Instructions for Completing Your Individual & Family Plan HMO Enrollment Application

You may use this application to apply for any of the available Health Net Individual & Family HMO plans and Individual Term Life Insurance. HMO plans are provided by Health Net of California, Inc. Term Life Insurance coverage is underwritten by Health Net Life Insurance Company.

The application must be completed by the applicant applying for coverage and can be completed by the applicant for minor dependents or by an interpreter for applicants who do not read/write English. Neither the broker nor any other person than those mentioned above may complete the Statement of Health on behalf of the applicant(s). Neither the broker nor any person other than the applicant or the applicant for minor dependents may sign the application and agreement on behalf of the applicant(s).

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 1-800-909-3447, option 2.

An interpreter who helped you read and complete this application must sign the application (see Part VIII). Also, the application is available in Chinese and Spanish language versions. If it is easier for you to read and speak in a language other than English, please complete and return the Language Preference Form included with this application.

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 1-800-909-3447, opción 2.

El intérprete que le ayudó a leer y completar esta solicitud debe firmar la solicitud (consulte la Parte VIII). Además, la Solicitud se encuentra disponible en las versiones de idioma chino y español. Si le resulta más fácil leer y hablar en un idioma que no sea inglés, complete y entregue el Formulario de Preferencias de Idiomas que se incluye con esta solicitud.

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 1-800-909-3447，再按 2，洽詢免費服務。

協助您閱讀及填寫本申請書的口譯人員必須於本申請書上簽名 (請見第 VIII 部分)。此外，本申請書備有中文和西班牙文版本。如果讀、說英語以外的語言對您而言更爲輕鬆，請填妥適用語言表並連同本申請書一併寄回。

- Please print clearly using black or blue ink.
- Fully complete the application to avoid a return of the application and delay in processing.
- Give complete name, address and phone number of all doctors indicated in Part VI (B).
- Children up to age 26 are eligible to apply as dependents.
- If approved, this application will become part of your Plan Contract.

Corrections to answers can be made by drawing a straight line through the incorrect answer and printing the correct response above the lined-out answer. Applicant must then initial and date the correction.

If you have questions or are not sure how to answer a question, call your broker/agent, or call Health Net toll-free at 1-800-909-3447, option 2. A broker who helped you read and complete this application must sign the application (see Part IX).

Part I, A, B, C:

- Effective dates can be the 1st of the month for HMO plans. For applicants under age 19, the effective date is determined based on when premium payment is received by Health Net. When premium payment is delivered or postmarked, whichever occurs earlier:
  - (a) within the first 15 days of the month, coverage under the plan becomes effective no later than the first of the following month; or
  - (b) after the 15th day of the month, coverage shall become effective no later than the first day of the second month.
- Select the reason for the Individual & Family Plan Enrollment Application.
- Select requested billing type.

  Health Net offers two payment modes: monthly by check and monthly by Automatic Bank Draft. If you prefer to pay by ABD, please complete the Simple Pay Option form on page 21.
- One application can be used for family members that want to apply for separate plans. Part II is for the primary applicant; use Part III to choose plan options for other applicants. Family members that choose separate plans will be billed separately at the individual "subscriber" rates. See Monthly Rate Guide for rates.

Plus Option

A Health Net "Plus" plan is a Health Net HMO plan with Health Net Dental and Vision coverage included. The "Plus" indicates the addition of the optional coverage. Please refer to the Monthly Rate Guide for rates. If you are applying for HMO Plus, you must select an HMO dentist. To find a listing of participating dentists, go to www.healthnet.com and:

- Select *Find a Doctor or Hospital.*
- Select *Find providers by city, county, state or ZIP.*
- Select *State,* then select *Next.*
- Select the box for *Dental (Dentists, Dental Hygenists, etc.)* then *Search.*
- Select *Commercial Health Plans – Optum.*

This will redirect you to a new page showing a disclaimer. Please read then click *Continue*. This will take you to Health Net Dental plans.

- Select the *Locate Dentist* link from the left navigation bar.
- Select *DHMO CA ONLY*.
- Select the appropriate search criteria, then key in the Search Fields and select *Submit*.
- Choose your dentist and include the Practice ID # in the specified area on the application.

Part IV, Special enrollment for children under 19 years of age

Your children under 19 years of age are eligible to enroll in an Individual & Family Plan during the following periods and cannot be declined due to a pre-existing medical condition.

1. Open enrollment period – annually, during the month of the child's birth date.
2. Late enrollee period – Within 63 days after a qualifying event, if the child is without coverage and did not enroll during the child's birth month, because of any of the following qualifying events:
   A. The child lost dependent coverage due to:
      i. The termination or change in employment status of the child or the person through whom the child was covered;
      ii. The loss of an employer's contribution toward an employee's or dependent's coverage;
      iii. The death of the person through whom the child was covered as a dependent;
      iv. Legal separation or divorce;
      v. The loss of coverage under the Healthy Families Program, Access for Infants and Mothers Program (AIM) or the Medi-Cal program.
   B. The child became a resident of California during a month that was not the child's birth month.
   C. The child is born as a resident of California and did not enroll in the month of birth.
   D. The child is mandated to be covered pursuant to a valid state or federal court order.
   E. The child is adopted.
   F. The child exhausted COBRA or Cal-COBRA continuation coverage.

Proof of the child's date of birth or qualifying event will be required.

If your children do not enroll during the periods specified above, they are still eligible to enroll, and will not be declined due to a pre-existing medical condition. However, Health Net may charge a premium rate of more than two times the standard risk rate, which will remain in effect until the next open enrollment period following enrollment.

Please consider your options carefully before failing to maintain or renew coverage for a child for whom you are responsible. If you attempt to obtain new individual coverage for that child, the premium for the same coverage may be higher than the premium you pay now.

Part VI, Statement of Health

Each individual applicant who is applying for coverage must complete the Statement of Health. If you are applying for coverage for yourself and your dependents, the Statement of Health must be completed for each person who is applying for coverage.

This enrollment application provides space for application of enrollment of three applicants. If enrollment is being requested for more than three applicants, please request an addendum from your broker/agent or call 1-800-909-3447, option 2.

Even though your children under 19 years of age cannot be declined due to pre-existing medical conditions, you are required to complete the Statement of Health for each of your children under 19 years of age for whom you are requesting enrollment, because the monthly premium for their coverage will be determined by Health Net's review of their medical history. Dependents age 19 and older must complete the Statement of Health, Part VI and can be declined due to pre-existing medical conditions.

An Authorization for Use or Disclosure of Information for Enrollment must be completed by the applicant for applicants age 18 and older, and by a parent or guardian for applicants under age 18.

Premium Payment

Ask your broker/agent for monthly rates or refer to the Monthly Rate Guide.

Checks should be made payable to "Health Net." Submit your completed and signed application to:

Health Net Individual & Family Enrollment
PO Box 1150
Rancho Cordova, CA 95741-1150

Your new health plan coverage with Health Net will be in force when all of the following events take place:

1. The application has been approved for issuance by the Underwriting Department.
2. The first full premium has been paid and received by Health Net.
3. Coverage will become effective based upon the effective date that you selected, subject to underwriting approval. Once approved, the effective date will not be changed without proof of other existing coverage. For applicants under age 19, the effective date is determined based on when premium payment is received by Health Net. When premium payment is delivered or postmarked, whichever occurs earlier: (a) within the first 15 days of the month, coverage under the plan becomes effective no later than the first of the following month; or (b) after the 15th day of the month, coverage shall become effective no later than the first day of the second month.
4. **Important: Do not terminate any existing coverage until you have been notified that your Health Net coverage is in effect.**

Individual & Family Plan HMO

Enrollment Application

Application must be typed or completed in *blue or black ink.* **The application must be completed by the applicant applying for coverage and can be completed by the applicant for minor dependents, or by an interpreter for applicants who do not read/write English. Neither broker nor any other person other than those mentioned above may complete the Statement of Health on behalf of the applicant(s). Neither the broker nor any person other than the applicant or the applicant for minor dependents may sign this application and agreement on behalf of the applicant(s).**

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El intérprete que le ayudó a leer y completar esta solicitud debe firmar la solicitud (consulte la Parte VIII). Además, la solicitud se encuentra disponible en las versiones de idioma chino y español. Si le resulta más fácil leer y hablar en un idioma que no sea inglés, complete y entregue el Formulario de Preferencias de Idiomas que se incluye con esta solicitud.

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 1-800-909-3447，再按 2，洽詢免費服務。

協助您閱讀及填寫本申請書的口譯人員必須於本申請書上簽名 (請見第 VIII 部分)。此外，本申請書備有中文和西班牙文版本。如果讀、說英語以外的語言對您而言更爲輕鬆，請填妥適用語言表並連同本申請書一併寄回。

If you need assistance in completing this application, a broker may assist you. A broker who helped you read and complete this application must sign the application (see Part IX).

Part I. Tell us who you are enrolling and select the product:

A. Requested effective date

☐ **1st of the month**[1] **Please note date: ______________/01/______________**

[1]For applicants under age 19, the effective date is determined based on when premium payment is received by Health Net. When premium payment is delivered or postmarked, whichever occurs earlier: (a) within the first 15 days of the month, coverage under the plan becomes effective no later than the first of the following month; or (b) after the 15th day of the month, coverage shall become effective no later than the first day of the second month.

B. Reason for application

Family type: ☐ Subscriber ☐ Subscriber and spouse/domestic partner[2] ☐ Subscriber and child ☐ Subscriber and children
☐ Family: Subscriber, spouse/domestic partner and child(ren)[2]

Enrollment type: ☐ New enrollment ☐ Change plan[3] ☐ Add dependent[3]

[2]*Please* ***circle*** *spouse or domestic partner*
[3]*Member ID number (listed on your ID card):* ______________________________

C. Billing options

Please select a billing option for your medical, dental and vision coverage. This billing option does not apply to Term Life, which is billed and administered separately.

First premium payment (select one)
☐ Automatic Bank Draft (Please complete the "Simple payment option" section on page 21.)
☐ Pay by check (Please include completed check and send with application. Amount must match monthly premium.)
☐ Credit card (Please complete the "Credit card" section on page 21.)

Ongoing monthly premium payments (select one)
☐ Automatic Bank Draft (Please complete the "Simple payment option" section on page 21.)
☐ Monthly bill

(continued)

Primary applicant's Social Security number

Primary applicant's name: ______________________________ ☐☐☐ ☐☐ ☐☐☐☐

Part I. Tell us who you are enrolling and select the product: (continued)

D. Coverage choices

Health Net offers the following coverage options:

1. Single coverage: If you are applying for coverage just for yourself, complete Part II.
2. Family coverage (applicant plus one or more dependents): For family coverage, you need to fill out both Parts II and III. Children up to age 26 are eligible to apply as dependents.

With family coverage, you have the option of enrolling in the same plan or choosing different plans for different family members. Please note that when each family member chooses a different plan, subscriber rates will apply to each family member. 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 in Part III.

Part II. Primary applicant

If you are applying for coverage with a spouse or domestic partner who is younger, indicating him or her as the primary applicant may qualify you for a more favorable rate. If you choose different plans for you and a spouse/domestic partner, "subscriber" rates will apply.

STEP 1. Choose your plan

(1st of the month effective dates) ☐ HMO 40 ☐ HMO Value 50

If you have applied for Individual HMO coverage and do not meet the underwriting requirements for preferred premiums for the HMO plan for which you applied, Health Net may elect to offer you our **Modified Issue HMO option**. The Modified offer may be a plan that will have **a rate that could be substantially higher** than the standard rate for which you applied. If you meet the underwriting requirements for Modified Issue HMO, you will be automatically enrolled unless otherwise specified. Please check this box if you do not want to be automatically enrolled into the **Modified Issue HMO option**.

☐ **No, do not enroll me in the Modified Issue HMO option.**

☐ **Add – Term Life Insurance coverage underwritten by Health Net Life Insurance Company – (Part VII must be completed.)**

☐ **Add – Dental and Vision Plus – If you are selecting different medical plans for each family member and noting these choices in Part III, please also note in Part III which family members you wish to enroll in Dental and Vision Plus.**

HMO primary dentist number: ______________________________

STEP 2. Tell us about yourself

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

Home address:

City:	State:	ZIP:	County applicant resides in:

Home phone number: ( )	Work phone number: ( )	Email address:
Primary applicant's birth date (mm/dd/yy): / /	Place of birth:	Primary applicant's Social Security number:

Height:	Weight (lbs):	Primary care physician ID # (if applicable):	Current patient: ☐ Yes ☐ No	Physician group ID #:

In the past 6 months, have you been a resident of the United States? ☐ Yes ☐ No

If "No," where was your last residence?

Occupation:

Would you be interested in other Health Net or affiliated entities, products and services? ☐ Yes ☐ No

May we contact you by email? ☐ Yes ☐ No ***If "Yes," a Health Net representative or Authorized Agent will contact you.***

How did you hear about Health Net's Individual & Family coverage?

☐ Radio ☐ Mail ☐ Billboard ☐ Newspaper ☐ Yellow Pages ☐ Broker ☐ Internet ☐ Other: ______________

Primary applicant's Social Security number

Primary applicant's name: ______________________ [ ][ ][ ] [ ][ ] [ ][ ][ ][ ]

Part III. Family member(s) to be enrolled

1. List all dependent family members to be enrolled other than you. If a listed family member's last name is different from yours, please explain on a separate sheet of paper. For additional dependents, please request an addendum.

   ☐ Check here if an addendum is attached.

2. Please complete Part IV for children under 19 years of age.

3. 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.

4. How to make different plan choices:

   a. If you wish to choose different medical and Dental and Vision Plus coverage for each family member, please complete the medical plan choice and Dental and Vision Plus coverage questions.[4]

   b. 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.

   c. 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 on 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 1-800-909-3447 to request provider information, or contact your Health Net authorized broker.

   d. 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 on to www.healthnet.com. See the "Plus Option" portion of the instructions to this application for additional instructions.

   e. See Part VII to enroll in Supplemental Term Life Insurance.

Relation – dependent 1	**Last name**	**First name**	**MI**	**Social Security number**	**Date of birth**	**Place of birth**	**Height/ weight (lbs.)**	**HMO primary care physician ID**
☐ Husband ☐ Wife ☐ Domestic partner ☐ Son ☐ Daughter								
Current patient	**HMO physician group ID #**		**Medical plan choice for each family member if different[4]**			**Add Dental and Vision Plus (if "Yes," please note HMO primary dentist #)**		
☐ Yes ☐ No						☐ Yes ☐ No Primary dentist #: ______		
Relation – dependent 2	**Last name**	**First name**	**MI**	**Social Security number**	**Date of birth**	**Place of birth**	**Height/ weight (lbs.)**	**HMO primary care physician ID**
☐ Son ☐ Daughter								
Current patient	**HMO physician group ID #**		**Medical plan choice for each family member if different[4]**			**Add Dental and Vision Plus (if "Yes," please note HMO primary dentist #)**		
☐ Yes ☐ No						☐ Yes ☐ No Primary dentist #: ______		

[4]Subscriber-only rates apply when you enroll each family member in a different medical plan.

Primary applicant's Social Security number

Primary applicant's name: ______________________

Part IV. Special enrollment for children under 19 years of age

	Your children under 19 years of age are eligible to enroll in an Individual & Family Plan during the periods described in the Instructions section and cannot be declined due to a pre-existing medical condition. While coverage is guaranteed, the premium may vary due to health history or failure to maintain health insurance prior to open enrollment. Please complete one of the applicable sections below.	**Primary applicant** (complete primary applicant column for child-only apps.)	**Dependent 1**	**Dependent 2**
A.	**My child(ren) are applying during the month of their birthday (annual open enrollment).** (Proof of date of birth may be required. If late enrollee, see below.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
B.	**My child(ren) are applying outside of an open enrollment period.**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	If "Yes" to A or B above: Throughout the previous 90 days, have your child(ren) been continuously covered by health insurance? If "Yes," proof of prior coverage is required.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Primary applicant name:	Insurer name:	Policyholder/member ID #:	Group #:
Plan name:	State:	Most recent coverage start date:	End date:
Dependent 1 name:	Insurer name:	Policyholder/member ID #:	Group #:
Plan name:	State:	Most recent coverage start date:	End date:
Dependent 2 name:	Insurer name:	Policyholder/member ID #:	Group #:
Plan name:	State:	Most recent coverage start date:	End date:

		Primary applicant	**Dependent 1**	**Dependent 2**
C.	**My child(ren) are currently without coverage and are applying during a late enrollee period. Please select the appropriate qualifying event below.**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Qualifying events If your child(ren) did not enroll during an open enrollment period, they may enroll within 63 days after any of the following qualifying events. Please select the appropriate box and attach supporting documentation.			
	a) The child lost dependent coverage due to:			
	i) The termination or change in employment status of the child or the person through whom the child was covered. (Proof of loss of status, such as an employer letter or collateral showing dependent criteria, will be required.)	☐	☐	☐
	ii) The loss of an employer's contribution toward an employee's or dependent's coverage. (Proof of loss of contribution, such as an employer letter or collateral showing employer's contributions, will be required.)	☐	☐	☐

(continued)

Primary applicant's Social Security number

Primary applicant's name: ______________________ ☐☐☐ ☐☐ ☐☐☐☐

Part IV. Special enrollment for children under 19 years of age (continued)

		Primary applicant	Dependent 1	Dependent 2
	iii) The death of the person through whom the child was covered as a dependent.	☐	☐	☐
	iv) Legal separation or divorce. (Proof of loss of coverage, such as a Certificate of Creditable Coverage or loss of coverage letter from the employer or insurer, will be required.)	☐	☐	☐
	v) The loss of coverage under the Healthy Families program, Access for Infants and Mothers (AIM) program or the Medi-Cal program. (Proof of loss of coverage, such as termination letter from these programs, will be required.)	☐	☐	☐
	b) The child became a resident of California during a month that was not the child's birth month.	☐	☐	☐
	c) The child was born as a resident of California and did not enroll in the month of birth.	☐	☐	☐
	d) The child is mandated to be covered pursuant to a valid state or federal court order. (As proof, a copy of the court order will be required.)	☐	☐	☐
	e) The child was adopted. (As proof, a copy of the legal adoption document will be required.)	☐	☐	☐
	f) The child exhausted COBRA or Cal-COBRA continuation coverage. (As proof, a Certificate of Creditable Coverage will be required.)	☐	☐	☐

Part V. Prior health coverage

A.	For applicants age 19 and older, during the previous 63 days, have you or any applicants been covered by health insurance?	☐ Yes ☐ No
B.	Have you or any applicants been covered under a Health Net of California Plan or Health Net Life Insurance Company Policy in the last 5 years?	☐ Yes ☐ No
C.	If you answered "Yes" to A or B above, please provide the following information for each applicant:	

Applicant name:	Insurer name:	Policyholder/member ID #:	Group #:
Plan name:	State:	Most recent coverage start date:	End date:
Applicant name:	Insurer name:	Policyholder/member ID #:	Group #:
Plan name:	State:	Most recent coverage start date:	End date:
Applicant name:	Insurer name:	Policyholder/member ID #:	Group #:
Plan name:	State:	Most recent coverage start date:	End date:

(continued)

Primary applicant's Social Security number

Primary applicant's name: ____________________ ☐☐☐ ☐☐ ☐☐☐☐

Part V. Prior health coverage (continued)

D.	**HIPAA Guaranteed Issue Coverage** If you do not qualify for the Individual HMO plan, you may be considered for coverage under the HIPAA Guaranteed Issue plans. If you meet all of the conditions below for HIPAA coverage and wish to apply for such coverage, please contact your Health Net broker or call Health Net at 1-800-909-3447, option 2, to request full details.	☐ Yes ☐ No
	1. Have you had a total of at least 18 months of health care coverage (including COBRA or Cal-COBRA, if applicable) without more than a 63-day break (excluding any employer-imposed waiting periods) in coverage? Please note that you must apply for HIPAA coverage within the 63-day break after your group health care coverage (including COBRA or Cal-COBRA, if applicable) ended.	☐ Yes ☐ No
	2. Was your most recent coverage through a group health plan (COBRA and Cal-COBRA are considered group coverage)?	☐ Yes ☐ No
	3. Are you currently eligible for coverage under a group health plan, Medicare or Medicaid? ***(If "Yes," you are not eligible for HIPAA coverage.)***	☐ Yes ☐ No
	4. Was your most recent coverage terminated because of nonpayment or fraud?	☐ Yes ☐ No
	5. Were you eligible under COBRA or Cal-COBRA? If "Yes," start date: ____________________; end date: ____________________ If "Yes," did you accept and use up all benefits that were available? If "No," please explain: ____________________ ____________________	☐ Yes ☐ No ☐ Yes ☐ No
E.	While I understand that I am applying for an Individual Plan, if I do not qualify for the Individual Plans, I would like to be considered for coverage under HIPAA. I understand that no underwriting (medical history review and determination of coverage) is required for HIPAA coverage, that if I am applying for HIPAA coverage only I do not need to complete a Statement of Health (Part VI), and that rates may be higher than for the Individual Plans. If I qualify, please offer the HIPAA coverage and send complete details regarding my options and rates.	☐ Yes ☐ No

Primary applicant's Social Security number

Primary applicant's name: ______________________ | | | | | | | | | |

Part VI. (A) Statement of Health

All questions must be answered.

This Statement of Health must be completed by each individual applicant applying for coverage, including spouses/domestic partners, by an adult applicant for minor dependents, or by an interpreter for applicants who do not read/write English.

See the "Special enrollment for children under 19 years of age" section in the instructions at the front of this application for information regarding enrolling children under age 19. Even though your children under 19 years of age cannot be declined due to pre-existing medical conditions, you are required to complete the Statement of Health for each of your children under 19 years of age for whom you are requesting enrollment because the monthly premium for their coverage will be determined by Health Net's review of their medical history. Dependents age 19 and older must complete this Statement of Health.

Please answer all questions "Yes," "No" or "Unsure." If "Yes" or "Unsure," please circle the specific conditions. Complete Part VI (B). For the purposes of this Statement of Health, a health care provider or practitioner is any health care professional capable of rendering any kind of health care service.

If you are applying for HIPAA coverage, you do not need to complete a Statement of Health. If you meet all of the HIPAA coverage requirements in Part V on the previous page and wish to apply for such coverage, please contact your Health Net broker or call Health Net at 1-800-909-3447, option 2, to request full details.

Genetic Information Nondiscrimination Act of 2008 (GINA) compliance statement: This Statement of Health is not a request for genetic information. In answering these 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.

NOTICE: You must provide truthful and complete answers to the following questions to the best of your ability. Even if you currently have health coverage or had prior coverage with Health Net, you must fully disclose and answer all health history questions. We are relying on the information you provide to determine whether you are eligible for coverage.

WHEN HEALTH NET CAN RESCIND A PLAN CONTRACT FOR FRAUD OR INTENTIONAL MISREPRESENTATION OF MATERIAL FACT:

Health Net may rescind a Plan Contract for any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact in any written information submitted by you or on your behalf or with this 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:

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.**

For additional information regarding rescission of membership, see Part X, "Conditions of enrollment."

If you require additional Statement of Health questionnaires, please request an addendum from the broker who represents you or call Health Net at 1-800-909-3447, option 2. ☐ **Check here if an addendum is attached.**		Primary applicant	Dependent 1	Dependent 2
1)	During the past 12 months, have you seen a health care provider(s) or practitioner(s), had a physical exam, laboratory test(s), EKG, X-ray(s), MRI, CT scan, PET, EEG, CAT scan, sonogram, ultrasound, mammogram, biopsy, colonoscopy, endoscopy, upper GI tests or series, urine test, or blood test(s) (other than an HIV test)? **If "Yes," please circle the applicable item(s).**	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
2)	Within the past 2 years, have you consulted with a health care provider(s) or practitioner(s) for, or been diagnosed with, or been treated for, any of the following **(please circle the applicable item(s)):**			
	A. Bursitis, arthritis, gout, muscle or tendon pain?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
	B. Chest pain, pneumonia, shortness of breath, pain or difficulty breathing, sleep apnea, or difficulty chewing or swallowing?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
	C. Acne, rosacea, psoriasis or keratosis, or eczema?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure

(continued)

Primary applicant's Social Security number

Primary applicant's name: ____________________ | | | | | | | | | | |

Part VI. (A) Statement of Health (continued)

		Primary applicant	Dependent 1	Dependent 2
	D. Jaundice, chronic diarrhea, unintentional or unexplained weight loss?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
	E. Dizziness?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
	F. Recurrent or chronic pain (including back pain)?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
	G. Ear infection (otitis), sinusitis, deviated nasal septum, TMJ (temporomandibular joint disorder), tonsillitis, or allergies?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
	H. Asthma?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
	If "Yes," have you been hospitalized or been to an emergency room in the past 24 months?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
	If "Yes," have you received any adrenaline or epinephrine injections?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
	I. Thyroid disorder?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
3)	During the past 5 years, have you consulted a health care provider(s) or practitioner(s) for any condition or symptom for which a diagnosis has not been established?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
4)	During the past 5 years, have you consulted a health care provider(s) or practitioner(s) for any condition or symptom for which you have not been made aware of the cause or diagnosis?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
5)	During the past 5 years, have you consulted a health care provider(s) or practitioner(s) for any condition or symptom for which you have been advised to have diagnostic test(s), treatment(s), surgery or hospitalization?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
6)	Are you waiting for the results of any diagnostic tests?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
7)	During the past 5 years, have you received Medicare benefits or any other disability benefits as a result of disability or chronic illness or condition?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
8)	Within the last 5 years, have you consulted with a health care provider(s) or practitioner(s) for, or been diagnosed with, or been treated for, any of the following **(please circle the applicable item(s))**:			
	A. High or low blood pressure, hypertension, high cholesterol, phlebitis, Raynaud's disease, calf pain when walking, loss of consciousness, seizure disorder, headaches, anemia, varicose veins, or paralysis?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
	B. Pyelonephritis, kidney stones, or kidney, bladder, or urinary tract disorder(s)?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
	C. Genital herpes, HPV (human papillomavirus), genital or anal warts, or any other sexually transmitted disease?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
	D. Carpal tunnel syndrome, osteopenia, osteoporosis, or muscle/bone/tendon/joint/vertebral disc injury or disorder(s)?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure

(continued)

Primary applicant's Social Security number

Primary applicant's name: ____________________ ☐☐☐ ☐☐ ☐☐☐☐

Part VI. (A) Statement of Health (continued)

		Primary applicant	Dependent 1	Dependent 2
	E. Pancreatitis, ulcers, spastic colitis, hemorrhoids, hernia or gallbladder, liver, stomach, intestines, or esophagus disorder(s)?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
	F. Cyst(s), lump(s), or tumor(s) in any part of the body?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
	G. Nervous, mental, emotional or behavioral disorder or panic attack(s)?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
	H. Anxiety, depression, Epstein-Barr virus, chronic fatigue syndrome, attention deficit disorder, or ADHD?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
	I. Developmental delay, premature birth, club foot, cleft lip or palate?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
	J. Glaucoma, cataracts or retinal degeneration?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
	K. Male reproductive system: disorder of the prostate, infections, impotency, sexual dysfunction, or male reproductive system disorder(s)?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
	L. Female reproductive system: disorder of the breast, repeated breast biopsy, bleeding/drainage from the nipple, fibroid tumors, menstruation disorders, abnormal Pap test, infections, abnormal bleeding, endometriosis, disorder of the ovaries, or female reproductive system disorder(s)?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
9)	Have you ever consulted with a health care provider(s) or practitioner(s) for, or been diagnosed with, or been treated for, any of the following **(please circle the applicable item(s)):**			
	A. Manic depression, bipolar disorder, schizophrenia, obsessive-compulsive disorder, suicide attempt, or eating disorder?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
	B. Cancer, melanoma, leukemia, bone marrow transplant, Kaposi's sarcoma, Hodgkin's disease, enlarged lymph nodes, or any other malignancy?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
	C. Cerebral palsy, Alzheimer's disease, Parkinson's disease, stroke, or brain or nervous system disorder(s)?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
	D. Heart attack, angina, heart murmur, heart valve replacement, irregular heart beat, palpitations, peripheral vascular disease, blood clot, poor circulation, pacemaker, shunt, heart disease, heart valve disorder, or heart, cardiovascular, or circulatory disorder(s)?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
	E. Emphysema, chronic obstructive pulmonary disease (COPD), pneumocystis carinii pneumonia, cystic fibrosis, tuberculosis or coughing up blood?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
	F. Colitis, ulcerative colitis, Crohn's disease, cirrhosis, liver disease, hepatitis, or gastric bypass surgery?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
	G. Infertility (infertility is defined as either (1) the presence of a demonstrated condition recognized by a licensed physician or surgeon as a cause of infertility, or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception)?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure

(continued)

Primary applicant's Social Security number

Primary applicant's name: ______________________

Part VI. (A) Statement of Health (continued)

		Primary applicant	Dependent 1	Dependent 2
	H. Ankylosing spondylitis, spondylosis, herniated, ruptured or bulging disc, rheumatoid arthritis, scleroderma, joint replacement, or fixation device(s) (pins, plates, rods)?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
	I. Amyotrophic lateral sclerosis (ALS), Lou Gehrig's disease, multiple sclerosis, muscular dystrophy, Down's syndrome, or any congenital disorder?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
	J. Diabetes, adrenal disorder, lupus, endocrine or metabolic disorder?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
	K. Alcoholism, alcohol or substance abuse/dependency?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
	L. Acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), or antiviral therapy? (Note: California law prohibits an HIV test from being required or used by health care service plans or insurance companies as a condition of obtaining coverage.)	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
	M. Breast implants, reconstructive or cosmetic surgery, or any other prosthesis or implant?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
	N. Hemophilia or blood or bleeding disorder(s)?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
	O. Organ transplant?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
10)	During the past 12 months, have you had a physical injury or experienced recurring pain or symptoms that have not been evaluated by a licensed health care provider or practitioner or for which you plan to have evaluated by a licensed health care provider or practitioner?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
11)	Within the past 2 years, have you visited or consulted a physician, psychiatrist, chiropractor, physician assistant, nurse practitioner, physical therapist, or other licensed health care provider or practitioner that has not been disclosed elsewhere on this application?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
12)	Are you currently taking prescription medication? If "Yes," please complete Part VI (B).	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
13)	Have you been prescribed or taken any prescription medication during the past 12 months?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
14)	During the past 12 months, have you smoked cigarettes, cigars, pipes or used chewing tobacco?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
15)	Do you consume alcoholic beverages? If "Yes," please indicate primary applicant, dependent 1 (dep. 1) or dependent 2 (dep. 2) and the number of alcoholic beverages you consume weekly (a beverage is 12 ounces of beer, 6 ounces of wine, 1 ounce of liquor):	☐ Yes ☐ No ☐ Unsure ______	☐ Yes ☐ No ☐ Unsure ______	☐ Yes ☐ No ☐ Unsure ______
16)	During the past 5 years, have you received counseling or been a member of a support group related to personal alcohol or substance abuse?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure

(continued)

Primary applicant's Social Security number ☐☐☐ ☐☐ ☐☐☐☐

Primary applicant's name: ____________________

Part VI. (A) Statement of Health (continued)

		Primary applicant	Dependent 1	Dependent 2
17)	During the past 5 years, have you been convicted of driving under the influence of alcohol or any controlled substance and as a consequence been required to receive counseling or attend a support group or class related to driving under the influence of alcohol or any controlled substance?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
Male applicant(s) only				
18)	Are you expecting a child with anyone, even if the mother is not listed on this application?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
19)	Has your spouse, even if not listed on this application, performed a home pregnancy test during the previous 90 days, which has indicated she was pregnant?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
Female applicant(s) only				
20)	Are you currently pregnant?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
21)	During the previous 90 days, have you performed a home pregnancy test which indicated you were pregnant?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
22)	A. Have you had a menstrual period in each of the last 6 months, including within the last 30 days? If "No," please indicate primary applicant, dep. 1 or dep. 2 and explain (attach additional pages as needed to provide complete information): ____________________	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
	B. (i) Have you had a pelvic exam? If "Yes," indicate primary applicant, dep. 1 or dep. 2 and date of last pelvic exam (mm/dd/yy): ____________________	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
	(ii) Have you had a Pap smear? If "Yes," indicate primary applicant, dep. 1 or dep. 2 and date of last Pap smear (mm/dd/yy): ____________________	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
	(iii) Were the results of the exam(s) normal? If "No," indicate primary applicant, dep. 1 or dep. 2, and please explain (attach additional pages as needed to provide complete information): ____________________	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
All applicants				
	Do you or any of the applicants have a Personal Health Record (PHR)? If "Yes," please include it with this application or mail it to Health Net, PO Box 1150, Rancho Cordova, CA 95741-1150.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Primary applicant's Social Security number

Primary applicant's name: ______________________

Part VI. (B) Statement of Health

If you answered "Yes" or "Unsure" to any questions in Part VI (A) (except a "Yes" or "Unsure" answer to questions 14, 15, 22(A) and 22(B)(iii)), please identify the question number and explain in FULL DETAIL below.

If additional space is necessary, please attach extra pages. ☐ Check here if additional pages are attached.

Question #	Indicate applicant	Diagnosis, condition, treatment or recommendation	Still under treatment?	Dates of treatment or hospitalization (mm/yy) Began	Ended	Full name, address and telephone number of every health care provider or practitioner, clinic, hospital or any other medical facility (include ZIP code)
	☐ Prim. app ☐ Dep. 1 ☐ Dep. 2		☐ Yes ☐ No			
	☐ Prim. app ☐ Dep. 1 ☐ Dep. 2		☐ Yes ☐ No			
	☐ Prim. app ☐ Dep. 1 ☐ Dep. 2		☐ Yes ☐ No			
	☐ Prim. app ☐ Dep. 1 ☐ Dep. 2		☐ Yes ☐ No			

Doctor's visits – Please provide information regarding the last health care provider or practitioner visit or physical examination.

If additional space is necessary, please attach extra pages. ☐ Check here if additional pages are attached.

Date of visit	Indicate applicant	Reason for visit	Result of visit	Full name, address and telephone number of every health care provider or practitioner, clinic, hospital or any other medical facility (include ZIP code) where you had your most recent provider or practitioner visit or physical examination
	☐ Prim. app ☐ Dep. 1 ☐ Dep. 2			
	☐ Prim. app ☐ Dep. 1 ☐ Dep. 2			
	☐ Prim. app ☐ Dep. 1 ☐ Dep. 2			
	☐ Prim. app ☐ Dep. 1 ☐ Dep. 2			

(continued)

Primary applicant's Social Security number

Primary applicant's name: ______________________ | | | | | | | | | |

Part VI. (B) Statement of Health (continued)

Medications – Please list all prescription medications you are currently taking.

If additional space is necessary, please attach extra pages. ☐ Check here if additional pages are attached.

Condition	Indicate applicant	Name of medication	Prescribing physician	Most recent refill date	Strength (# of milligrams)	Dosage and frequency (How many pills and how often taken?)	Number of refills per year
	☐ Prim. app ☐ Dep. 1 ☐ Dep. 2						
	☐ Prim. app ☐ Dep. 1 ☐ Dep. 2						
	☐ Prim. app ☐ Dep. 1 ☐ Dep. 2						
	☐ Prim. app ☐ Dep. 1 ☐ Dep. 2						

Part VII. Individual Term Life Insurance

Underwritten by Health Net Life Insurance Company – Complete this section only if you wish to apply for life insurance coverage. Life insurance coverage is different and separate from the Individual HMO Health Care Coverage previously discussed in this application. The primary applicant and/or any dependents that are approved for a Health Net HMO medical plan will also qualify for Term Life coverage. Applicants under the age of one year and applicants being offered Modified Issue or HIPAA plans are ineligible for Term Life Insurance. Coverage is optional and can be purchased at an additional charge.

This insurance also is not intended to replace any life insurance policy currently in force. If you would like supplemental Term Life coverage:

1. Please list all family members applying for Term Life Insurance coverage (available for ages 1–64).
2. Life insurance requires an additional premium. You will be billed for the premium after enrollment is confirmed by Health Net.
3. Complete the beneficiary information. You can have one or more beneficiaries. If you have more than one, the percentages must add up to 100%.

Full name of family member	Relationship to primary applicant	Birthdate (mm/dd/yyyy)	Amount
	Self		☐ $10,000 max amount for children age 1–17 ☐ $20,000 ☐ $40,000 ☐ $30,000 ☐ $50,000
Beneficiary name	**Beneficiary relationship**		**Percentage**
Signature of applicant:		Date:	

Full name of family member	Relationship to primary applicant	Birthdate (mm/dd/yyyy)	Amount
	Dependent 1		☐ $10,000 max amount for children age 1–17 ☐ $20,000 ☐ $40,000 ☐ $30,000 ☐ $50,000
Beneficiary name	**Beneficiary relationship**		**Percentage**
Signature of spouse/domestic partner or dependent 18 years of age or older:		Date:	

(continued)

Primary applicant's Social Security number

Primary applicant's name: ____________________ ☐☐☐ ☐☐ ☐☐☐☐

Part VII. Individual Term Life Insurance (continued)

Full name of family member	Relationship to primary applicant	Birthdate (mm/dd/yyyy)	Amount
	Dependent 2		☐ $10,000 max amount for children age 1–17 ☐ $20,000 ☐ $40,000 ☐ $30,000 ☐ $50,000

Beneficiary name	Beneficiary relationship	Percentage

Signature of dependent 18 years of age or older:	Date:

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

Instructions for Part VIII: 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 1-800-909-3447, option 2, for information about qualified interpreter services and how to obtain them. This form must be submitted with the Individual & Family Plan HMO 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. ☐ The Statement of Health.

☐ 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:	

(continued)

Primary applicant's Social Security number

Primary applicant's name: ______________________________ | | | | | | | | | | |

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

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.

☐ The Statement of Health.

☐ Other (explain): ______________________________

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

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:

Primary applicant's Social Security number

Primary applicant's name: ______________________ | | | | - | | | - | | | | |

Part IX. Agent/broker information

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

Instructions for Part IX: The following form is to be completed by the agent/broker (if applicable).

Health Net Broker ID: ______________________

Name (print): ______________________

Address: ______________________

____

Phone number: ______________________

Fax number: ______________________

Email address: ______________________

____

Broker signature and 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: ______________________

Primary applicant's Social Security number

Primary applicant's name: ______________________ | | | | | | | | | | |

Part X. Conditions of enrollment

GENERAL CONDITIONS: Health Net reserves the right to reject any application for enrollment. Health Net may selectively accept the applicant or only a dependent(s). Children under age 19 are eligible to enroll in an Individual & Family Health Plan during certain enrollment periods and cannot be declined due to a pre-existing medical condition as described in the instructions at the front of this application under "Special enrollment for children under 19 years of age." There is no coverage until this application is accepted by Health Net's Underwriting 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. Cashing your check does not mean your application is approved. If rejected, your money will be returned to you. No other department, officer, agent or employee of Health Net is authorized to grant enrollment. The applicant's broker or agent cannot grant approval, change terms or waive requirements of this application.
Health Net may require that you take a medical examination and you will be responsible for payment of any related fees in such event. This application and all medical information or examination reports shall become a part of the Plan Contract.

Family members who are covered under another Health Net Individual Plan are not eligible for coverage hereunder. Should a family member enrolling for coverage become covered under another Health Net Individual Plan at a later date, his or her coverage under this plan will terminate on the effective date of coverage under the other Health Net Individual Plan.

For applicants age 19 and older, to determine whether or not you will be offered enrollment in an individual HMO plan, Health Net of California ("Health Net") will review your medical history based on the information you provide in this application, including the Statement of Health, Addendum (if applicable) and any supplemental health questionnaires requested by Health Net during its review of your medical history. This process is called medical underwriting. Should you have questions or need assistance completing this application, especially the Statement of Health, you can call Health Net at 1-800-909-3447, option 2, for assistance. If any health information changes after you submit the application to Health Net, but before enrollment is offered, you should contact Health Net prior to any possible effective date of coverage at 1-800-909-3447, option 2, to provide that new health information.

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 to the Statement of Health 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 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, 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 without medical underwriting;
3. explain that your monthly premium will be modified to reflect the number of members that remain under the Plan Contract; and
4. explain your right to appeal Health Net's decision to rescind coverage.

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 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.

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 VIII of this application, "Individual & Family Plans Exception to Standard Enrollment – Statement of Accountability.")

Primary applicant's Social Security number

Primary applicant's name: ____________________ | | | | | | | | | | |

Part XI. 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 service 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 1-800-909-3447, option 2). 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. The applicant 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.

Make personal check payable to "Health Net." Return completed application to:
Health Net Individual & Family Enrollment
PO Box 1150
Rancho Cordova, CA 95741–1150

Primary applicant's Social Security number

Primary applicant's name: ______________________ | | | | - | | | - | | | | |

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.

Simple Payment Options for Individual & Family Plans

Automatic Bank Draft (ABD) ☐ First month's payment ☐ Monthly premium payment

Monthly premium charge can be withdrawn directly from your personal checking or savings account. The premium will be withdrawn from your bank account about ten days in advance of the due date. Please select your account type: ☐ Checking ☐ Savings

Transit routing number (9 digits):	Account number:
Bank name:	State:

I understand that by requesting the automatic payment option, I am authorizing Health Net of California, Inc. and Health Net Life Insurance Company ("Health Net"), and my financial institution named above, to debit my checking or savings account for my monthly premium payment(s).

I understand that the premium withdrawn from my account will be for the future billing period, plus any past due balances. I understand that my premium payments will automatically adjust if my monthly premium changes.

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 debit. ***(Note: A 30-day notice is required to discontinue this service due to the time required to initiate this change with my bank.)***

I understand that ABD transmissions are withdrawn from my bank account on approximately the 20th of every month for the following month's premium. I understand that if there are insufficient funds at the time my account is debited, a service fee of $25.00 (in addition to any fees my bank may charge me) will be assessed by Health Net for all dishonored payments. I further agree that if any such debit is dishonored, whether with or without cause and whether intentionally or inadvertently, Health Net shall be under no liability whatsoever even though such dishonor may result in the loss of health coverage.

Signature of account holder (required to process):	Date:

☐ **Credit card for first month's payment**

First month's premium can be charged directly to your credit card account. All future premiums due may be made by Automatic Bank Draft (complete the form above) or by mailing a check. **Your card will be charged for the first month's premium on the day your application is approved by underwriting.**

First name (as on card):	Middle (as on card):	Last name (as on card):	Card type: ☐ Visa ☐ MasterCard
Account number 16 digits (complete):		Expiration date (mm/yyyy):	
Billing address:		City:	State: ZIP[1]:

As a convenience, I request and authorize Health Net to charge my credit card account identified above for the payment of my initial premium. I understand that my first month's withdrawal charge may be for multiple periods depending upon my date of approval and the bill period. 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. I further agree that if my credit card is declined for payment, whether with or without cause and whether intentionally or inadvertently, **I will be charged a $25 service charge.**

Signature of credit card account holder (required to process):	Date:

[1]The ZIP code must match the cardholder's address; otherwise, the credit card cannot be processed.

Health Net®

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 Health Net's Commercial Contact Center at 1-800-522-0088. Individual and Family Plan (IFP) or Farm Bureau applicants please call 1-800-909-3447, 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 an 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 grupo de empleadores deben llamar al Centro de Comunicación Comercial de Health Net al 1-800-522-0088. Los solicitantes del Plan Individual y Familiar (IFP, por sus siglas en inglés) o de la Oficina Agrícola, deben llamar al 1-800-909-3447, 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，部分文件可以翻譯成您的語言並寄送給您。如需協助，請撥打您會員卡上所列的電話號碼，雇主團體申請人請致電 Health Net 的商業聯絡中心，電話 1-800-522-0088。個人和家庭計畫 (IFP) 或農業局申請人請撥打 1-800-909-3447，請按 2。若您投保 PPO 計畫，請致電 1-800-927-4357 與加州保險局聯絡，詢求額外協助。若您投保 HMO 計畫，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 cấp dịch vụ thông dịch. Quý vị có thể được người khác đọc giúp các tài liệu bằng ngôn ngữ của quý vị và cũng có thể được cấp tài liệu phiên dịch sang 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 theo nhóm do hãng sở đài thọ xin gọi Trung Tâm Liên Lạc Thương Mại của Health Net tại số 1-800-522-0088. Những người muốn xin bảo hiểm của Chương Trình Bảo Hiểm Cá Nhân và Gia Đình (IFP) hoặc Farm Bureau, xin gọi số 1-800-909-3447, bấm số 2. Để được giúp đỡ thêm, xin gọi Bộ Bảo Hiểm California tại số 1-800-927-4357 nếu quý vị đang 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. 고용주 그룹 가입 신청자님의 경우 Health Net 의 상업(Commercial) 고객 서비스 센터, 안내번호 1-800-522-0088 번으로 전화해 주십시오. 개인 및 가족 플랜 (IFP) 혹은 Farm Bureau 가입 신청자님은 안내번호 1-800-909-3447번, 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

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, o para sa employer group applicants, mangyaring tumawag sa Commercial Contact Center ng Health Net sa 1-800-522-0088. Para sa Individual and Family Plan (IFP) o Farm Bureau applicants, mangyaring tumawag sa 1-800-909-3447, opsyon 2. Para sa karagdagang tulong, tumawag sa CA Dept. of Insurance sa 1-800-927-4357 kung ikaw ay nag-eenroll sa isang PPO plan. Kung ikaw ay nag-eenroll sa isang HMO plan, tawagan ang DMHC Helpline sa 1-888-HMO-2219.
Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար ձեր լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված համարով, կամ եթե գործատիրոջ խմբի դիմորդ եք, խնդրում ենք 1-800-522-0088 համարով զանգահարել Health Net-ի Հաճախորդի Կապի Կենտրոն: Անհատական և Ընտանեկան Ծրագրի (Individual and Family Plan/IFP) դիմորդներից խնդրվում է զանգահարել 1-800-909-3447 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 плана группового страхования по месту работы могут обратиться в коммерческий контактный центр компании Health Net по телефону 1-800-522-0088. Участники планов индивидуального или семейного страхования (Individual and Family Plan, IFP), а также планов страхования Фермерского бюро: пожалуйста, звоните по номеру 1-800-909-3447, 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

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。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。雇用者団体への加入申込の方は、Health Net 民間コンタクト・センター、1-800-522-0088 までご連絡ください。個人・家族プラン (IFP) またはファーム・ビューローへの加入申込の方は、1-800-909-3447（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-HMO-2219 までご連絡ください。
Japanese

خدمات مجانی 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. و یا متقاضیان گروههای کارفرمایان لطفاً با مرکز تجاری Health Net به شماره 1-800-522-0088 تماس بگیرند. متقاضیان «طرح افراد و خانواده ها» (IFP) یا «دفتر مزارع» لطفاً به شماره 1-800-909-3447 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

ਮੁਫ਼ਤ 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, ਜਾਂ, ਇੰਪਲਾਇਰ ਗਰੁੱਪ ਦੇ ਮੈਂਬਰ ਕਿਰਪਾ ਕਰਕੇ ਹੈਲਥ ਨੈਟ ਦੇ ਵਪਾਰਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ 1-800-522-0088 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਪਲਾਨ (IFP) ਜਾਂ ਫਾਰਮ ਬਿਊਰੋ ਅਰਜ਼ੀਦਾਤਾ ਕਿਰਪਾ ਕਰਕੇ 1-800-909-3447, ਔਪਸ਼ਨ ੨ ਤੇ ਫੋਨ ਕਰੋ। ਜੇ ਤੁਸੀਂ ਕਿਸੇ ਫਫੌ ਪਲਾਨ ਲਈ ਨਾਂ ਲਿਖਵਾ ਰਹੇ ਹੋ ਤਾਂ ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫੋਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਜੇ ਤੁਸੀਂ ਕਿਸੇਂ 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

ការបកប្រែភាសាដោយឥតអស់ថ្លៃ ។ អ្នកអាចទទួលអ្នកបកប្រែភាសា និងឲ្យគេអានឯកសារជូនអ្នកជាភាសាខ្មែរបាន ។ សំរាប់ជំនួយ សូមទូរស័ព្ទមកយើង តាមលេខដែលមានកត់នៅលើអតសញ្ញាណប័ណ្ណរបស់អ្នក ឬអ្នកដាក់ពាក្យសុំជាក្រុមនៃក្រុមហ៊ុនការងារ សូមទូរស័ព្ទទៅ មណ្ឌលទំនាក់ទំនងពាណិជ្ជកម្មរបស់ Health Net តាមលេខ 1-800-522-0088 ។ គំរោងបុគ្គលម្នាក់ៗ និងជាគ្រួសារ (IFP) ឬអ្នកដាក់ពាក្យសុំ Farm Bureau សូមទូរស័ព្ទទៅលេខ 1-800-909-3447 ចុចជំរើសទី 2 ។ សំរាប់ជំនួយថែមទៀត សូមទូរស័ព្ទទៅ ក្រសួងធានារ៉ាប់រងកាលីហ្វ័រនីញ៉ា តាមលេខ 1-800-927-4357 បើសិនជាអ្នកកំពុងតែចុះឈ្មោះក្នុងគំរោង PPO ។ បើសិនជាអ្នកកំពុងតែចុះឈ្មោះក្នុងគំរោង HMO សូមទូរស័ព្ទទៅ ខ្សែជំនួយ DMHC តាមលេខ 1-888-HMO-2219 ។
Khmer

Cov Kev Pab Txhais Lus Uas Tsis Tau Them Nqi. Koj thov tau kom muaj ib tug neeg txhais lus thiab nyeem cov ntawv ua koj hom lus rau koj. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis cov neeg thov kev pab tom hauj lwm thov hu rau Health Net's Commercial Contact Center ntawm 1-800-522-0088. Cov neeg thov kev pab hauv pawg Tus Kheej thiab Tsev Neeg (Individual and Family Plan [IFP]) los sis Farm Bureau thov hu rau 1-800-909-3447, xaiv nqe 2. Yog xav tau kev pab ntxiv hu rau CA Qhov Chaw Saib Xyuas Txog Kev Tuav Pov Hwm (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

T'áá Hó Hasaad Bee 'Áka'e'eyeed Doo Bą́ą́h 'Ílíní Da. Haíshį́į́ shá 'ata' hodoolnih nínízinígíí łá' ná choídoot'eeł. Ła' naaltsoos t'áá ni nizaad bee nich'į' yídóolta dóó naaltsoos bee hadadilyaago nich'į' 'ádadoolnííł. Shiká'e'doowoł nínízingo, ninaaltsoos nitł'izí bine'dę́ę́' béésh bee hane'í biká'ígíí bich'į' holne' dooleeł, doodago nidaalnishí hada'diilaaígíí 'éí Na'iiłniihí 'Atsíís Bik'ih 'Adeest'į́į́' 'Iłnáhane' Bił Haz'áníjį' kojį' béésh bee holne' dooleeł 1-800-522-0088. T'áá Ła' Jizį dóó Hooghan Haz'ánígi Bił Nahat'a' (IFP) doodago Dá'ák'eh Yá Dah Háaztánígíí bił náha'dit'éego kojį' béésh bee holne' dooleeł 1-800-909-3447, naaki góne'ígíí bił yaa 'adidíílchił. PPO bił náhadilnééhdą́ą́' 'éí CA Béeso 'Ách'ą́ą́h Naa'nil Bił Haz'ánígííjį' shiká'e'doowoł diníigo béésh bee holne dooleeł 1-800-927-4357. HMO bił náhadilnééhdą́ą́', DMHC 'Áka'aná'áwo'go Bił Haz'áníjį' béésh bee holne' dooleeł 1-888-HMO-2219.
Navajo

خدمات لغوية بدون تكلفة. يمكنك الاستعانة بمترجم وطلب قراءة الوثائق لك بلغتك. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك (ID). وبالنسبة لمجموعات المصالح التجارية رجاء الاتصال بمركز خدمات القطاع التجاري لمؤسسة Health Net على الرقم 1-800-522-0088. المتقدمين بطلبات الحصول على تأمين لشخص واحد أو لعائلة (IFP) أو Farm Bureau رجاء الاتصال بالرقم 1-800-909-3447، خيار 2. للحصول على المزيد من المساعدة، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357 إذا كنت مشتركاً في برنامج PPO. إذا كنت مشتركاً في برنامج HMO اتصل بالخط الساخن لـ DMHC على الرقم 1-888-HMO-2219.

Arabic

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 your 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 1-866-692-6901 (TTY 1-866-346-3642). 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.

All references to "Health Net" herein include the affiliates and subsidiaries of Health Net, Inc. which underwrite or administer the coverage to which the Enrollment Application applies. 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.

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Authorization *for Use or Disclosure of Information for* Enrollment

By signing this authorization,

1. I authorize the following to disclose medical information to Health Net: Any medical professional, hospital, or other health care facility, clinic, pharmacy, pharmacy benefit manager, insurer or health benefit plan administrator, MIB, Inc., ("MIB"), or any other health care provider or health plan that has medical information, to include diagnosis, treatment or prognosis with respect to any physical, accident, illness, medical or mental condition, including but not limited to, alcohol or substance abuse, mental or emotional disorders, AIDS (Acquired Immune Deficiency Syndrome), or ARC (AIDS Related Complex), 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 health care 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 1-866-692-6901 (TTY 1-866-346-3642). 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. Information for consumers about MIB may be obtained on its website at www.mib.com.

   I also authorize Health Net, and its reinsurers, to release information from their file to other insurance companies to whom I 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 one 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 associate contracts to conduct underwriting activities on behalf of Health Net or do post enrollment review of any information for determination of whether a policy should be rescinded for intentional misrepresentation, of material facts, who have agreed to safeguard protected health information from unauthorized use or disclosure.

3. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, in which case it may no longer be protected by federal privacy rules governing the privacy of health information.

4. I understand that my or my dependent's(s') enrollment in Health Net's health plan may be conditioned on signing this authorization. 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 or its business associates in reliance on this authorization. I may send a written and dated revocation to Health Net at the address below. This authorization will become effective immediately and shall remain valid for thirty (30) months from the date the authorization form is signed, except that, for California residents, this authorization will remain in effect for one year from the date of the authorization.

5. 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: ____

   ____

(continued on back page)

A photocopy of this form is as valid as the original. You have the right to receive a copy of this authorization upon request.

Signatures (required in ink):

Printed name of applicant	Signature of applicant or his or her personal representative	Date
Printed name of spouse or dependent child (age 18 or older)	Signature of spouse or dependent child (age 18 or older) or his or her personal representative	Date
Printed name of dependent child (age 18 or older)	Signature of dependent child (age 18 or older) or his or her personal representative	Date
Printed name of dependent child (age 18 or older)	Signature of dependent child (age 18 or older) or his or her personal representative	Date
Printed name of dependent child (age 18 or older)	Signature of dependent child (age 18 or older) or his or her personal representative	Date
Printed name of dependent child (age 18 or older)	Signature of dependent child (age 18 or older) or his or her personal representative	Date

Please return this form to:
Health Net Individual & Family Plans
PO Box 1150
Rancho Cordova, CA 95741-1150

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.

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.

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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)：_______________