Número del Seguro Social/ 社會安全號碼：_____

Written Language/ Idioma Escrito/ 書寫語言：_____

Spoken Language/ Idioma Hablado/ 口說語言：_____

Race (optional)/ Raza (opcional)/ 種族 (非必填)：_____

Ethnicity (optional)/ Origen Étnico (opcional)/ 族裔 (非必填)：_____