Health Net®
LIFE INSURANCE COMPANY

Health Net Life Individual Medicare Supplement

Enrollment Form

Optional Supplemental Benefits Package

Package plan #1: Monthly plan premium: $29; Benefits: Hearing care, Standard PPO Dental and PPO Vision

Package plan #2: Monthly plan premium: $43; Benefits: Hearing care, Enhanced PPO Dental and PPO Vision

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

Premiums for Optional Supplemental Benefit Packages will be added to the current 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 Individual Medicare Supplement Plan and reside in the State of California. Please keep the yellow 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 am currently enrolled in, a Health Net Life Individual 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

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 Insurance Company (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: 711)**. From October 1 through February 14, our office hours are 8:00 a.m. to 8:00 p.m., 7 days a week, excluding certain holidays. However, after February 14, our office hours are 8:00 a.m. to 8:00 p.m., Monday through Friday.

Dental services are offered by Health Net Dental, but are underwritten by Unimerica Life Insurance Company and administered by Dental Benefit Administrative Services.

STATEMENT OF UNDERSTANDING

I have read this application and represent that the information shown on it is true and complete to the best of my knowledge or belief. I understand that: (a) no insurance will become effective unless my application is approved and the appropriate premium is received by Unimerica Life Insurance Company with this application; (b) if other dental insurance exists that duplicates coverage under the dental plan being applied for, the existing dental coverage must be terminated prior to the effective date of this coverage; (c) if coverage is issued, the coverage will not be a continuation of any prior coverage; and (d) the policy being applied for may contain waiting periods for certain benefits. Incorrect or incomplete information on this application may result in voidance of coverage and claim denial. The information provided in this application, and any supplement or amendments to it, will be made a part of any policy that may be issued. I understand that, for an application sent by mail or sent by any electronic means, insurance, if approved, will be effective the later of: (i) the requested effective date; or (ii) the effective date that Unimerica Life Insurance Company notifies me coverage begins.

Print name:	
Proposed insured's signature:	Date: __ __/__ __/__ __ __ __ M M/ D D / Y Y Y Y
Signature of authorized representative (if applicable):	

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: _____