For groups of 51+

# Health Net's *Exclusive* ID Card Express

Jesus Hao
*Health Net*

*ID cards mailed in 10 days or we pay you!*

Health Net®

# *Some* promises *can't be broken, we* guarantee *it!*

Health Net – A trusted partner with performance you can count on. The old adage "there are no guarantees" just doesn't cut it at Health Net. We're putting our money where our mouth is – $5,000 worth – with our one-of-a-kind **ID Card Express**, exclusive to new Health Net mid-size clients!

## *The Health Net Guarantee*

Our exclusive ***ID Card Express*** is the perfect way to ensure your clients' employees have access to their health care benefits right away, while giving you another opportunity to boost your business. Here's everything you need to know about who's eligible for this guarantee and how it works.

### Group eligibility:[1]

- New California groups only;
- With 51 to 300 employees; and
- That select plans from our Health Net Starting Line-Up (SLU) Portfolio.

### Here's how it works:

1. Once your client's application and enrollment package is approved by our Underwriting Department, they'll receive a letter welcoming them to Health Net and letting them know they qualify for the ***ID Card Express***.
2. We'll then *guarantee* that Health Net ID cards will be sent to their employees ***within 10 business days*** from the date of the letter. It couldn't be easier!
3. And if we don't live up to our promise, **we'll pay your client $5,000!** That's right. No other California health care company makes this offer.

### Working with you

Your Health Net sales representative will work closely with you and your client to keep you informed about group eligibility and if the enrollment forms meet the qualification requirements for this guarantee. If there are any issues with the enrollment forms, or if their eligibility changes during the process, you and your client will be advised right away.

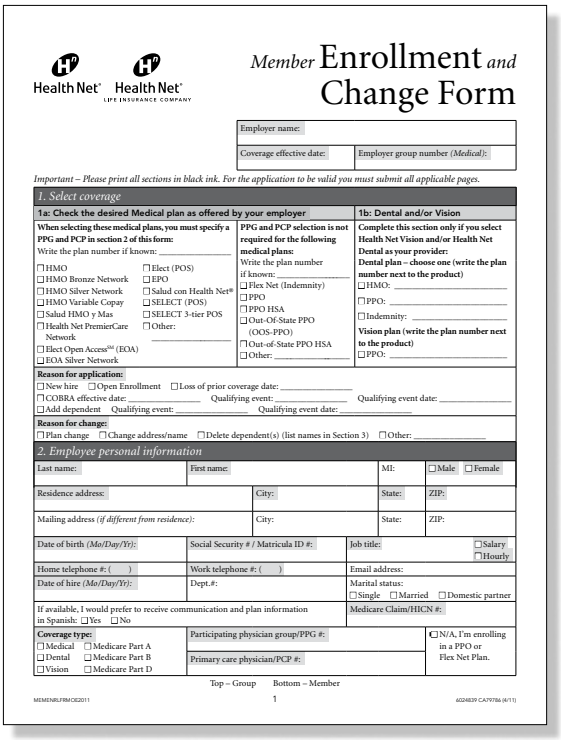
### Guarantee tips – what you can do to make it happen

Your client will appreciate anything you can do to make this guarantee happen for them! Here are a few things that will ensure your client meets the guarantee criteria:

- Remind them to do all they can to provide ***all*** of their employee enrollment forms **to Health Net as soon as possible** so they can be processed with the **initial submission**.
  - Late or incomplete enrollment forms may cause disqualification of the guarantee.
- Encourage them to review each and every enrollment form.
  - Enrollment forms must be filled out **completely and accurately with no more than 30 percent discrepancies** to qualify for the guarantee. Inaccurate or incomplete enrollment forms will delay ID cards and will not be included in this guarantee.

[1]Health Net's ID Card Express guarantee does not apply to custom ID cards and mailings, tape groups, renewing groups, Dental, Vision, or Medicare COB.

- Remind them to double check all of the **highlighted critical fields** – just like the sample shown here.



Health Net® Health Net® LIFE INSURANCE COMPANY

*Member* Enrollment *and* Change Form

Employer name:

Coverage effective date: | Employer group number *(Medical)*:

*Important – Please print all sections in black ink. For the application to be valid you must submit all applicable pages.*

*1. Select coverage*

**1a: Check the desired Medical plan as offered by your employer**

**When selecting these medical plans, you must specify a PPG and PCP in section 2 of this form:**
Write the plan number if known: _____

☐ HMO ☐ Elect (POS)
☐ HMO Bronze Network ☐ EPO
☐ HMO Silver Network ☐ Salud con Health Net®
☐ HMO Variable Copay ☐ SELECT (POS)
☐ Salud HMO y Mas ☐ SELECT 3-tier POS
☐ Health Net PremierCare Network ☐ Other: _____
☐ Elect Open Access℠ (EOA)
☐ EOA Silver Network

**PPG and PCP selection is not required for the following medical plans:**
Write the plan number if known: _____
☐ Flex Net (Indemnity)
☐ PPO
☐ PPO HSA
☐ Out-Of-State PPO (OOS-PPO)
☐ Out-of-State PPO HSA
☐ Other: _____

**1b: Dental and/or Vision**

**Complete this section only if you select Health Net Vision and/or Health Net Dental as your provider:**
**Dental plan – choose one (write the plan number next to the product)**
☐ HMO: _____
☐ PPO: _____
☐ Indemnity: _____

**Vision plan (write the plan number next to the product)**
☐ PPO: _____

**Reason for application:**
☐ New hire ☐ Open Enrollment ☐ Loss of prior coverage date: _____
☐ COBRA effective date: _____ Qualifying event: _____ Qualifying event date: _____
☐ Add dependent Qualifying event: _____ Qualifying event date: _____

**Reason for change:**
☐ Plan change ☐ Change address/name ☐ Delete dependent(s) (list names in Section 3) ☐ Other: _____

*2. Employee personal information*

Last name: | First name: | MI: | ☐ Male ☐ Female

Residence address: | City: | State: | ZIP:

Mailing address *(if different from residence)*: | City: | State: | ZIP:

Date of birth *(Mo/Day/Yr)*: | Social Security # / Matricula ID #: | Job title: | ☐ Salary ☐ Hourly

Home telephone #: ( ) | Work telephone #: ( ) | Email address:

Date of hire *(Mo/Day/Yr)*: | Dept.#: | Marital status: ☐ Single ☐ Married ☐ Domestic partner

If available, I would prefer to receive communication and plan information in Spanish: ☐ Yes ☐ No | Medicare Claim/HICN #:

**Coverage type:**
☐ Medical ☐ Medicare Part A
☐ Dental ☐ Medicare Part B
☐ Vision ☐ Medicare Part D

Participating physician group/PPG #: | Primary care physician/PCP #: | ☐ N/A, I'm enrolling in a PPO or Flex Net Plan.

Top – Group Bottom – Member

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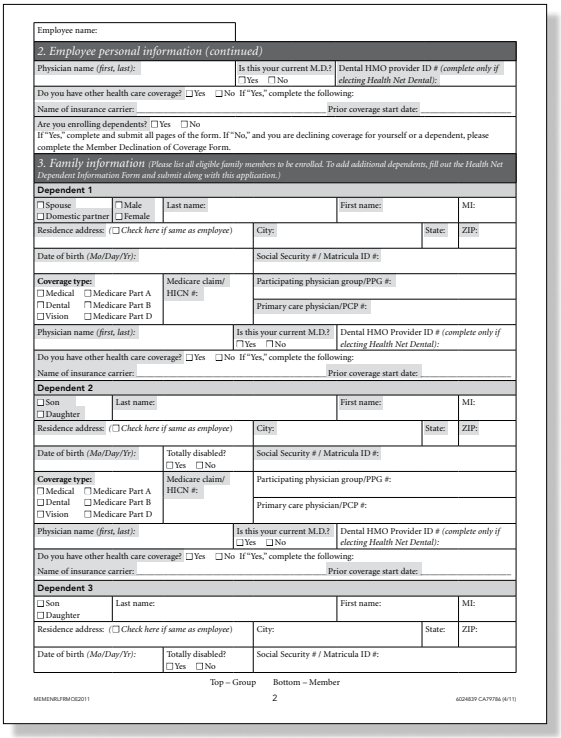

Employee name:

*2. Employee personal information (continued)*

Physician name *(first, last)*: | Is this your current M.D.? ☐ Yes ☐ No | Dental HMO provider ID # *(complete only if electing Health Net Dental)*:

Do you have other health care coverage? ☐ Yes ☐ No If "Yes," complete the following:
Name of insurance carrier: _____ Prior coverage start date: _____

Are you enrolling dependents? ☐ Yes ☐ No
If "Yes," complete and submit all pages of the form. If "No," and you are declining coverage for yourself or a dependent, please complete the Member Declination of Coverage Form.

*3. Family information (Please list all eligible family members to be enrolled. To add additional dependents, fill out the Health Net Dependent Information Form and submit along with this application.)*

**Dependent 1**

☐ Spouse ☐ Domestic partner | ☐ Male ☐ Female | Last name: | First name: | MI:

Residence address: (☐ *Check here if same as employee*) | City: | State: | ZIP:

Date of birth *(Mo/Day/Yr)*: | Social Security # / Matricula ID #:

**Coverage type:**
☐ Medical ☐ Medicare Part A
☐ Dental ☐ Medicare Part B
☐ Vision ☐ Medicare Part D

Medicare claim/ HICN #: | Participating physician group/PPG #: | Primary care physician/PCP #:

Physician name *(first, last)*: | Is this your current M.D.? ☐ Yes ☐ No | Dental HMO Provider ID # *(complete only if electing Health Net Dental)*:

Do you have other health care coverage? ☐ Yes ☐ No If "Yes," complete the following:
Name of insurance carrier: _____ Prior coverage start date: _____

**Dependent 2**

☐ Son ☐ Daughter | Last name: | First name: | MI:

Residence address: (☐ *Check here if same as employee*) | City: | State: | ZIP:

Date of birth *(Mo/Day/Yr)*: | Totally disabled? ☐ Yes ☐ No | Social Security # / Matricula ID #:

**Coverage type:**
☐ Medical ☐ Medicare Part A
☐ Dental ☐ Medicare Part B
☐ Vision ☐ Medicare Part D

Medicare claim/ HICN #: | Participating physician group/PPG #: | Primary care physician/PCP #:

Physician name *(first, last)*: | Is this your current M.D.? ☐ Yes ☐ No | Dental HMO Provider ID # *(complete only if electing Health Net Dental)*:

Do you have other health care coverage? ☐ Yes ☐ No If "Yes," complete the following:
Name of insurance carrier: _____ Prior coverage start date: _____

**Dependent 3**

☐ Son ☐ Daughter | Last name: | First name: | MI:

Residence address: (☐ *Check here if same as employee*) | City: | State: | ZIP:

Date of birth *(Mo/Day/Yr)*: | Totally disabled? ☐ Yes ☐ No | Social Security # / Matricula ID #:

Top – Group Bottom – Member

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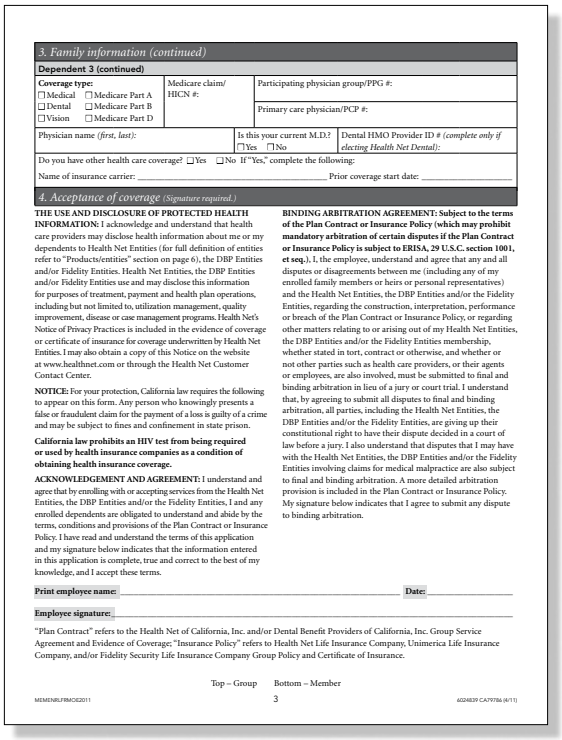

*3. Family information (continued)*

**Dependent 3 (continued)**

**Coverage type:**
☐ Medical ☐ Medicare Part A
☐ Dental ☐ Medicare Part B
☐ Vision ☐ Medicare Part D

Medicare claim/ HICN #: | Participating physician group/PPG #: | Primary care physician/PCP #:

Physician name *(first, last)*: | Is this your current M.D.? ☐ Yes ☐ No | Dental HMO Provider ID # *(complete only if electing Health Net Dental)*:

Do you have other health care coverage? ☐ Yes ☐ No If "Yes," complete the following:
Name of insurance carrier: _____ Prior coverage start date: _____

*4. Acceptance of coverage (Signature required.)*

**THE 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 Entities (for full definition of entities refer to "Products/entities" section on page 6), the DBP Entities and/or Fidelity Entities. Health Net Entities, the DBP Entities and/or Fidelity Entities use and may disclose this information for purposes of treatment, payment and health plan operations, including but not limited to, utilization management, quality improvement, disease or case management programs. Health Net's Notice of Privacy Practices is included in the evidence of coverage or certificate of insurance for coverage underwritten by Health Net Entities. I may also obtain a copy of this Notice on the website at www.healthnet.com or through the Health Net Customer Contact Center.

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

**California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.**

**ACKNOWLEDGEMENT AND AGREEMENT:** I understand and agree that by enrolling with or accepting services from the Health Net Entities, the DBP Entities and/or the Fidelity Entities, I and any enrolled dependents are obligated to understand and abide by the terms, conditions and provisions of the Plan Contract or Insurance Policy. I 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 to the best of my knowledge, and I accept these terms.

**BINDING ARBITRATION AGREEMENT: Subject to the terms of the Plan Contract or Insurance Policy (which may prohibit mandatory arbitration of certain disputes if the Plan Contract or Insurance Policy is subject to ERISA, 29 U.S.C. section 1001, et seq.),** I, the employee, understand and agree that any and all disputes or disagreements between me (including any of my enrolled family members or heirs or personal representatives) and the Health Net Entities, the DBP Entities and/or the Fidelity Entities, regarding the construction, interpretation, performance or breach of the Plan Contract or Insurance Policy, or regarding other matters relating to or arising out of my Health Net Entities, the DBP Entities and/or the Fidelity Entities membership, whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or employees, are also involved, must be submitted to final and binding arbitration in lieu of a jury or court trial. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties, including the Health Net Entities, the DBP Entities and/or the Fidelity Entities, are giving up their constitutional right to have their dispute decided in a court of law before a jury. I also understand that disputes that I may have with the Health Net Entities, the DBP Entities and/or the Fidelity Entities involving claims for medical malpractice are also subject to final and binding arbitration. A more detailed arbitration provision is included in the Plan Contract or Insurance Policy. My signature below indicates that I agree to submit any dispute to binding arbitration.

**Print employee name:** _____ **Date:** _____

**Employee signature:** _____

"Plan Contract" refers to the Health Net of California, Inc. and/or Dental Benefit Providers of California, Inc. Group Service Agreement and Evidence of Coverage; "Insurance Policy" refers to Health Net Life Insurance Company, Unimerica Life Insurance Company, and/or Fidelity Security Life Insurance Company Group Policy and Certificate of Insurance.

Top – Group Bottom – Member

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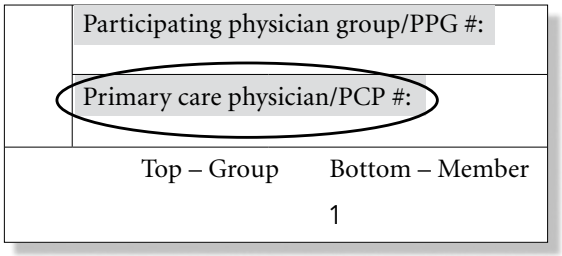
- Make sure HMO enrollees **show a primary care physician/provider (PCP) selection** on their form – this is quite often overlooked.




*(continued)*

### What's next

There's nothing else you or your client need to do. Just leave the rest to us. We'll stick to our promise by making sure your client's employees receive their ID cards in a timely manner. And isn't that what it's really all about!

As Health Net members and insureds, your clients and their employees can access their benefits right away, as well as find helpful services at www.healthnet.com, such as:

- For your clients – easy-to-use *Online Billing and Enrollment* that gives them the flexibility to manage their account when it's convenient for them.
- For their employees – a wide array of useful online tools and resources to help them view their benefits and claims history, find doctors with *ProviderSearch*, access wellness programs, and so much more.

### Better solutions, better service

That's what it's all about at Health Net. As your trusted partner, it's our mission to make doing business with us easier by providing the solutions and service you can count on.

Call us today for more information about our ***ID Card Express***. It's just another way we're working harder with you.