



Health Net Life Insurance Company

# Individual & Family Plans PPO Enrollment Application

Requested effective date

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

**Effective date of coverage:** Coverage is only available for enrollment during the annual open enrollment period, which is November 1, 2015, through January 31, 2016, or during a special enrollment period. Applications must be received within 60 days of a qualifying event. Generally, for applications received between the 1st and 15th, coverage will be effective the first day of the month following submission of the application. For applications received between the 16th and month's end, coverage will be effective the first day of the second month following submission of the application.

If you are currently enrolled in a Medicare plan, you are ineligible to apply for an individual and family plan.

Health Net Life Insurance Company (Health Net) needs a Social Security number (SSN) for everyone enrolling for health insurance, including spouses and dependent children. This is necessary so that we can provide you with verification of coverage for your tax return, as required by the Affordable Care Act. Health Net will not use your SSN for other purposes or share it with anyone other than as required by law.

**The agent/broker may not sign this application and agreement on behalf of the applicant.**

**Important: Please see Part V if the applicant does not read/write English.** The Individual & Family Plan PPO Enrollment Application is available in Chinese and Spanish language versions. You can also have someone help you read it. For free help, please call 1-877-609-8711. If you need assistance in completing this application, an agent/broker may assist you. An agent/broker who helped you read and complete this application must sign the application (see Part VI).

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

- Annual open enrollment period     Special enrollment period (see Part IV)

### Part I. Applicant information

Primary applicant's last name:		First name:	MI:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Billing address:				
Mailing address:				
Home address:				
City:		State:	ZIP:	County applicant resides in:
Home phone number: (    )	Work phone number: (    )	Cell phone number: (    )		Email address:
Primary applicant's birth date (mm/dd/yy): /  /	Primary applicant's Social Security number (required for all applicants): -  -		Primary subscriber's Health Net ID (applicable for adding dependents and change requests only):	

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

### Part II. Tell us who you are enrolling and select the product

A. Reason for application	B. Payment information
<input type="checkbox"/> <b>New application (Check family type below)</b> <input type="checkbox"/> Self <input type="checkbox"/> Self and spouse <input type="checkbox"/> Self and domestic partner <input type="checkbox"/> Self and child <input type="checkbox"/> Self and children <input type="checkbox"/> Self, spouse and child(ren) <input type="checkbox"/> Self, domestic partner and child(ren) <input type="checkbox"/> Child only <input type="checkbox"/> <b>Adding dependent</b> <input type="checkbox"/> <b>Change request (only available during open or special enrollment period)</b>	<b>First premium payment</b> <input type="checkbox"/> Pay by check (Amount must match monthly premium.) <b>Mailing application</b> Include completed check with completed application and mail to: Health Net Individual & Family Enrollment PO Box 1150 Rancho Cordova, CA 95741-1150 <b>Faxing application</b> Fax completed application to 1-800-977-4161, and mail completed check to: Health Net Individual & Family Enrollment PO Box 894702 Los Angeles, CA 90189-4072 Current members can go to <a href="http://www.healthnet.com">www.healthnet.com</a> , and click the <i>Make A Payment Now</i> button for additional payment options.

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**Part II. Tell us who you are enrolling and select the product (continued)**

**C. Choice of coverage**

Health Net Life Insurance Company PPO plans utilize Health Net's PPO provider network.

- Health Net Platinum 90 PPO
- Health Net Gold 80 PPO
- Health Net Silver 70 PPO
- Health Net Bronze 60 PPO
- Health Net Minimum Coverage PPO – Available to individuals who are under age 30. You may also be eligible for this plan if you are age 30 or older and are exempt from the federal requirement to maintain minimum essential coverage. Proof of exemption must be submitted with this application.

**Optional coverage: Dental / Vision plan for adults (age 19 and over).**

- Dental<sup>1</sup> and Vision Plus** – If Dental and Vision Plus is purchased for the primary applicant, all family members over age 19 will also be enrolled in the Dental and Vision Plus plan. Dental and Vision plus can only be purchased with, or added to, medical coverage during the open enrollment or special enrollment periods.

<sup>1</sup>The Dental plan is an Indemnity/Scheduled reimbursement plan. **Note: All medical plans include pediatric dental PPO and pediatric vision coverage. Individuals will receive pediatric dental and vision coverage under the medical plans until the last day of the month in which the individual turns 19.**

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

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

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

**Note:** If a family member is requesting a different health insurance plan than the primary subscriber, a separate application for each family member requesting a different plan should be filled out and submitted. Being on a different policy means that each person will be subject to the individual deductible and out-of-pocket maximum of the plan selected and that the family cannot collectively contribute to a family deductible and/or out-of-pocket maximum.

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.

Relation	Last name	First name	MI
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner			
<b>Social Security number</b>		<b>Date of birth</b>	
- -		/ /	
Relation Child 1	Last name	First name	MI
<input type="checkbox"/> Son <input type="checkbox"/> Daughter			
<b>Social Security number</b>		<b>Date of birth</b>	
- -		/ /	
Relation Child 2	Last name	First name	MI
<input type="checkbox"/> Son <input type="checkbox"/> Daughter			
<b>Social Security number</b>		<b>Date of birth</b>	
- -		/ /	
Relation Child 3	Last name	First name	MI
<input type="checkbox"/> Son <input type="checkbox"/> Daughter			
<b>Social Security number</b>		<b>Date of birth</b>	
- -		/ /	

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

**Addition of a dependent child to an existing policy (newborn, adopted/placed for adoption, stepchild, or assumption of a parent-child relationship)**

Dependent child's last name:		First name:		MI:
Dependent child's date of birth (mm/dd/yy):		Date of adoption/placement for adoption or other applicable qualifying event (mm/dd/yy):		
<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security number:		Primary subscriber's Health Net ID:	
Primary care physician ID:			Current patient: <input type="checkbox"/> Yes <input type="checkbox"/> No	

GENERAL CONDITIONS: Health Net Life Insurance Company (HNL) reserves the right to reject any application for enrollment not received within 60 days of the birth date, date of adoption or other applicable qualifying event. 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 primary insured's broker or agent cannot grant approval, change terms or waive requirements of this application. This application shall become a part of the Insurance Policy.

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

The application and Arbitration Clause must be signed by the primary insured. The primary insured 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 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.

**Part IV. Special enrollment period**

In addition to the open enrollment period, you and your dependents are eligible to enroll or change plans during a special enrollment period, which is within 60 days of certain qualifying events. Generally, for applications received between the 1st and 15th, coverage will be effective the first day of the month following submission of application. For applications received between the 16th and month's end, coverage will be effective the first day of the second month following submission of application. **Exceptions to these effective dates include birth, adoption, placement for adoption, or through a child support order or other court order, which will be effective the date of the qualifying event or court order. Marriage will be effective the first day of the month after the application receipt.** The application must be received within 60 days<sup>2</sup> of the qualifying event. Documentation of the qualifying event is required. Please write in the applicable qualifying event below and the name of the person to whom it applies. For additional dependents, please attach a separate sheet of paper.

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

(continued)

<sup>2</sup>If your application is received before the loss of coverage, your effective date will be the first day of the month following the loss of coverage. If the application is received during the 60-day period after the loss of coverage, the effective date will be the first day of the month after the application receipt.

**Part IV. Special enrollment period (continued)**

Qualifying event	Examples of documentation
1) The qualified individual, or his or her dependent, loses minimum essential coverage, which could be due to one of the following reasons (not including voluntary termination of your previous coverage or termination due to failure to pay premium):	
A. The death of the covered employee.	Copy of one of the following: <ul style="list-style-type: none"> <li>• Loss of coverage notice from former insurance carrier.</li> <li>• Loss of coverage notice from employer.</li> <li>• Front and back of former insurance carrier's ID card.</li> </ul>
B. The termination, or reduction of hours, of the covered employee's employment.	
C. The divorce or legal separation of the covered employee from the employee's spouse.	
D. The covered employee becoming entitled to benefits under Medicare.	
E. A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan.	
F. A proceeding in a case under Title 11 bankruptcy, commencing on or after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time. In this case, a loss of coverage includes a substantial elimination of coverage with respect to a qualified beneficiary (spouse/domestic partner, dependent child or surviving spouse/domestic partner) within one year before or after the date of commencement of the proceeding.	
G. Is enrolled in any non-calendar year group health plan or individual health insurance coverage, even if the qualified individual or his or her dependent has the option to renew such coverage. The date of the loss of coverage is the last day of the plan or policy year.	Documentation would depend on circumstance.
H. Loss of minimum essential coverage for any reason other than failure to pay premiums or situations allowing for a rescission for fraud or intentional misrepresentation of material fact.	
I. Termination of employer contributions.	Notice from employer of contributions termination.
J. Exhaustion of COBRA continuation coverage.	COBRA paperwork reflecting exhaustion of coverage.
2) A. The qualified individual gains a dependent or becomes a dependent through marriage, domestic partnership, birth, adoption, placement for adoption, or assumption of a parent-child relationship.	Court documentation, discharge records or notarized affidavit of assumption of parent-child relationship.
B. The enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by State law in the State in which the divorce or legal separation occurs, or if the enrollee, or his or her dependent, dies.	
3) The qualified individual's, or his or her dependent's, enrollment or non-enrollment in a health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of the Exchange or the Department of Health and Human Services, or its instrumentalities as evaluated and determined by the Exchange.	Documentation would depend on circumstance.
4) The health plan in which the enrollee, or his or her dependent, is enrolled substantially violated a material provision of its contract.	Documentation would depend on circumstance.
5) The qualified individual or enrollee, or his or her dependent, gains access to a new health plan as a result of a permanent move.	Copy of one of the following: <ul style="list-style-type: none"> <li>• Lease.</li> <li>• Mortgage statement.</li> <li>• First utility or phone bill.</li> </ul>
6) He or she is mandated to be covered as a dependent pursuant to a valid state or federal court order.	Court documentation.
7) He or she has been released from incarceration.	Probation or parole paperwork.

(continued)

**Part IV. Special enrollment period (continued)**

Qualifying event	Examples of documentation
8) He or she was receiving services under another health benefit plan, from a contracting provider who is no longer participating in that health plan, for any of the following conditions: (a) an acute condition (a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration); (b) a serious chronic condition (a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration); (c) a terminal illness (an incurable or irreversible condition that has a high probability of causing death within one year or less); (d) a pregnancy; (e) care of a newborn between birth and 36 months; or (f) a surgery or other procedure that has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered insured, and that provider is no longer participating in the health plan.	Dated letter from a physician.
9) He or she demonstrates to the Exchange, with respect to health benefit plans offered through the Exchange, or to the California Department of Insurance, with respect to health benefit plans offered outside the Exchange, that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period available to the individual because he or she was misinformed that he or she was covered under minimum essential coverage.	Documentation would depend on circumstance.
10) He or she is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code.	Active duty status documentation.
11) Newly eligible or ineligible for advance payments of the premium tax credit, or change in eligibility for cost-sharing reductions.	Advanced Premium Tax Credit (APTC) paperwork that shows the premium assistance you are eligible for.
12) He or she loses medically needy coverage under Medicaid (not including voluntary termination of your previous coverage or termination due to failure to pay premium).	Medicaid documentation.
13) He or she loses pregnancy-related coverage under Medicaid (not including voluntary termination of your previous coverage or termination due to failure to pay premium).	Medicaid documentation.

**Part V. Individual & Family Plans Exception to Standard Enrollment – Statement of Accountability**

**Instructions for Part V:** The following process is to be used when the applicant cannot complete the application because he or she cannot read, write and/or speak the language of the application. Health Net requires that if you need assistance in completing this application, you must obtain the assistance of a qualified interpreter. Health Net will provide a qualified interpreter upon request at no cost to you. Please contact Health Net at 1-877-609-8711 for information about qualified interpreter services and how to obtain them. This form must be submitted with the Individual & Family Plan enrollment application when applicable.

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

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

Do not read the language of this application.       Do not speak the language of this application.

Do not write the language of this application.       Other (explain): \_\_\_\_\_

A qualified interpreter assisted me with the completion of:  The entire application.

Other (explain): \_\_\_\_\_

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

Signature of applicant:

Today's date:

Date application was interpreted:

Time application was interpreted:

Qualified interpreter number:

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### Part VI. Applicant's agent/broker information

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

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

#### Agent/broker certification

I, \_\_\_\_\_ (name of agent/broker),

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

(\_\_\_\_\_) did not assist the applicant(s) in any way in completing or submitting this application. All information was completed by the applicant(s) with no assistance or advice of any kind from me.

OR

(\_\_\_\_\_) assisted the applicant(s) in submitting this application. I advised the applicant(s) that he or she should answer all questions completely and truthfully and that no information requested on the application should be withheld. I explained that withholding information could result in rescission or cancellation of coverage in the future. The applicant(s) indicated to me that he or she understood these instructions and warnings. To the best of my knowledge, the information on the application is complete and accurate. I explained to the applicant, in easy to understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation.

If I willfully state as true any material fact I know to be false, I shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to ten thousand dollars (\$10,000). **Please answer all questions 1 through 3.**

1. Who filled out and completed the application form? \_\_\_\_\_
2. Did you personally witness the applicant(s) sign the application?  Yes  No
3. Did you review the application after the applicant(s) signed it?  Yes  No

### Part VII. Conditions of enrollment

**GENERAL CONDITIONS: Health Net reserves the right to reject any application for enrollment if the applicant is not eligible for coverage due to not meeting eligibility conditions.** There is no coverage unless this application is accepted by Health Net's Membership Department and a Notice of Acceptance is issued to the applicant even though you paid money to Health Net for the first month's premium. 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 agent or broker cannot grant approval, change terms or waive requirements of this application. This application shall become a part of the Insurance Policy.

**ANY FRAUDULENT OR INTENTIONAL MISREPRESENTATION OF MATERIAL FACTS** in application materials is cause for disenrollment and rescission of the Insurance Policy during the 24-month period after the insurance policy is issued. Health Net may recoup from the policyholder (or from you or from the applicant) any amounts paid for covered services obtained as a result of such fraudulent or intentional misstatement of material fact.

**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 the 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 or a notarized affidavit of assumption of parent-child relationship must be submitted with this application.

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

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### Part VIII. Important provisions

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

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

**ACKNOWLEDGEMENT AND AGREEMENT:** I, the applicant, understand and agree that by enrolling with or accepting services from Health Net, I and any enrolled dependents shall comply with the terms, conditions and provisions of the Insurance Policy. To obtain a copy of the Insurance Policy, call Health Net at 1-877-609-8711. I, the applicant, represent that I have read and understand the terms of this application, and my signature below indicates that, to the best of my knowledge and belief, 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 Insurance Policy 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 Insurance Policy. Mandatory Arbitration may not apply to certain disputes if the Insurance Policy is subject to ERISA, 29 U.S.C. §§ 1001-1461. My signature below indicates that I understand and agree with the terms of this Binding Arbitration Agreement and agree to submit any disputes to binding arbitration instead of a court of law.

Applicant or parent or legal guardian's signature if applicant is under 18 years old:	Date signed:	Signature of applicant's dependent (age 18 or older):	Date signed:
Signature of spouse/domestic partner or applicant's dependent (age 18 or older):	Date signed:	Signature of applicant's dependent (age 18 or older):	Date signed:
Signature of applicant's dependent (age 18 or older):	Date signed:	Signature of applicant's dependent (age 18 or older):	Date signed:

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

Make personal check payable to "Health Net." If you are returning the completed application by mail, send to: Health Net Individual & Family Enrollment, PO Box 1150, Rancho Cordova, CA 95741-1150. If you want to fax your application, please fax to 1-800-977-4161, and mail your check to: Health Net Individual & Family Enrollment, PO Box 894702, Los Angeles, CA 90189-4072.

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. "Insurance Policy" refers to Health Net Life Insurance Company Individual & Family Plan Policy PPO Plan.

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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 & Family Plan (IFP) applicants please call 1-877-609-8711. For more help: If you are enrolled in a PPO or EPO insurance policy underwritten by Health Net Life Insurance Company, call the CA Dept. of Insurance at 1-800-927-4357. If you are enrolled in a HMO or HSP plan provided by Health Net of California, Inc., call the DMHC Helpline at 1-888-HMO-2219. Your ID card indicates whether your plan was issued by Health Net Life Insurance Company or Health Net of California, Inc.

**English**

Servicios de Idiomas Sin Costo. Usted puede solicitar un intérprete. Puede solicitar que se le lean los documentos y que algunos de ellos se le envíen en su idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación; los solicitantes 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 (por sus siglas en inglés, IFP) deben llamar al 1-877-609-8711. Para obtener más ayuda: Si está inscrito en una póliza de seguro PPO o EPO asegurada por Health Net Life Insurance Company, llame al Departamento de Seguros de CA al 1-800-927-4357. Si está inscrito en un plan HMO o HSP proporcionado por Health Net of California, Inc., llame a la Línea de Ayuda del Departamento de Cuidado Médico (por sus siglas en inglés, DMHC) de California al 1-888-HMO-2219. Su tarjeta de identificación indica si su plan fue emitido por Health Net Life Insurance Company o Health Net of California, Inc.

**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，也可以把部分翻譯成您語言的文件寄送給您。如需協助，請撥您會員卡上所列的電話號碼與我們聯絡，雇主團體申請人請撥 Health Net 的商業聯絡中心，電話 1-800-522-0088。Individual and Family Plan (IFP) 申請人請撥 1-877-609-8711。如需其他協助：如果您投保的是 Health Net Life Insurance Company 核保的 PPO 或 EPO 保險保單，請撥 California Department of Insurance 電話 1-800-927-4357。如果您投保的是 Health Net of California, Inc. 提供的 HMO 或 HSP 計畫，請撥 DMHC 協助專線 1-888-HMO-2219。您的會員卡會註明您的計畫是由 Health Net Life Insurance Company 或 Health Net of California, Inc. 核發。

**Chinese**

Dịch vụ ngôn ngữ miễn phí. Quý vị có thể được cấp thông dịch viên và người đọc giúp các tài liệu bằng ngôn ngữ của quý vị cho quý vị. Để được trợ giúp, vui lòng gọi cho chúng tôi theo số điện thoại ghi trên thẻ hội viên của quý vị; người ghi danh theo nhóm của hãng sở xin gọi Trung tâm Liên lạc Thương mại của Health Net theo số 1-800-522-0088. Người ghi danh theo Chương trình bảo hiểm dành cho cá nhân và gia đình (Individual and Family Plan, IFP) xin gọi số 1-877-609-8711. Để được trợ giúp bổ túc: Nếu quý vị ghi danh trong các hợp đồng bảo hiểm PPO hoặc EPO do Health Net Life Insurance Company cam kết tài trợ, vui lòng gọi Bộ Bảo hiểm của California theo số 1-800-927-4357. Nếu quý vị ghi danh trong chương trình bảo hiểm HMO hoặc HSP do Health Net of California, Inc. cung cấp, xin gọi Đường dây trợ giúp của DMHC theo số 1-888-HMO-2219. Trên thẻ hội viên của quý vị có ghi rõ chương trình bảo hiểm của quý vị là do Health Net Life Insurance Company hay Health Net of California, Inc. cung cấp.

**Vietnamese**

무료 언어 지원 서비스. 무료 통역사 서비스 및 여러분에게 편한 언어로 서류 낭독 서비스를 받을 수 있습니다. 도움이 필요하신 분은 본인의 ID 카드상에 있는 안내번호로 전화해 주십시오. 고용주 그룹 가입 신청자님의 경우 Health Net의 상업 (Commercial) 고객 서비스 센터, 안내번호 1-800-522-0088번으로 전화해 주십시오. 개인 및 가족 플랜 (IFP) 가입 신청자님은 안내번호 1-877-609-8711번으로 전화해 주십시오. 더 많은 도움이 필요하시면: 만일 귀하가 Health Net Life Insurance Company가 인수한 PPO 또는 EPO 보험 폴리시에 가입하신 경우, 캘리포니아 보험국 (CA Dept. of Insurance), 안내번호 1-800-927-4357번으로 문의하십시오. 만일 귀하가 Health Net of California, Inc.에서 제공하는 HMO 또는 HSP 플랜에 가입하신 경우, 보건관리부 (DMHC) 헬프라인, 안내번호 1-888-HMO-2219번으로 문의하십시오. 귀하의 ID 카드상에 귀하의 플랜이 Health Net Life Insurance Company에서 제공되는지 또는 Health Net of California, Inc.에서 제공되는지 명시되어 있습니다.

**Korean**

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք բանավոր թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ 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 Հանձնարողի Կապի Կենտրոն: Անհատական և Ընտանեկան Ծրագրի (Individual and Family Plan/IFP) դիմորդներից խնդրվում է զանգահարել 1-877-609-8711 համարով: Լրացուցիչ օգնության համար՝ 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք (CA Dept. of Insurance), եթե գրանցվել եք PPO կամ EPO ապահովագրական ապահովագրի, որի կրողն է Health Net Life Insurance Company-ն: Եթե գրանցվել եք HMO կամ HSP ծրագրում, որի մատակարարն է Health Net of California, Inc.-ը, 1-888-HMO-2219 համարով զանգահարեք DMHC-ի Օգնության Գծին: Ձեր ինքնության տոմսը նշում է, թե ով է թողարկել Ձեր ծրագիրը՝ Health Net Life Insurance Company-ն, թե՞ Health Net of California, Inc.-ը:

**Armenian**

無料の言語サービス。日本語の通訳が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。雇用者団体プランへの加入をお申込みの方は、Health Netの民間コンタクト・センター、1-800-522-0088までお電話ください。個人・家族プラン (IFP) への加入をお申込みの方は、1-877-609-8711までお電話ください。さらに援助が必要な場合、Health Net Life Insurance Companyが保険引受会社となるPPOまたはEPO保険ポリシーにご加入の方は、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Health Net of California, Inc.が提供するHMOまたはHSPプランにご加入の方は、カリフォルニア州管理医療庁 (DMHC) のヘルプライン、1-888-HMO-2219までご連絡ください。お客様のプランの発行者がHealth Net Life Insurance CompanyまたはHealth Net of California, Inc.のどちらであるかは、IDカードに記載されています。

**Japanese**

الخدمات اللغوية المجانية: يمكنك الحصول على مترجم فوري للمساعدة في قراءة مستنداتك باللغة التي تتحدث بها. للحصول على المساعدة يُرجى الاتصال بنا على الرقم الموضح على بطاقة التعريف الخاصة بك، أو إذا كنت من مقدمي الطلبات من الموظفين يُرجى الاتصال بمركز التواصل مع العملاء لدى Health Net على الرقم 1-800-522-0088. بالنسبة لمقدمي طلبات خطة الفرد والأسرة (IFP)، يُرجى الاتصال على الرقم 1-877-609-8711. للحصول على المزيد من المساعدة: إذا كنت مسجلاً في سياسة التأمين بخطة PPO أو EPO التي تكتتبها شركة التأمين على الحياة Health Net Life Insurance Company، يُرجى الاتصال بـ CA Dept. of Insurance (وزارة التأمين بولاية كاليفورنيا) على الرقم 1-800-927-4357. إذا كنت مسجلاً في خطة HMO أو HSP التي توفرها شركة Health Net of California, Inc.، يُرجى الاتصال بخط المساعدة لدى DMHC على الرقم 1-888-HMO-2219. توضح بطاقة التعريف الخاصة بك ما إذا كان تم إصدار خطتك عبر شركة التأمين على الحياة Health Net Life Insurance Company أو شركة Health Net of California, Inc.

**Arabic**

خدمات بی هزینه مربوط به زبان می توانید از خدمات یک مترجم شفاهی برخوردار شده و بگویند تا نوشته ها به زبان خودتان برایتان خوانده شوند. برای دریافت کردن کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است تماس بگیرید، و یا متقاضیان گروه کارفرمایان لطفاً با مرکز تجاری تماس Health Net به شماره 1-800-522-0088 تماس بگیرند. متقاضیان "طرح افراد و خانواده ها" (IFP) لطفاً به شماره 1-877-609-8711 تلفن کنند. برای دریافت کمک بیشتر: اگر برای یک بیمه نامه PPO یا EPO به توسط Health Net Life Insurance Company تضمین شده است ثبت نام کرده اید، به اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تلفن کنید. اگر در یک طرح HMO یا HSP که توسط Health Net of California, Inc. فراهم شده است ثبت نام میکنید، به خط کمکی DMHC به شماره 1-888-HMO-2219 تلفن کنید. کارت شناسائی نشان میدهد که آیا طرح شما توسط Health Net Life Insurance Company صادر شده است یا Health Net of California, Inc.

**Farsi**

Walang Gastusin na Mga Serbisyo sa Wika. Maaari kang kumuha ng interpreter at basahin sa iyong wika ang mga dokumento. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card, o para sa mga aplikante ng pangkat ng employer, mangyaring tawagan ang Commercial Contact Center ng Health Net sa 1-800-522-0088. Para sa mga aplikante ng Individual & Family Plan (IFP), mangyaring tumawag sa 1-877-609-8711. Para sa karagdagang tulong: Kung naka-enroll ka sa isang insurance policy ng PPO o EPO na napapailalim sa Health Net Life Insurance Company, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Kung naka-enroll ka sa isang plano ng HMO o HSP na ipinagkakaloob ng Health Net of California, Inc., tawagan ang DMHC Helpline sa 1-888-HMO-2219. Isinasaad ng iyong ID card kung ang iyong plano ay ibinigay ng Health Net Life Insurance Company o Health Net of California, Inc.

**Tagalog**

KeV Pab Lus Tsis Muaj Nqi Them. Koj txais tau tus neeg txhais lus thiab muab tau cov ntawv los nyeem rau koj ua koj hom lus. Kom tau kev pab, hu rau peb ntawm tus xovtooj sau rau koj daim npav ID, lossis cov tib neeg yuav thov kev pab tom chaw haujlwm thov hu rau Health Net Lub Chaw Pab Cov Tib Neeg Siv Cov Kev Pab (Customer Contact Center) ntawm 1-800-522-0088. Cov neeg thov kev pab hauv pawg Tus Kheej & Tsev Neeg (Individual and Family Plan; IFP) thov hu rau 1-877-609-8711. Yog xav tau kev pab ntxiv: Yog koj muaj npe nkag nrog PPO lossis EPO cov kev tuav pov hwm los ntawm Health Net Life Insurance Company, hu rau CA Qhov Chaw Saib Xyuas Txog Kev Tuav Pov Hwm (Dept. of Insurance) ntawm 1-800-927-4357. Yog koj muaj npe nkag nrog ib qho kev npaj pab HMO lossis HSP uas los ntawm Health Net of California, Inc., hu rau DMHC (Tus Xovtooj) Muab Kev Pab ntawm 1-888-HMO-2219. Koj daim npav ID yuav qhia tau tias koj qhov kev npaj pab yog los ntawm Health Net Life Insurance Company lossis Health Net of California, Inc.

**Hmong**

Doo Bqah 'Alinígóó Saad Bee 'áka'anída'awo'ígíí. 'Ata' halne'í dóo naaltsoos bee 'éédahozinígíí t'áa ni nizaad bee hadadilyaago nich'í' yídóoltah. 'Áka'a'eyeed biniyégó, ninaaltsoos nitl'izi bee nééhozinígíí bine'déé' béesh bee haneí biká'ígíí bee nich'í' hodíilnih, doodago ninaalishí bíl hada'dil'ínígíí t'áa shóqdí Health Net Commercial Hane' 'Íl'íh Bíl Haz'ánijí' 1-800-522-0088 hodíilnih. Ła' Jizíh dóo Hooghan Haz'áqgi Naaltsoos Hadadit'éhígíí (IFP) hada'dile'ígíí t'áa shóqdí kohjí' 1-877-609-8711 hodíilnih. T'áa náásgóó 'áka'a'eyeed biniyégó: PPO doodago EPO béeso 'ách'áqáh naa'nil bibee haz'ánii Health Net Life Insurance Company, bich'í' haidiilaagíí bíl ha'dit'éhígíí bíl ha'dil'éehgo, CA Dept. béeso 'ách'áqáh naa'nil bíl haz'ánígíí bich'í' kohjí' 1-800-927-4357 hodíilnih. Health Net of California, Inc. biyaadóó HMO doodago HSP bíl ha'dit'éhígíí bíl ha'dil'éehgo, DMHC 'Áka'aná'awo' Bíl Haz'ánígíí kohjí' 1-888-HMO-2219 hodíilnih. Health Net Life Insurance Company doodago Health Net of California, Inc. bíl naaltsoos bíl náha'dit'éhígíí ninaaltsoos nitl'izi bine'déé' bikáá'.

**Navajo**

ਭਾਸ਼ਾ ਦੀਆਂ ਮੁਫਤ ਸੇਵਾਵਾਂ। ਤੁਹਾਨੂੰ ਦੁਭਾਸ਼ੀਆਂ ਮਿਲ ਸਕਦਾ ਹੈ ਅਤੇ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈ ਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ, ਜਾਂ ਇੰਪਲਾਇਰ ਗਰੁੱਪ ਦੇ ਅਰਜ਼ੀਦਾਤਾ ਕਿਰਪਾ ਕਰਕੇ Health Net ਦੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ 1-800-522-0088 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਯੋਜਨਾ (IFP) ਵਾਲੇ ਅਰਜ਼ੀਦਾਤਾ ਕਿਰਪਾ ਕਰਕੇ 1-877-609-8711 ਨੰਬਰ ਤੇ ਸੰਪਰਕ ਕਰੋ। ਹੋਰ ਮਦਦ ਲਈ: ਜੇ ਤੁਸੀਂ Health Net Life Insurance Company ਵਲੋਂ ਜਾਰੀ ਕਿਸੇ PPO ਜਾਂ EPO ਬੀਮਾ ਪਾਲਿਸੀ ਲਈ ਨਾਂ ਲਿਖਵਾਇਆ ਹੈ ਤਾਂ ਕੈਲੀਫੋਰਨਿਆ ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ 1-800-927-4357 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਜੇ ਤੁਸੀਂ Health Net of California, Inc. ਵਲੋਂ ਮੁਹੱਈਆ ਕੀਤੀ ਗਈ ਕਿਸੇ HMO ਜਾਂ HSP ਯੋਜਨਾ ਲਈ ਨਾਂ ਲਿਖਵਾਇਆ ਹੈ ਤਾਂ DMHC ਦੀ ਰੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਤੁਹਾਡੇ ਆਈ ਡੀ ਕਾਰਡ ਤੇ ਦਿਖਾਇਆ ਗਿਆ ਹੈ ਕਿ ਤੁਹਾਡੀ ਯੋਜਨਾ Health Net Life Insurance Company ਵਲੋਂ ਜਾਰੀ ਕੀਤੀ ਗਈ ਸੀ ਜਾਂ Health Net of California, Inc. ਵਲੋਂ।

**Punjabi**

ਸੇਵਾਬਕਾ ਪ੍ਰੋਗਰਾਮਾਂ ਦੀ ਸਹੂਲਤ। ਸ਼ੁੱਕਰਵਾਰ ਤੋਂ ਸ਼ੁੱਕਰਵਾਰ ਤੱਕ ਸੇਵਾਵਾਂ ਮਿਲ ਸਕਦੀਆਂ ਹਨ ਅਤੇ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈ ਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ, ਜਾਂ ਇੰਪਲਾਇਰ ਗਰੁੱਪ ਦੇ ਅਰਜ਼ੀਦਾਤਾ ਕਿਰਪਾ ਕਰਕੇ Health Net ਦੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ 1-800-522-0088 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਯੋਜਨਾ (IFP) ਵਾਲੇ ਅਰਜ਼ੀਦਾਤਾ ਕਿਰਪਾ ਕਰਕੇ 1-877-609-8711 ਨੰਬਰ ਤੇ ਸੰਪਰਕ ਕਰੋ। ਹੋਰ ਮਦਦ ਲਈ: ਜੇ ਤੁਸੀਂ Health Net Life Insurance Company ਵਲੋਂ ਜਾਰੀ ਕਿਸੇ PPO ਜਾਂ EPO ਬੀਮਾ ਪਾਲਿਸੀ ਲਈ ਨਾਂ ਲਿਖਵਾਇਆ ਹੈ ਤਾਂ ਕੈਲੀਫੋਰਨਿਆ ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ 1-800-927-4357 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਜੇ ਤੁਸੀਂ Health Net of California, Inc. ਵਲੋਂ ਮੁਹੱਈਆ ਕੀਤੀ ਗਈ ਕਿਸੇ HMO ਜਾਂ HSP ਯੋਜਨਾ ਲਈ ਨਾਂ ਲਿਖਵਾਇਆ ਹੈ ਤਾਂ DMHC ਦੀ ਰੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਤੁਹਾਡੇ ਆਈ ਡੀ ਕਾਰਡ ਤੇ ਦਿਖਾਇਆ ਗਿਆ ਹੈ ਕਿ ਤੁਹਾਡੀ ਯੋਜਨਾ Health Net Life Insurance Company ਵਲੋਂ ਜਾਰੀ ਕੀਤੀ ਗਈ ਸੀ ਜਾਂ Health Net of California, Inc. ਵਲੋਂ।

**Khmer**

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и вам могут прочесть документы на вашем языке. Если вам требуется помощь, звоните нам по номеру телефона, указанному на вашей идентификационной карте. Участники плана группового страхования по месту работы могут обратиться в Коммерческий контактный центр компании Health Net (Commercial Contact Center) по телефону 1-800-522-0088. Участники планов индивидуального и семейного страхования (Individual and Family Plan, IFP), пожалуйста, звоните по номеру 1-877-609-8711. Для получения дополнительной помощи: если у вас страховой полис Организации с предпочтительными поставщиками услуг (Preferred Provider Organization, PPO) или Организации с обязательными поставщиками услуг (Exclusive Provider Organization, EPO), который предоставляется компанией Health Net Life Insurance Company, обращайтесь в Департамент страхования штата Калифорния (CA Dept. of Insurance) по телефону 1-800-927-4357. Если вы зарегистрированы в плане HMO или HSP, который предоставлен компанией Health Net of California, Inc., звоните на телефон Горячей линии Департамента организованного медицинского обслуживания (DMHC Helpline) по номеру 1-888-HMO-2219. На вашей идентификационной карте указано, был ли ваш план оформлен компанией Health Net Life Insurance Company или компанией Health Net of California, Inc.

**Russian**