



Small Business Application

for Group Enrollment and Change

Medical and Life/AD&D plans are provided by Health Net of California, Inc. and/or Health Net Life Insurance Company (together, "Health Net"). Dental HMO plans, other than pediatric dental, are offered and administered by Dental Benefit Providers of California, Inc., and dental PPO and indemnity insurance plans, other than pediatric dental, are underwritten by Unimerica Life Insurance Company and administered by Dental Benefit Administrative Services (together, "DBP"). Vision plans, other than pediatric vision, are provided by Fidelity Security Life Insurance Company and serviced by EyeMed Vision Care, LLC (together, "Fidelity").

Pediatric dental HMO plans are provided by Health Net of California, Inc. Pediatric dental PPO and indemnity plans are provided by Health Net Life Insurance Company.

Neither DBP nor Fidelity are affiliated with Health Net. Obligations under dental and vision plans, other than pediatric dental or vision, are neither obligations of, nor guaranteed by, Health Net.

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.
- 2a. **If you are declining coverage** for yourself and/or your dependents, section 7 is required. Do not fill out any other sections.
- 2b. **If you are accepting coverage** for yourself and/or your dependents, sections 1, 2, 3, 5, and 8 are required.

The Affordable Care Act (ACA) requires Health Net to provide to the IRS confirmation of health care coverage for yourself, as the subscriber, and your covered dependents. The IRS uses this information to confirm each member has minimum essential coverage and is not subject to the ACA's individual shared responsibility payment provision. Please ensure that the Social Security number (SSN) is accurate for yourself and each dependent you are enrolling. For more information about the individual shared responsibility payment provision, go to <http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision>.

3. If you choose to enroll in the WholeCare HMO, SmartCare HMO, Salud HMO y Más, PureCare HSP, or Dental HMO (DHMO) plans, you must select your participating physician group (PPG), primary care physician (PCP) or dental provider. Be sure to fill in the names and numbers as they appear in Health Net's online ProviderSearch tool.

Note: If you do not select a PPG, PCP and/or a dental provider, one will be selected for you.

4. If you choose to enroll in a PPO or EPO insurance plan, you are not required to select a PPG or PCP to enroll.
5. Make a copy of the completed application for your records. **If a correction is needed, cross out and initial each correction. Please do not use a white-out product.**

For administrative use only:	
Existing Business/Group	New Business/Group
PO Box 9103	Please send all completed
Van Nuys, CA 91409-9103	paperwork to your designated
www.healthnet.com	account executive or broker.



To be completed by employer	
Employer name:	
Requested effective date:	Employer group number (medical):
Employee eligibility date (new hire only): <input type="checkbox"/> Same as hired date <input type="checkbox"/> Other: _____	

Important: Please print all sections in black ink. You are entitled to see a Summary of Benefits and Coverage (SBC) before you choose a plan. Please contact your employer if you do not have the SBC for the plan you have selected.

1. Health plan information (All medical plans include pediatric dental and vision coverage.)

Full Network HMO ¹		CommunityCare HMO ²	
Platinum <input type="checkbox"/> \$10 <input type="checkbox"/> \$20	Gold <input type="checkbox"/> \$30 <input type="checkbox"/> \$40 <input type="checkbox"/> \$50	Gold <input type="checkbox"/> \$5	Silver <input type="checkbox"/> \$20
WholeCare HMO ¹		SmartCare HMO ³	
Platinum <input type="checkbox"/> \$10 <input type="checkbox"/> \$20	Gold <input type="checkbox"/> \$30 <input type="checkbox"/> \$40 <input type="checkbox"/> \$50	Platinum <input type="checkbox"/> \$10 <input type="checkbox"/> \$20	Gold <input type="checkbox"/> \$30 <input type="checkbox"/> \$40 <input type="checkbox"/> \$50
Salud HMO y Más ⁴			
Platinum <input type="checkbox"/> \$10 <input type="checkbox"/> \$20	Gold <input type="checkbox"/> \$30 <input type="checkbox"/> \$40 <input type="checkbox"/> \$50		
PureCare One EPO ¹		PureCare HSP ¹	
<input type="checkbox"/> Health Net Gold 80 EPO 1000/20 Alternate <input type="checkbox"/> Health Net Silver 70 EPO 1800/30 Alternate	<input type="checkbox"/> Health Net Platinum 90 HSP 0/20 <input type="checkbox"/> Health Net Gold 80 HSP 0/35	<input type="checkbox"/> Health Net Silver 70 HSP 1500/45 <input type="checkbox"/> Health Net Bronze 60 HSP 6000/70	
PPO			
<input type="checkbox"/> Health Net Platinum 90 PPO 0/20 <input type="checkbox"/> Health Net Bronze 60 PPO 6000/70	<input type="checkbox"/> Health Net Gold 80 PPO 0/35 <input type="checkbox"/> Health Net Bronze 60 HSA PPO 4750/15 Alternate	<input type="checkbox"/> Health Net Silver 70 PPO 1500/45	
Other plan(s):			

Dental (DHMO)	Dental (DPPO)	Vision (PPO)
<input type="checkbox"/> HN Plus 150 <input type="checkbox"/> HN Plus 225	<input type="checkbox"/> Classic 5 1500 (w/ortho) <input type="checkbox"/> Essential 2 1000 <input type="checkbox"/> Essential 6 1500 <input type="checkbox"/> Classic 4 1500 <input type="checkbox"/> Essential 5 1500 (w/ortho)	<input type="checkbox"/> Preferred 1025-2 <input type="checkbox"/> Preferred 1025-3 <input type="checkbox"/> Preferred Value 10-2

2. Reason for application

<input type="checkbox"/> Plan change <input type="checkbox"/> Change address/name <input type="checkbox"/> Delete dependent (list names below) <input type="checkbox"/> Other: _____	<input type="checkbox"/> New hire <input type="checkbox"/> Open Enrollment Special Enrollment Period Qualifying event date: ____/____/____ Add dependent: <input type="checkbox"/> Marriage <input type="checkbox"/> Newborn/Adoption/Legal Guardianship/Court Order/Assumption of parent-child relationship <input type="checkbox"/> Loss of prior coverage <input type="checkbox"/> Other (specify): _____	COBRA⁵ <input type="checkbox"/> Effective date: ____/____/____ Qualifying event date: ____/____/____
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3. Employee personal information

Last name:	First name:	MI:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Residence address:	City:	State:	ZIP:
Date of birth (mm/dd/yyyy):	Social Security #/Matricular ID # (required for all applicants):	Job title:	
Telephone #: () ()	Work phone #: () ()	Email address:	
Date of hire: / /	Dept. #:	Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic partner	
If available, I would prefer to receive communication and plan information in Spanish: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Participating physician group:		Primary care physician:	
PPG/PCP Enrollment ID # (4-digit PPG and 6-digit PCP numbers):		Is this your current PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dental HMO provider name:		Dental HMO provider ID #:	

Employee name: _____

Last 4 digits of Social Security #: _____

4. Family information, please list all eligible family members to be enrolled.*(Attach additional sheets if necessary.)*

Spouse/Domestic partner <input type="checkbox"/> M <input type="checkbox"/> F	Last name:	First name:	MI:
Residence address: <input type="checkbox"/> Check here if same as subscriber		City:	State: ZIP:
Date of birth (mm/dd/yyyy):		Social Security #/Matricular ID # (required for all applicants):	
Participating physician group:		Primary care physician:	
PPG/PCP Enrollment ID # (4-digit PPG and 6-digit PCP numbers):		Is this your current PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dental HMO provider name:		Dental HMO provider ID #:	

<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Last name:	First name:	MI:
Residence address: <input type="checkbox"/> Check here if same as subscriber		City:	State: ZIP:
Date of birth (mm/dd/yyyy):		Social Security #/Matricular ID # (required for all applicants):	
Participating physician group:		Primary care physician:	
PPG/PCP Enrollment ID # (4-digit PPG and 6-digit PCP numbers):		Is this your current PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dental HMO provider name:		Dental HMO provider ID #:	

<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Last name:	First name:	MI:
Residence address: <input type="checkbox"/> Check here if same as subscriber		City:	State: ZIP:
Date of birth (mm/dd/yyyy):		Social Security #/Matricular ID # (required for all applicants):	
Participating physician group:		Primary care physician:	
PPG/PCP Enrollment ID # (4-digit PPG and 6-digit PCP numbers):		Is this your current PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dental HMO provider name:		Dental HMO provider ID #:	

<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Last name:	First name:	MI:
Residence address: <input type="checkbox"/> Check here if same as subscriber		City:	State: ZIP:
Date of birth (mm/dd/yyyy):		Social Security #/Matricular ID # (required for all applicants):	
Participating physician group:		Primary care physician:	
PPG/PCP Enrollment ID # (4-digit PPG and 6-digit PCP numbers):		Is this your current PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dental HMO provider name:		Dental HMO provider ID #:	

Employee name: _____

Last 4 digits of Social Security #: _____

5. Do you or your dependents have other health care coverage?

No Yes If "Yes," please complete this section including Medicare.

<input type="checkbox"/> Self	Name:	Name of other insurance carrier:		Prior coverage start date (mm/dd/yy):	
Prior coverage end date (mm/dd/yy):	Reason for ending coverage:	Group #/Policy ID #:	Does it cover? Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare: <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare claim/HICN #:

<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner	Name:	Name of other insurance carrier:		Prior coverage start date (mm/dd/yy):		
Prior coverage end date (mm/dd/yy):	Reason for ending coverage:	Group #/Policy ID #:	Is this your dependent's primary coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does it cover? Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare: <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare claim/HICN #:

<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Name:	Name of other insurance carrier:		Prior coverage start date (mm/dd/yy):		
Prior coverage end date (mm/dd/yy):	Reason for ending coverage:	Group #/Policy ID #:	Is this your dependent's primary coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does it cover? Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare: <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare claim/HICN #:

<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Name:	Name of other insurance carrier:		Prior coverage start date (mm/dd/yy):		
Prior coverage end date (mm/dd/yy):	Reason for ending coverage:	Group #/Policy ID #:	Is this your dependent's primary coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does it cover? Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare: <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare claim/HICN #:

<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Name:	Name of other insurance carrier:		Prior coverage start date (mm/dd/yy):		
Prior coverage end date (mm/dd/yy):	Reason for ending coverage:	Group #/Policy ID #:	Is this your dependent's primary coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does it cover? Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare: <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare claim/HICN #:

6. Group term life insurance, if applicable. (Attach separate sheet for additional or contingent beneficiaries.)

Life/AD&D coverage: Yes No

Life beneficiary (full name):	Relationship:	%
Life beneficiary (full name):	Relationship:	%
Life beneficiary (full name):	Relationship:	%
Life beneficiary (full name):	Relationship:	%

¹Available in all or parts of Alameda, Contra Costa, El Dorado, Fresno, Kern, Kings, Los Angeles, Madera, Marin, Merced, Napa, Nevada, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare, Ventura, and Yolo counties.

²Available in Los Angeles and Orange counties.

³Available in all or parts of Los Angeles, Orange, Riverside, San Diego, San Bernardino, Santa Clara, and Santa Cruz counties.

⁴Available in Orange County and select ZIP codes of Kern, Los Angeles, Riverside, San Diego, and San Bernardino counties.

⁵Note: Generally, 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.

“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’s Group Policy and Certificate of Insurance.

Employee name: _____

Last 4 digits of Social Security #: _____

7. Declination of coverage (Complete this section if any coverage is being declined by you or your eligible dependents.)

Employee personal information

Last name:	First name:	MI:	Social Security #/Matricular ID #:
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Declining medical coverage for: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner <input type="checkbox"/> Dependent(s) Name(s): _____	Reason: <input type="checkbox"/> Other group coverage through this employer <input type="checkbox"/> Individual coverage <input type="checkbox"/> Other group coverage by another group (i.e., spouse's employer) <input type="checkbox"/> Other: _____
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Declining dental coverage for: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner <input type="checkbox"/> Dependent(s) Name(s): _____	Reason: <input type="checkbox"/> Other group coverage through this employer <input type="checkbox"/> Individual coverage <input type="checkbox"/> Other group coverage by another group (i.e., spouse's employer) <input type="checkbox"/> Other: _____
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Declining vision coverage for: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner <input type="checkbox"/> Dependent(s) Name(s): _____	Reason: <input type="checkbox"/> Other group coverage through this employer <input type="checkbox"/> Individual coverage <input type="checkbox"/> Other group coverage by another group (i.e., spouse's employer) <input type="checkbox"/> Other: _____
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IF YOU ARE DECLINING COVERAGE – STOP AND READ CAREFULLY

I have decided to decline coverage for myself and/or my dependent(s). I acknowledge that my dependents and I may have to wait to be enrolled until the next annual Open Enrollment Period or Special Enrollment Period due to a qualifying event. The available coverages have been explained to me by my employer, and I have been given the chance to apply for the available coverages. Additionally, by signing below, I certify, to the best of my knowledge or belief, 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.)

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

ACKNOWLEDGMENT AND AGREEMENT: I understand and agree that by enrolling with or accepting services from Health Net, DBP and/or Fidelity, 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 represent that 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 belief, 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 Evidence of Coverage or Certificate of Insurance or my Health Net membership or 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 Evidence of Coverage or Certificate of Insurance. Mandatory Arbitration may not apply to certain disputes if the Employer's plan 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.

Employee signature: _____ Date: _____

(Sign only if accepting coverage. If signed in error, please cross out and initial.)

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

English	1-800-522-0088
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, vision or life coverage, please call:

Dental	1-866-249-2382
Vision	1-866-392-6058
Life	1-800-865-6288

If you have questions about your PPG or PCP, call your PPG 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.

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 urgent care 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 participating physician group as soon as possible to inform them about your condition.
- Call the number on your ID card within 48 hours of being admitted, or as soon as possible.

Precertification:

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

For precertification, please call 1-800-977-7282.

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 occurs 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: PureCare HSP Network, CommunityCare HMO Network, Full HMO Network, WholeCare HMO Network, SmartCare HMO Network, and Salud HMO y Más Network.

Health Net Life Insurance Company offers the following products: PureCare One EPO Network, PPO, Life and AD&D insurance.

Dental Benefit Providers of California, Inc. offers the following products: Dental HMO (DHMO).

Unimerica Life Insurance Company offers the following products: Dental PPO and Dental Indemnity.

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 60 days of the loss of coverage or acquisition of a new dependent.

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 폴리스에 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 Մատուցումներ: Դուք կարող եք բանավոր թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ Ձեր լեզվով: Օգնություն կամար մեզ զանգահարեք Ձեր ինքնություն (ID) տոմսի վրա նշված կամարով, կամ եթե գործատիրոջ խմբի դիմորդ եք, խնդրում ենք 1-800-522-0088 կամարով զանգահարել Health Net-ի Հանախորդի կապի կենտրոն: Անհատական և Ընտանեկան Ծրագրի (Individual and Family Plan/IFP) դիմորդներից խնդրում է զանգահարել 1-877-609-8711 կամարով: Լրացուցիչ օգնություն կամար 1-800-927-4357 կամարով 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 կամարով զանգահարեք DMHC-ի Օգնության Գծին: Ձեր ինքնություն 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 تكتبها 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 بخطة 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

