Health Net®
LIFE INSURANCE COMPANY

Life Premium Accounting & Eligibility
Post Office Box 9103 • Van Nuys, California 91409-9103

GROUP EMPLOYEE / DEPENDENT ENROLLMENT

❑ Enrollment
❑ Change

Missing information will delay the processing of this enrollment form.

EMPLOYER

POLICYHOLDER NAME			POLICY #
EMPLOYEE OCCUPATION TITLE	DATE OF HIRE	COVERAGE EFFECTIVE DATE	EMPLOYEE SALARY $ _____ ❑ Hourly ❑ Weekly ❑ Monthly ❑ Yearly
EMPLOYEE CLASS (IF APPLICABLE)	# OF HOURS WORKED PER WEEK		

Employer: Send copy to Health Net Life Insurance Company at the above address.

EMPLOYEE

A. GENERAL INFORMATION

EMPLOYEE LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY#	DATE OF BIRTH	SEX	MARITAL STATUS

STREET ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NUMBER ( )

	LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY#	DATE OF BIRTH	SEX
Spouse/ Domestic Partner						
Child						
Child						

Note: Additional children should be listed on a separate sheet attached to this form.

B. COVERAGE INFORMATION

❑ Basic Amount (Employee) $_____ (Includes AD&D)

❑ Dependent Life $_____

- ❑ Spouse/Domestic Partner Amount $_____
- ❑ Child Amount $_____

Note: Infant Amount = 10% of Child

❑ Supplemental Life Amount $_____

❑ Supplemental AD&D Amount $_____

- ❑ Spouse/Domestic Partner Amount $_____
- ❑ Child Amount $_____

C. BENEFICIARY DESIGNATION (Required with Life and AD&D coverages.)

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY#	RELATIONSHIP TO EMPLOYEE

STREET ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NUMBER ( )

Note: Additional or contingent Beneficiaries should be indicated on a separate sheet attached to this form.

D. STATEMENTS

I request coverage under my employer's group insurance plan as noted and also verify the accuracy of the employee section. Furthermore, I authorize my employer to deduct from my earnings any payments, if applicable, for this coverage.

If I have checked NO to any or all of the above life and/or dependent coverages, I understand that Health Net Life Insurance Company may not approve my request to change this decision unless I provide satisfactory evidence of insurability.

SIGNATURE	DATE
X	

GROUP EMPLOYEE / DEPENDENT ENROLLMENT

INSTRUCTIONS FOR COMPLETING THE ENROLLMENT FORM

Employers Complete Employer section.

Employees Complete sections A through D.

SECTION A

- Eligible dependents include your husband, or wife, or domestic partner (in accordance with California law) and unmarried children under age 21 or under the age specified in the plan for students.

SECTION B

- Check Yes/No for each coverage option and identify the amount of coverage. (If you are unsure of the benefits for which you are eligible, please ask your Employer's Benefit Administrator.)
- Indicate whether your coverage is a flat dollar amount or based on a multiple of your salary. (If you are unsure of your benefit design or the amounts of coverage that you are eligible for, please ask your Employer's Benefit Administrator.)
- If Supplemental Life and Supplemental AD&D coverage is elected above the guaranteed issue amount, you are required to submit Evidence of Insurability (EOI).

SECTION C

- Beneficiaries are required for Life and AD&D coverage.

  Please use the full name of the beneficiary (e.q., Smith, Mary J., not Smith, Mrs. John T.)

  If you have indicated that your beneficiary is a trust or last will, we will send you special forms to complete. You will also need to complete special forms if you don't want your beneficiaries to receive payment in a lump sum.

  If beneficiaries are trustees of a Pension Plan, please provide the name of the plan.

  We will pay all your beneficiaries equally unless you indicate that we should pay them in different percentages.

SECTION D

- You must sign this section, but a witness signature is required only if you have declined any of the coverages.
- Make a copy of the completed application for your records.

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