



Small Business Application

for Group Service Agreement/Group Policy

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 not obligations of, and are not guaranteed by, Health Net.

Application is hereby made for a Group Service Agreement/Group Policy provided by Health Net, DBP and/or Fidelity, the provisions of which are to be made available to all eligible employees, as defined, and their eligible dependents desiring or requiring coverage hereunder. The following information regarding employee and/or dependent data is being submitted to allow Health Net, DBP and/or Fidelity to determine the eligibility of employees and/or dependents seeking enrollment.

Welcome to Health Net

Simple steps for completing the form:

1. Carefully review and select the plan option(s) that are best for your business.
2. 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.**

Health Net Medical: 1-800-522-0088 (*English*)
1-800-331-1777 (*Spanish*)
1-877-891-9053 (*Mandarin*)

Health Net Life: 1-800-865-6288

Health Net Dental: 1-866-249-2382

Health Net Vision: 1-866-392-6058

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.



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Important: If adding Dental or Vision to your existing coverage, please complete sections 2, 3, 4, 7, 8, 10, 11, and 12; for all other changes to existing coverage, please complete only sections 2, 3, 4, and 11.

1. Health plan information

Groups taking multiple plans, select your package:

☐ Enhanced Choice A ☐ Enhanced Choice B

Full Network HMO¹

Platinum

☐ \$10 ☐ \$20

Gold

☐ \$30 ☐ \$40 ☐ \$50

CommunityCare HMO²

Gold

☐ \$5

Silver

☐ \$20

WholeCare HMO¹

Platinum

☐ \$10 ☐ \$20

Gold

☐ \$30 ☐ \$40 ☐ \$50

SmartCare HMO³

Platinum

☐ \$10 ☐ \$20

Gold

☐ \$30 ☐ \$40 ☐ \$50

Salud HMO y Más⁴

Platinum

☐ \$10 ☐ \$20

Gold

☐ \$30 ☐ \$40 ☐ \$50

PureCare One EPO¹

☐ Health Net Gold 80 EPO 1000/20 Alternate
☐ Health Net Silver 70 EPO 1800/30 Alternate

PureCare HSP¹

☐ Health Net Platinum 90 HSP 0/20 ☐ Health Net Silver 70 HSP 1500/45
☐ Health Net Gold 80 HSP 0/35 ☐ Health Net Bronze 60 HSP 6000/70

PPO

☐ Health Net Platinum 90 PPO 0/20 ☐ Health Net Gold 80 PPO 0/35 ☐ Health Net Silver 70 PPO 1500/45
☐ Health Net Bronze 60 PPO 6000/70 ☐ Health Net Bronze 60 HSA PPO 4750/15 Alternate

Other plan(s):

Ancillary options

Note: All medical plans include pediatric dental and pediatric vision coverage. Individuals will receive pediatric dental and vision coverage under the medical plan until the last day of the month in which the individual turns 19.

Dental (DHMO)

☐ HN Plus 150
☐ HN Plus 225

Dental (DPPO)

☐ Classic 5 1500 (w/ortho) ☐ Essential 2 1000
☐ Essential 6 1500 ☐ Classic 4 1500
☐ Essential 5 1500 (w/ortho)

Vision (PPO)

☐ Preferred 1025-2 ☐ Preferred 1025-3
☐ Preferred Value 10-2

Optional Rider ☐ Chiropractic (Optional coverage available on all plans except PPO.) ☐ Infertility

2. Employer group information

Company name:		DBA:	Group #:	SIC code:
Tax ID number (TIN):		Total number of employees worldwide:		
Type of business:	Type of entity (corporation, sole prop., LLC, partnership):	How long in business:	Effective date (renewal date):	
Company contact:		Telephone:	Fax:	
Physical address:		City:	State:	ZIP:
Billing address (if different from physical address):		City:	State:	ZIP:
Email address (print clearly):				
Company contact for coordination of benefits (COB) (if different from above):				
COB address (if different from physical address):		City:	State:	ZIP:

3. Employer contribution (Note: Employer contribution for Health is a minimum of 50% of the lowest cost plan (excluding Salud) or \$100 per employee, and for Life is 100% (1–9 enrollees) and 50% (10–100 enrollees)).

Employee Health: _____% or \$ _____ Employee Life: _____% Employee Dental: _____% Employee Vision: _____%
Dependent Health: _____% or \$ _____ Dependent Dental: _____% Dependent Vision: _____%

Note: Dental and Vision can be either voluntary or employer-paid. If employer-paid, you must complete the employer contribution. If you select Dental and/or Vision with no contribution, indicate “0.”

4. Eligibility information

1. Will there be eligibility conditions that will apply prior to the probationary period (e.g., being in an eligible job classification, achieving job-related licensure requirements, or satisfying a “reasonable and bona fide employment-based orientation period”)? ☐ Yes ☐ No
 2. Employer’s probationary period for new hires/rehires – First of the month following: ☐ Date of hire ☐ 1 mo. ☐ 30 days ☐ 60 days*
*Health Net will adjust the effective date for new enrollees if needed to ensure that the waiting period does not exceed 90 days.
 3. Do you want to waive the probationary period for all enrollees at initial enrollment? ☐ Yes ☐ No
 4. Average number of hours worked per week required to be eligible for medical insurance coverage: ☐ 20 ☐ 30
- | | Medical | Life | Dental | Vision |
|---|---|--|---------------|---------------|
| 5. Number of eligible employees (including eligible owner(s)): | _____ | _____ | _____ | _____ |
| 6. Total number of Health Net enrollees (excluding COBRA enrollees): | _____ | _____ | _____ | _____ |
| 7. Number of Health Net COBRA enrollees (applying for health coverage): | _____ | _____ | _____ | _____ |
| 8. Number of waivers (Please include an enrollment form with Section 7 “Declination of Coverage” indicated.): | _____ | _____ | _____ | _____ |
| 9. What type of COBRA ⁵ are you subject to?
If federal COBRA, how would you like your COBRA enrollees to be billed? | <input type="checkbox"/> Federal COBRA
<input type="checkbox"/> Group billed | <input type="checkbox"/> Cal-COBRA
<input type="checkbox"/> Member billed | | |
| 10. Within the last 12 months, has the employer held a Health Net contract? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 11. Do the eligible enrollees represent a carve-out either by location or union affiliation? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 12. Does the group file a DE-9C? | <input type="checkbox"/> Yes <input type="checkbox"/> No ⁶ | | | |

5. Life and AD&D benefit selection (If Health Net Life is selected, all full-time employees are eligible.)

- ☐ **Option A** – \$15,000 flat amount for all employees.
- ☐ **Option B** – \$25,000 flat amount for all employees (15–50 employees).
- ☐ **Option C** – \$50,000 flat amount for all employees (25–100 employees).

6. Pre-tax solutions (e.g., IRS code section 125 premium-only plans and Flex plans.)

If you are interested in learning about the tax savings potential for your employees and company, please contact Total Administrative Services Corporation (TASC) at 1-800-422-4661.

7. Current carrier (List current carrier if any.)

Is your company currently active with other health insurance? ☐ Yes ☐ No

If so, will you be canceling your other health insurance if approved with Health Net? ☐ Yes ☐ No

Current health insurance carrier: _____

Will Health Net be the only carrier? ☐ Yes ☐ No If "No," name of other carrier: _____

Plan(s) offered: _____

Workers' compensation carrier: _____

Number of enrollees not covered by workers' compensation: _____

(Employers required to have workers' compensation must have a policy in effect to be eligible with Health Net.)

8. Off-cycle dental/vision plan addition renewal cycle

Your renewal date for your dental and/or vision plan addition will be coordinated with your medical plan renewal date.

9. Mailing methods

Where would you like your Administration Kit mailed? ☐ Broker ☐ Employer

10. Underwriting criteria

General conditions

The issuance of coverage and a Group Service Agreement/Group Policy is subject to underwriting review and approval by Health Net, DBP and/or Fidelity and receipt of the first month's premium. The initial quoted rates are subject to Health Net, DBP and/or Fidelity's review and revision based on actual enrollment and any other variations in the group from conditions outlined in the Underwriting Assumptions.

Coverage will be effective on the noted effective date if the application is accepted and approved by Health Net, DBP and/or Fidelity as appropriate within specified time requirements.

11. Arbitration agreement and other important terms

Please complete all of the information requested before signing this application. Please initial any changes.

This is an application only. Coverage and the issuance of a Group Service Agreement/Group Policy is subject to review and approval by Health Net, DBP and/or Fidelity and receipt of the first month's premium.

The undersigned hereby acknowledge that the preceding information constitutes true and complete representations to Health Net, DBP and/or Fidelity. Should it be determined at the time of enrollment or during the 24-month period after the Group Agreement/Group Policy is issued that there has been an intentional misrepresentation of material fact, as prohibited by the terms of this Group Agreement/Group Policy, the Group Agreement/Group Policy may be canceled with 30 days advance notice of such cancellation.

Upon policy anniversary date, submission of renewal premium will confirm acceptance of that renewal and subsequent premium year.

Applicant, in the event this application is accepted, agrees to make authorized payroll dues deductions for such eligible employees who enroll under the Group Service Agreement/Group Policy and to forward such amounts in advance of the due date to Health Net, DBP and/or Fidelity, together with the reports necessary to maintain accurate and complete membership records.

Furthermore, applicant agrees to comply with the applicable regulations pertaining to membership requirements, additions to the group, and deletions from the group. Please return this application to your Health Net account executive or broker as specified.

Applicant, in the event this application is accepted, agrees to cooperate with Health Net in complying fully with the requirements of section 2715 of the Public Health Service Act to disclose summary plan and benefit information to eligible and renewing plan participants and beneficiaries. Applicant acknowledges that it has received information provided by the Health Net "Summary of Benefits and Coverage to Eligible and Covered Persons – Instructions for Reproduction and Distribution" and agrees to assume the responsibilities assigned to the "Group" thereunder. The undersigned hereby acknowledge responsibility for obtaining and for sending an electronic or printed copy of the Summary of Benefits and Coverage document ("SBC") to plan participants and beneficiaries. To retrieve your group's SBCs, go to www.healthnet.com/sbc.

The following standard minimum participation and contribution requirements apply unless modified in quote or renewal Underwriting assumptions.

11. Arbitration agreement and other important terms (continued)

Minimum contribution is defined as: The employer contribution toward Health Net's premium that must be equal to or greater than 50% or \$100 of employee single premium.

Minimum participation is defined as: For groups of 1–5 eligible employees, a minimum of 66% participation is required. For groups of 6–100 eligible employees, a minimum of 50% participation is required.

Failure to maintain these minimum contribution and minimum participation requirements may result in termination or non-renewal.

This Application for Group Service Agreement/Group Policy and any attached Addendum, together with the Health Net, DBP and/or Fidelity Plan Contract or Insurance Policy (as referenced herein), and the employee enrollment forms form the entire agreement between the parties.

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.

BINDING ARBITRATION AGREEMENT: On behalf of Group Applicant, and subject to certain restrictions prohibiting application of mandatory arbitration to members of employer groups subject to ERISA, 29 U.S.C. SECTION 1001, et seq., I understand and agree that any and all disputes or disagreements between Group (or enrolled members) and Health Net, DBP and/or Fidelity regarding the construction, interpretation, performance or breach of the Health Net, DBP and/or Fidelity Plan Contract or Insurance Policy, or regarding other matters relating to or arising out of the Health Net, DBP and/or Fidelity Plan Contract or Insurance Policy, whether stated in tort, contract or otherwise, 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 Health Net, DBP and/or Fidelity, are giving up their constitutional rights to the extent permitted by law to have their dispute decided in a court of law before a jury. I also understand that disputes with Health Net, DBP and/or Fidelity involving claims for medical services 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. In the event that the total amount of damages claimed is \$50,000 or less with respect to disputes involving alleged professional liability or medical malpractice, the parties shall, within 30 days of submission of the demand for arbitration, appoint a mutually acceptable single neutral arbitrator who shall hear and decide the case and have no jurisdiction to award more than \$50,000. If the parties fail to reach an agreement during this time frame, then either party may apply to a court of competent jurisdiction for appointment of the arbitrator(s) to hear and decide the matter, in accordance with California Code of Civil Procedure 1281.6. A more detailed arbitration provision is included in the Health Net, DBP and/or Fidelity Plan Contract or Insurance Policy.

Officer of the company signature:

Officer title:

Date:

Applicant's signature above confirms to the best of their knowledge or belief: 1) Applicant's agreement to all the terms and conditions set out in this Application, including the conditions of enrollment and Underwriting Assumptions; and 2) the accuracy and completeness of the information that the Applicant has entered in this Application.

12. Broker information

Broker name:	Health Net broker ID #:	Broker lic. #:	Date submitted:
Agency name:	Telephone #:	Fax #:	Email address:
Address:	City:	State:	ZIP:
Broker/Consultant signature:	Date:	Account executive name:	Date:
General agent/ID #:	Date:		

13. 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

14. For Health Net use only

Underwriter signature:	Date:	Approved: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision Declined: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Billing #:	Effective date:
SBG representative signature:	Date:	Group # (Health):	Policyholder # (Life):	Medical plan:

Health Net of California, Inc. offers the following products: HMO, Salud con Health Net HMO y Más and HSP. Health Net Life Insurance Company offers the following products: PPO, EPO and Life and AD&D insurance. Unimerica Life Insurance Company offers the following products: Dental PPO and Dental Indemnity. Dental Benefit Providers of California, Inc. offers the following product: Dental HMO. Fidelity Security Life Insurance Company offers the following product serviced by EyeMed Vision Care, LLC: Vision PPO.

"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.

Small Business Group submission checklist

To ensure prompt processing, please make sure to include the following documents.

Groups applying for a 1st-of-the-month effective date must be submitted to Health Net by the 5th of the month. Paperwork must be completed by the 20th of the month; otherwise, the group will be rolled to the following month.

- ☐ A signed original application for Group Service Agreement (GSA)/Group Policy
- ☐ A complete employee application for each eligible employee enrolling/waiving coverage
- ☐ A check or a Check-by-Fax form for the first month's premium drawn from the group account
- ☐ The latest quarter DE-9C, reconciled:
 - If the group has not been in business long enough to have a DE-9C, six weeks of payroll, including withholdings, may be submitted.
 - 2-week payroll is required for all employees that don't appear on the current DE-9C.
 - For wages exceeding part-time and wages below full-time status, payroll will be required.
 - To reconcile the DE-9C, please indicate next to each employee's name one of the following:
T – Terminated (including termination date)
E – Eligible and enrolling
W – Eligible and waiving coverage
S – Seasonal
WP – Waiting period (include date of hire for those in waiting period)
TEMP – Temporary employees
PT – Part-time
Covered by another carrier – add carrier name.
- ☐ Ownership paperwork (required if owner/partners' names do not appear on the DE-9C or payroll records). Must list each person's first and last name. Paperwork must be filed with the state or county. Documentation may include:

For sole proprietor:

- California Business License
- Fictitious Business Name Statement
- Schedule C Tax Form

For partnership:

- California Business License (showing both names)
- Fictitious Business Name Statement (showing both names)
- Schedule K Tax Form (for all eligible owners)
- Tax certificate (showing both names)

For corporation:

- Articles of Incorporation
- Statement of Information
- Tax Form 1120

Note: Please consult your sales representative for acceptable ownership documentation for other business structures.

For PPO plans:

- ☐ Copies of EOBs for employees requesting Deductible Credit from prior carrier

Send all completed paperwork to your designated account executive or broker.

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.

⁵**Note:** 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.

⁶If a DE-9C is not available, please provide a letter of explanation and supporting documentation, subject to underwriting approval, with this group service agreement application.

Health Net of California, Inc. and Health Net Life Insurance Company are subsidiaries of Health Net, Inc. Health Net and Salud con Health Net are registered service marks of Health Net, Inc. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

Ensure Your Employees Understand Their Health Care

Summary of Benefits and Coverage to eligible and covered persons

Instructions for
reproduction
and distribution.

Affordable Care Act (ACA)¹ requirement for employers that sponsor group health plans

As required by the ACA, health plans and employer groups must provide the Summary of Benefits and Coverage (SBC) to eligible employees and family members, who are:

- currently enrolled in the group health plan, or
- eligible to enroll in the plan, but not yet enrolled, or
- covered under COBRA Continuation coverage.

Health Net is committed to ensuring compliance with all timing and content requirements with regard to the distribution of the SBC. To meet this goal, you are required to provide the SBC in the **exact and unmodified form**, including appearance and content, as provided to you by Health Net.

Please follow the instructions below so you will know how to distribute the SBC.

SBC form and manner

You may provide the SBC to eligible or covered individuals in paper or electronic form (i.e., email or Internet posting).

- If you provide a paper copy, the SBC must be in the exact format and font provided by Health Net, and, as required under the ACA, must be copied on *four double-sided pages*.
- If you mail a paper copy, you may provide a single SBC to the employee's last known address, unless you know that a family member resides at a different address. In that case, you must provide a separate SBC to that family member at the last known address.
- For covered individuals, you may provide the SBC electronically if certain requirements from the U.S. Department of Labor are met.²
- If you email the SBC, you must send the SBC in the exact electronic PDF format provided to you by Health Net.
- If you post the SBC on the Internet, you must advise your employees by email or paper that the SBC is available on the Internet, and provide the Internet address. You must also inform your employees that the SBC is available in paper form, free of charge, upon request. You may use the Model Language below for an e-card or postcard in connection with a website posting of a SBC:

(continued)

¹26 C.F.R. § 54.9815-2715; 29 C.F.R. § 2590.715-2715; and 45 C.F.R. § 147.200.

²Such requirements can be found at 29 C.F.R. § 2520.140b-1(b)

This document is provided to you as a customer courtesy and is not intended to be legal advice. Please consult with your own legal counsel to determine your responsibilities under the SBC regulations of the Affordable Care Act.

Availability of Summary Health Information

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC). The SBC summarizes important information about any health coverage option in a standard format to help you compare across options.

The SBC is available online at: <group's website.com>. A paper copy is also available, free of charge, by calling the toll-free number on your ID card.

Timing of SBC distribution

- **Upon application.** If you distribute written application materials, you must include the SBC with those materials. If you do not distribute written application materials for enrollment, you must provide the SBC *by the first day the employee is eligible to enroll in the plan.*
- **Special enrollees.** For special enrollees³, you must provide the SBCs *within 90 days following enrollment.*
- **Upon renewal.** If open enrollment materials are required for renewal, you must provide the SBC *no later than the date on which the open enrollment materials are distributed.* If renewal is automatic, you must provide the SBC *no later than 30 days prior to the first day of the new plan year.* If your group health plan is renewed less than

30 days prior to the effective date, you must provide the SBC *as soon as practicable, but no later than 7 business days after issuance of new policy or the receipt of written confirmation of intent to renew your group health plan.*

At the time your plan renews, you are not required to provide the Health Net SBC to an employee who is not currently enrolled in a Health Net plan. However, if an employee requests a Health Net SBC, you must provide the SBC as soon as you can, but no later than 7 business days following your receipt of the request.

Notice of SBC modification

Occasionally, there will be a material change(s) to the SBCs other than in connection with a renewal, such as changes in coverage. You must provide notice of the material changes to employees *no later than 60 days prior to the date on which change(s) become effective.* You must provide this notice in the same number, form and manner as described above. When such changes are initiated by Health Net, Health Net will provide you with modified SBCs for distribution.

Uniform glossary

Employees and family members can access a glossary of bolded terms used in the SBC by visiting www.cciio.cms.gov, or by calling Health Net at the number on the ID card to request a copy. Health Net shall provide a written copy of the glossary to callers within 7 business days after Health Net receives their request.

If you have any questions, please contact your Health Net client manager.

³Special enrollees are individuals who request coverage through special enrollment. Regulations regarding special enrollment are found in the U.S. Code of Federal Regulations, at 45 C.F.R. 146.117 and 26 C.F.R. 54.9801-6, and 29 C.F.R. 2590.701-6