

# Federal Employee Non-FEHB DHMO Plus 225 Plan - Enrollment Form



## INSTRUCTIONS FOR COMPLETING ENROLLMENT FORM

- **Check all appropriate boxes and print all information clearly.** (Please retain the brochure information until you receive your ID card.)
- **Subscriber:** Fill out section completely. **Remember to indicate the Provider ID Number you have selected.**
- **Dependents:** All dependents you wish to be covered should be listed in this section with their selected **Provider ID Number.**
- **Method of Payment:** Please indicate your preferred method of payment.
- **Terms and Conditions:** Read the Terms and Conditions on the adjacent page and sign in the box at the "X" on the bottom of the sheet. This form must be signed for coverage to be effective. Your payment and completed enrollment form must be received by the 20th of the month for coverage to be effective the 1st of the following month.

SUBSCRIBER (You)		Please Complete all sections. This form cannot be processed if information is incomplete.			
Last Name		First Name		MI	
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Social Security Number		Home Phone	
Mailing Address		City	State	Zip	Work Phone
Provider ID Number			Have you received treatment from this dental office? <input type="checkbox"/> Yes <input type="checkbox"/> No		
For Federal Employees Only - Employer:			Agency		
DEPENDENTS (Your spouse and/or children)					
<b>1</b>	Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son	Last Name		First Name MI	
	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth		Social Security Number	
	Provider ID Number			Have you received treatment from this dental office? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>2</b>	Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son	Last Name		First Name MI	
	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth		Social Security Number	
	Provider ID Number			Have you received treatment from this dental office? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>3</b>	Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son	Last Name		First Name MI	
	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth		Social Security Number	
	Provider ID Number			Have you received treatment from this dental office? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>4</b>	Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son	Last Name		First Name MI	
	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth		Social Security Number	
	Provider ID Number			Have you received treatment from this dental office? <input type="checkbox"/> Yes <input type="checkbox"/> No	
I understand and agree to the terms and conditions on the adjacent page.					
<b>X</b>					
Enrollee Signature				Date	

**Mail to:**

Attn: Health Net IFP Enrollment  
P.O. Box 1150, Rancho Cordova, CA 95741-1150  
Tel: 1-800-909-3447 · Fax: 1-800-977-4161



- Remember to select a provider!
- Be sure to read the terms and conditions below and sign in the box at the "X."

**TERMS AND CONDITIONS (Please read and sign on adjacent page)**

I agree and understand that any all disputes, including claims relating to the delivery of services under the plan and claims of medical/dental malpractice (that is as to whether any dental services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) except for claims subject to ERISA, between myself and my dependents enrolled in the plan (including any heirs or assigns) and Health Net of California, Inc. (HNCA) or any of its parents, subsidiaries or affiliates shall be determined by submission to binding arbitration. However, in the event the amount in controversy in the dispute including any claims of damage is not greater than \$5,000.00, such disputes are not subject to binding arbitration hereunder. Disputes in which more than \$5,000.00 is in controversy will not be resolved by a lawsuit or resort to court process, except as applicable law may provide for judicial review of arbitration proceedings. By enrolling in HNCA both member (including any heirs or assigns) and HNCA entities agree to waive the constitutional right to a jury trial and instead voluntarily agree to the use of binding arbitration as described in the Evidence of Coverage.

**I AM ENCLOSING A CHECK FOR FIRST MONTH'S PREMIUM PAYMENT.**

Checks should be made payable to Health Net, Inc. and mailed with the completed application to:

Health Net Individual & Family Enrollment  
PO Box 1150  
Rancho Cordova, CA 95741-1150

**Bank draft for first month's premium payment**

Please select your account type:  Checking  Savings

Transit routing number (9 digits)

Account number

Bank name

State

I understand that, by requesting the bank draft payment option, I am authorizing Health Net of California ("Health Net") and my financial institution named above, to debit my checking or savings account for my initial premium. I understand my premium amount may vary due to enrollment status changes, which may include retroactive premiums due.

I understand that if there are insufficient funds at the time my account is debited, a service fee of \$25.00 (in addition to any fees my bank may charge me) will be assessed by Health Net for all dishonored payments. I further agree that if any such debit is dishonored, whether with or without cause and whether intentionally or inadvertently, Health Net shall be under no liability whatsoever even though such dishonor may result in the loss of health coverage.

**X**

Signature of account holder (required to process)

Date