Health Net Life California Farm Bureau Federation Medicare Supplement

Enrollment Form

Optional Supplemental Benefits Package

Package plan #1: Monthly Plan Premium: $27; Benefits: Standard PPO Dental and PPO Vision Plans

Package plan #2: Monthly Plan Premium: $41; Benefits: Enhanced PPO Dental and PPO Vision Plans

Please refer to the Optional Supplemental Benefits Guide Outline of Coverage for detailed benefits and costs associated with each plan.

Premiums for Optional Supplemental Benefit Packages will be added to your Medicare Supplement Health Plan billing statement and set up on the same premium payment mode (i.e., check, automatic bank draft) as your health plan.

In order to enroll in an Optional Supplemental Benefits Package, you must enroll in or be enrolled in a Health Net Life Insurance Company California Farm Bureau Federation Medicare Supplement Plan and reside in the state of California. Please keep the pink copy of this form as your proof of enrollment.

Your personal information (please print):		
Last name:	First name:	MI:
Primary residence address (PO Box is not allowed):		
City:	State:	ZIP:
Mailing address (only if different from primary residence address):		
City:	State:	ZIP:
Subscriber / Reference ID #:	Medicare claim #:	
Home telephone #: (___ ___ ___) ___ ___ ___ – ___ ___ ___ ___	Date of birth: ___ ___/___ ___/___ ___ ___ ___ M M / D D / Y Y Y Y	

Please check one of the following:

☐ I am enrolling in or currently enrolled in a Health Net Life California Farm Bureau Federation Medicare Supplement Plan and wish to enroll in the Optional Supplemental Benefits Package Plan #_________ for an additional monthly premium of $________________.
Requested effective date ___ ___/___ ___/___ ___ ___ ___
M M / D D / Y Y Y Y

☐ I am currently enrolled in Optional Supplemental Benefits Package Plan #_________ and would like to transfer to Optional Supplemental Benefits Package Plan #_________.
Requested effective date ___ ___/___ ___/___ ___ ___ ___
M M / D D / Y Y Y Y

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White – Health Net   Yellow – Writing Agent   Pink – Member

I understand that my signature on this application means that I have read and understand the contents of this application.

Print name:	
Your signature[1]: ______________________________	Date: __ __/__ __/__ __ __ __ M M / D D / Y Y Y Y

[1]Or the signature of the person authorized to act on behalf of the individual under the laws of the state where the individual resides. If signed by the authorized individual (as described above), this signature certifies that: (a) this person is authorized under state law to complete this enrollment, and (b) a copy of the authorization form, Durable Power of Attorney for Health Care or similar document, is included with this application.

If you are the authorized representative, you must provide the following information:			
Last name:	First name:		MI:
Address:	City:	State:	ZIP:
Phone #: (__ __ __) __ __ __ – __ __ __ __	Relationship to enrollee:		

If you terminate coverage, you must wait 12 months until you may again apply for coverage.

Health Net Life will notify you when your effective date of coverage begins.

Thank you for choosing Health Net Life. If you have any questions about enrolling in a Health Net Life Optional Supplemental Benefits Package, call Health Net Life at **1-800-944-7287 (TTY/TDD 1-800-929-9955)**, Monday through Friday, 8:00 a.m. to 6:00 p.m., except holidays.

Broker office use only

Broker name: ______________________________

Phone #: ______________ ID #: ______________

FMO/GA/Agency name: ______________________________

Phone #: ______________ ID #: ______________

Broker rep received date: ______________ Broker email address: ______________

Health Net sales rep office use only

Sales rep name: ______________________________

Phone #: ______________ ID #: ______________

Sales rep received date: ______________ Sales rep email address: ______________

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