Health Net®

Open Enrollment Medical Plan Change Request *Form*

Effective through 12/1/2016

Please use this form to indicate plan changes for your employees and their dependents during your renewal. Please call your authorized Health Net of California, Inc. or Health Net Life Insurance Company (Health Net) broker or Health Net account manager, or refer to the Group Policy and Procedures Guide, for acceptable plan changes and guidelines.

Group contact information

Group number:	Group name:		Renewal effective date:
Group contact:	Contact phone:	Contact fax:	Contact email address:

Optional Rider information

Do you want to add the Infertility Rider Benefit to your medical plan offerings?: ☐ Yes ☐ No

NOTE: You must provide the *Summary of Benefits and Coverage* (SBC) to each individual listed on this form before the individual makes the plan choice and PRIOR TO SUBMITTING THIS FORM TO HEALTH NET. To download and print an SBC, go to www.healthnet.com/sbc. Or, please contact your Health Net account manager to obtain a copy. Please indicate with a check, using blue or black ink, the plan each member wishes to move into.

Please list all **currently enrolled** members making plan changes during Open Enrollment on this form. New enrollees will need to submit separate enrollment applications. Please photocopy this form if more space is required. Please fax completed forms to the Health Net Account Management Department. For groups located in Southern California, please fax to (818) 676-6297, and for Northern California, please fax to 1-800-303-3110.

Member's name	Member's SSN or reference ID #	Group #	Primary care physician's enrollment ID #	HMO																				
				Full network					WholeCare					SmartCare					Salud					CommunityCare	
				Platinum $10	Platinum $20	Gold $30	Gold $40	Gold $50	Platinum $10	Platinum $20	Gold $30	Gold $40	Gold $50	Platinum $10	Platinum $20	Gold $30	Gold $40	Gold $50	Platinum $10	Platinum $20	Gold $30	Gold $40	Gold $50	Gold $5	Silver $20

(continued)

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Member's name	Member's SSN or reference ID #	Group #	Primary care physician's provider ID #[1]	PPO					PureCare HSP				PureCare One EPO	
				Platinum 90 PPO 0/20	Gold 80 PPO 0/35	Silver 70 PPO 1500/45	Bronze 60 PPO 6000/70	Bronze 60 HSA PPO 4750/15 Alternate	Platinum 90 HSP 0/20	Gold 80 HSP 0/35	Silver 70 HSP 1500/45	Bronze 60 HSP 6000/70	Gold 80 EPO 1000/20 Alternate	Silver 70 EPO 1800/30 Alternate

[1]Selecting a primary care physician is not required on PPO or PureCare One EPO plans.

As an owner or officer of stated company, I hereby authorize the above changes to our Health Net Group medical coverage. I have informed the employees listed above that the enrollment terms of the Health Net form they completed previously at enrollment are still in force and a copy is available upon request.

Printed name	Signature	Date