Health Net®

SMALL BUSINESS GROUP
ENROLLMENT AND CHANGE FORM

Medical and Life/AD&D plans are provided by Health Net of California, Inc. and/or Health Net Life Insurance Company (together, the "Health Net Entities"). Dental plans are provided by SafeGuard Health Plans, Inc. and/ or its affiliate, SafeHealth Life Insurance Company, (together "SafeGuard Entities"). Vision plans are provided by Fidelity Security Life Insurance Company and serviced by Eyemed Vision Care LLC (together the "Fidelity Entities").

Neither the SafeGuard Entities nor The Fidelity Entities are affiliated with the Health Net Entities. Obligations under dental and vision plans are not obligations of, and are not guaranteed by, the Health Net Entities.

Welcome to Health Net

SIMPLE STEPS FOR COMPLETING THE FORM:

1) Review the materials enclosed in your enrollment packet. Be sure that you understand the coverage options that are available to you by your employer.

2) Carefully review and select the plan option(s) that are best for you and your covered family members.

3) If you choose to enroll in the HMO, HMO Silver Network, HMO Salud con Health Net, SELECT (POS), ELECT Open Access (EOA) or Dental HMO (DHMO), you must select your dental provider, physician group and primary care physician. Be sure to fill in the names and numbers as they appear in the HMO Health Net Directory of Providers, or call the Customer Contact Center from 8:00 a.m.- 6:00 p.m., Monday through Friday for assistance.

   Small Business Group (English): 1-800-361-3366
   Small Business Group (Spanish): 1-800-331-1777
   Health Net Life: 1-800-865-6288
   Health Net Dental: 1-800-880-8113
   Health Net Vision: 1-866-392-6058

4) If you choose to select PPO or Flex Net, you are not required to select a primary care physician or physician group to enroll.

   Post Office Box 9103
   Van Nuys, California 91409-9103
   www.healthnet.com

HEALTH NET ENROLLMENT AND CHANGE FORM FOR SMALL BUSINESS GROUP

EMPLOYER NAME

EFFECTIVE DATE

EMPLOYER GROUP NUMBER *(Medical)*

SOCIAL SECURITY NUMBER

(Sections 1, 2, 3, 4 and 8 are required.)

IMPORTANT: PLEASE PRINT ALL SECTIONS IN BLACK INK.

1 SELECTED COVERAGE

PPO
Standard
❑PPO 10
❑PPO 20
❑PPO 30
❑PPO 40
Value
❑PPO 10
❑PPO 20
❑PPO 30
❑PPO 40

HSA
❑HSA 10 (1500)
❑HSA 20 (2500)
❑HSA 30 (3500)
❑HSA 40 (4500)

POS
❑POS 10
❑POS 20

HMO
Standard
❑HMO 10
❑HMO 20
❑HMO 30
❑HMO 40
Value
❑HMO 10
❑HMO 20
❑HMO 30
❑HMO 40

HMO SILVER NETWORK
Standard
❑HMO 10
❑HMO 20
❑HMO 30
❑HMO 40
Value
❑HMO 10
❑HMO 20
❑HMO 30
❑HMO 40

EOA
Standard
❑EOA 10
❑EOA 20
❑EOA 30
❑EOA 40
Value
❑EOA 10
❑EOA 20
❑EOA 30
❑EOA 40

Hⁿ OPTIONS
❑Options PPO 250
❑Options PPO 500
❑Options PPO 1500
❑Options PPO 1750
❑Options PPO 3000 *(HSA compatible)*
❑Options PPO 4000 *(HSA compatible)*
❑Options HMO 25
❑Options HMO 35
❑Options EOA 25
❑Options EOA 35

SALUD CON HEALTH NET
❑Salud HMO y más (available in Los Angeles and Orange counties)
❑Salud PPO (available in Los Angeles, Orange and Ventura counties)
❑Salud Mexico (available in San Diego and Imperial counties)
❑Salud EPO (available in Los Angeles, Orange and Ventura counties)

FLEX NET
❑Indemnity (Out of service area only)

DENTAL
DHMO
❑Advantage 150 Plan
❑Advantage 225 Plan
DPPO
❑HB Plan _____
❑HC Plan _____
❑HD Plan _____

VISION PPO
❑Preferred 1025-2
❑Preferred 1025-3
❑ Value 10-2

REASON FOR CHANGE:
❑ Plan change ❑ Change address/name ❑ Delete dependent *(list names below)*
❑ Other _____

REASON FOR APPLICATION:
❑ New hire ❑ Open Enrollment ❑ Loss of prior coverage date _____
❑ COBRA[1] effective date _____
❑ ADD DEPENDENT: Qualifying event _____
Qualifying event date _____

[1]Employers who normally employed 20 or more employees during the previous calendar year are subject to federal COBRA. Employers who employed 2-19 employees on at least 50% of its working days the previous calendar year are subject to Cal-COBRA. Please consult your legal counsel if you need help determining which law applies to you.

2 PERSONAL INFORMATION

Last Name	First Name	M.I.	❑ Male ❑ Female
Street Address	City	State	Zip

Telephone no. ( )	Job Title	Work Phone no. ( )

Date of Hire / /	Class	Dept. no.	Email Address	Employment Status ❑ Salaried ❑ Hourly	Marital Status ❑ Single ❑ Married ❑ Domestic Partner

For Salud con Health Net Members: If available, I would prefer to receive communication or plan information in Spanish. ❑ Yes ❑ No

3 EMPLOYEE & FAMILY INFORMATION Please list yourself and all eligible family members to be enrolled. (Attach additional sheets if necessary).

	Last Name, First Name, M.I.	Residence address, City, State, ZIP	Date of Birth	Social Security #/ Matricular ID #
❑ Self			Mo Day Yr	

Medicare	Overage Dependent Type	Participating Physician Group/PPG#	Health Net Primary Care Physician/PCP #	Physician Name (First, Last)	Is this your current M.D.?	Dental HMO Provider ID #
❑ Part A ❑ Part B	Not Applicable				❑ Yes ❑ No	

	Last Name, First Name, M.I.	Residence address, City, State, ZIP	Date of Birth	Social Security #/ Matricular ID #
❑ Spouse ❑ Domestic Partner ❑ M ❑ F			Mo Day Yr	

Medicare	Overage Dependent Type	Participating Physician Group/PPG#	Health Net Primary Care Physician/PCP #	Physician Name (First, Last)	Is this your current M.D.?	Dental HMO Provider ID #
❑ Part A ❑ Part B	Not Applicable				❑ Yes ❑ No	

	Last Name, First Name, M.I.	Residence address, City, State, ZIP	Date of Birth	Social Security #/ Matricular ID #
❑ Son ❑ Daughter			Mo Day Yr	

Medicare	Overage Dependent Type	Participating Physician Group/PPG#	Health Net Primary Care Physician/PCP #	Physician Name (First, Last)	Is this your current M.D.?	Dental HMO Provider ID #
❑ Part A ❑ Part B	❑ Disabled ❑ Full-time Student ❑ Over 50% support				❑ Yes ❑ No	

	Last Name, First Name, M.I.	Residence address, City, State, ZIP	Date of Birth	Social Security #/ Matricular ID #
❑ Son ❑ Daughter			Mo Day Yr	

Medicare	Overage Dependent Type	Participating Physician Group/PPG#	Health Net Primary Care Physician/PCP #	Physician Name (First, Last)	Is this your current M.D.?	Dental HMO Provider ID #
❑ Part A ❑ Part B	❑ Disabled ❑ Full-time Student ❑ Over 50% support				❑ Yes ❑ No	

SOCIAL SECURITY NUMBER

4 DO YOU OR YOUR DEPENDENTS HAVE OTHER HEALTH CARE COVERAGE? If yes, please complete ths section including Medicare.

Please fill out the following information to receive proper credit for PREVIOUS COVERAGE, if immediately prior to becoming eligible for this plan, you or your dependents were covered under any public or private health care coverage (including MediCal or individual coverage). According to federal law, your employer or FORMER CARRIER must provide you with a certificate that shows evidence of your prior coverage. We reserve the right to request a copy of this certificate.

	Name		Name of Other Insurance Carrier			Prior Coverage Start Date
❑ Self						Mo Day Yr
Prior Coverage End Date	**Reason for Ending Coverage**	**Group #/ Policy ID #**	**Is this your dependent's primary coverage?**	**Does it cover?**	**Medicare**	**Medicare Claim/ HICN #**
Mo Day Yr			❑ Yes ❑ No	Medical: ❑ Yes ❑ No Dental: ❑ Yes ❑ No Vision: ❑ Yes ❑ No	❑ Part A ❑ Part B	
	Name		**Name of Other Insurance Carrier**			**Prior Coverage Start Date**
❑ Spouse ❑ Domestic Partner						Mo Day Yr
Prior Coverage End Date	**Reason for Ending Coverage**	**Group #/ Policy ID #**	**Is this your dependent's primary coverage?**	**Does it cover?**	**Medicare**	**Medicare Claim/ HICN #**
Mo Day Yr			❑ Yes ❑ No	Medical: ❑ Yes ❑ No Dental: ❑ Yes ❑ No Vision: ❑ Yes ❑ No	❑ Part A ❑ Part B	
	Name		**Name of Other Insurance Carrier**			**Prior Coverage Start Date**
❑ Son ❑ Daughter						Mo Day Yr
Prior Coverage End Date	**Reason for Ending Coverage**	**Group #/ Policy ID #**	**Is this your dependent's primary coverage?**	**Does it cover?**	**Medicare**	**Medicare Claim/ HICN #**
Mo Day Yr			❑ Yes ❑ No	Medical: ❑ Yes ❑ No Dental: ❑ Yes ❑ No Vision: ❑ Yes ❑ No	❑ Part A ❑ Part B	
	Name		**Name of Other Insurance Carrier**			**Prior Coverage Start Date**
❑ Son ❑ Daughter						Mo Day Yr
Prior Coverage End Date	**Reason for Ending Coverage**	**Group #/ Policy ID #**	**Is this your dependent's primary coverage?**	**Does it cover?**	**Medicare**	**Medicare Claim/ HICN #**
Mo Day Yr			❑ Yes ❑ No	Medical: ❑ Yes ❑ No Dental: ❑ Yes ❑ No Vision: ❑ Yes ❑ No	❑ Part A ❑ Part B	

5 YOUR EMPLOYER COMPLETES THIS SECTION (if applying for Group Life AD&D.)

Effective Date	Annual Salary	Occupation	Life Class	Life / AD&D Amount

6 GROUP TERM LIFE INSURANCE If applicable. (Attach separate sheet for additional or contingent beneficiaries.)

Life coverage ❑ Yes ❑ No If yes, I am applying for ❑ Basic Life/AD&D $_____ ❑ Dependent Life $_____

Life Beneficiary (Full Name)	Relationship	%
		%
Life Beneficiary (Full Name)	Relationship	%
		%
Life Beneficiary (Full Name)	Relationship	%
		%
Life Beneficiary (Full Name)	Relationship	%
		%

SOCIAL SECURITY NUMBER

7 DECLINATION OF COVERAGE (Complete this section if any coverage is to be declined by you or your eligible dependents.)

❑ **Declining Medical coverage for:** ❑ Self ❑ Spouse ❑ Dependent(s) ❑ Domestic Partner _____ **Reason:** ❑ Other group coverage through this employer ❑ Individual Coverage ❑ Other _____ ❑ Other group coverage by another group *(i.e. spouse's employer)*

❑ **Declining Dental coverage for:** ❑ Self ❑ Spouse ❑ Dependent(s) ❑ Domestic Partner _____ **Reason:** ❑ Other group coverage through this employer ❑ Individual Coverage ❑ Other _____ ❑ Other group coverage by another group *(i.e. spouse's employer)*

❑ **Declining Vision coverage for:** ❑ Self ❑ Spouse ❑ Dependent(s) ❑ Domestic Partner _____ **Reason:** ❑ Other group coverage through this employer ❑ Individual Coverage ❑ Other _____ ❑ Other group coverage by another group *(i.e. spouse's employer)*

The available coverages have been explained to me by my employer. I have been given the chance to apply for the available coverages. I have decided not to enroll myself and/or my dependent(s).

By declining coverage I acknowledge that my dependents and I may have to wait to be enrolled until the next Open Enrollment period or qualifying event. Additionally, by signing below I certify that the reason I am declining coverage is accurate as indicated by the check marks above.

Employee Signature_____ **Date**_____
(SIGN ONLY IF DECLINING COVERAGE. If signed in error, please cross out and initial.)

8 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, the SafeGuard Entities and/or Fidelity Entities. Health Net Entities, the SafeGuard 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 SafeGuard 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, 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 Safeguard 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 Safeguard 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 Safeguard 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 Safeguard 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.

Employee Signature_____ **Date**_____

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

Health Net® Health Net® LIFE INSURANCE COMPANY

Please contact the Health Net Customer Contact Center at the toll free numbers below should you need assistance in completing this form or if you have questions about your coverage:

English	1-800-361-3366
Cantonese	1-877-891-9050
Korean	1-877-339-8596
Mandarin	1-877-891-9053
Spanish	1-800-331-1777
Tagalog	1-877-891-9051
Vietnamese	1-877-339-8621

If you have questions about your dental or vision coverage, please call:

Dental	1-800-880-8113
Vision	1-866-392-6058

If you have questions about your physician or physician group, call your physician group directly or contact Health Net Provider Services at 1-800-641-7761.

You can use your copy of the Health Net enrollment form as your temporary ID card until you receive your permanent ID card.

HMO, HMO Silver Network, Salud con Health Net HMO, SELECT, ELECT Open Access, EPO Dental HMO Enrollees:
Participating Physician Group (PPG), Primary Care Physician (PCP) and Dental Provider Selection.

Please note, if you do not select a participating physician group, Primary Care Physician, or Dental Provider for yourself and each of your eligible dependents, a physician group, Primary Care Physician, and Dental Provider will be selected for you.

Emergency and Urgently Needed Care

- **If your situation is life threatening or an emergency:** Call **911** or go to the nearest Hospital.
- **If your situation is not so severe:** If you cannot call your Primary Care Physician or physician group, or you need medical care right away, go to the nearest hospital or medical center.
- **If you are outside your physician group's service area:** Go to the nearest hospital, medical center or call **911**. In all cases, contact your Primary Care Physician or physician group as soon as possible to inform them about your condition.

PPO, FLEX NET Enrollees:
Emergency and Urgently Needed Care

- **If your situation is life threatening or an emergency:** Call **911** or go to the nearest hospital. Please call the appropriate number within 48 hours of being admitted, or as soon as possible.

PRE-CERTIFICATION

You the member are responsible for obtaining certification for certain services. Please check your plan certificate for a list of services requiring pre-certification.

For pre-certification, please call 1-800-977-7282

Pre-existing Conditions and Creditable Coverage
Your coverage under the PPO, EPO and Flex Net benefit plans may be subject to pre-existing condition limitations for a maximum period of six months from the effective date of your enrollment. In accordance with state and federal law, Health Net Life Insurance Company will credit any prior coverage that you document at the time you apply to enroll in PPO, EPO or FLEX NET, provided the prior coverage qualifies as "creditable coverage" as defined under federal and state law. Creditable coverage will be applied to offset (in part or whole) the pre-existing condition limitation, which may apply to your coverage under this policy. If you're unable to provide documentation of bona fide creditable coverage at enrollment time, Health Net Life Insurance Company may provide assistance in obtaining the necessary documentation upon request. Note: Prior coverage, which is interrupted by a period of 63 days (or 180 days if your previous employer terminated the coverage) or more, does not qualify as creditable coverage.

Disabling Conditions:
If you or your family member were disabled as of the date of termination of coverage with a prior health insurer and the loss of coverage was due to the termination of the employer's insurance policy, you may be entitled to an extension of health benefits according to California Insurance Code section 10128. Under this law, the prior insurer retains responsibility until whichever of the following occur first: (a) the member is no longer totally disabled; (b) the maximum benefits of the prior insurer's coverage are paid; or (c) a period of 12 consecutive months has passed since the date coverage ended with prior insurer.

Products/Entities:
Health Net of California, Inc. offers the following products: ELECT Open Access, HMO and SELECT POS.

Health Net Life Insurance Company offers the following products: EPO, Flex Net, PPO, Salud con Health Net EPO & PPO, Life and AD&D insurance.

SafeGuard Health Plans, Inc. offers the following products: Dental HMO (DHMO) and DHMO Ortho Rider.

SafeHealth Life Insurance Company offers the following products: PPO Dental, Indemnity Dental, Indemnity Ortho Rider.

Fidelity Security Life Insurance Company offers the following products serviced by EyeMed Vision Care, LLC: PPO Vision.

Declination of Coverage:
If you decline coverage for yourself or an eligible dependent because of coverage under other health insurance and you lose that coverage, or, if you acquire a new dependent due to marriage, birth, adoption, or placement for adoption, you and your dependent may be eligible for special enrollment rights. You must request special enrollment within 30 days of the loss of coverage or acquisition of a new dependent.