Please print out the form below and mail your completed form to:

Health Net Enrollment Services
PO Box 10420
Van Nuys, CA 91410-0420

HEALTH NET MEDICARE PROGRAMS INDIVIDUAL ENROLLMENT FORM

Please follow these simple instructions to enroll in Health Net Medicare Programs.

ARE YOU ELIGIBLE?

You are eligible to enroll in Health Net Medicare Programs if:

- You are entitled to Medicare Part A (hospital insurance) and enrolled in Part B (medical insurance). For Dual Eligible Seniority Plus Amber I and Seniority Plus Amber II you need to be enrolled in Medi-Cal plans.
- You reside in one of the Health Net Medicare Programs plans service areas.
- You do not have end-stage renal disease (ESRD) – kidney failure,[1] or if you had ESRD but have had a transplant that restored kidney function and you no longer require a regular course of dialysis to maintain life (documentation from your physician is required).

[1]An individual with ESRD whose enrollment in an MA plan was terminated on or after December 31, 1998, as a result of a contract termination, non-renewal, or service area reduction can make one enrollment request into a new MA plan.

Mail us your completed enrollment form *in the envelope provided.* Your effective date of coverage depends on when you return this form to us.

We will be in touch soon. We'll send you a letter confirming your effective date of enrollment. We'll also send a welcome kit with your ID card. Until you receive your ID card, please use your pink copy of this enrollment form as your temporary ID card.

If you have any questions, please call our representatives:

- For Health Net Seniority Plus and Healthy Heart, call: 1-800-977-6738 (TDD/TTY 1-800-929-9955)
- For Health Net Options Plus, call: 1-800-579-9096 (TDD/TTY 1-800-929-9955)

Representatives are available from 8:00 a.m. to 8:00 p.m., 7 days a week.

Health Net Seniority Plus, Healthy Heart and Health Net Options Plus mailing address:

P. O. Box 10420
Van Nuys, CA 91410-0420

Material ID# M0004-CA-08-5034 (H0562, H5439)
CMS Approval 10/08

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Health Net® MEDICARE PROGRAMS

HEALTH NET MEDICARE PROGRAMS
INDIVIDUAL ENROLLMENT FORM

1. CHOOSE YOUR PLAN – PLEASE CHOOSE ONLY ONE

Please refer to the Summary of Benefits for detailed information, service areas, benefits and costs associated with each plan. Some plans are not available in all service areas.

Are you currently a Health Net member? ☐ Yes ☐ No

Please check which plan you want to enroll in:

____ Health Net Healthy Heart I (includes prescription drug coverage)

____ Health Net Healthy Heart II (includes prescription drug coverage)

____ Health Net Seniority Plus Green (does not include prescription drug coverage)
(in San Diego County, please check ☐ Plan 1 ☐ Plan 2 ☐ Plan 3)

____ Health Net Seniority Plus Ruby (includes prescription drug coverage)
(in San Diego County, please check ☐ Plan 2 ☐ Plan 3)

____ Health Net Seniority Plus Amber (Congestive Heart Failure/Chronic Obstructive Pulmonary Disease) (includes prescription drug coverage)

____ Health Net Seniority Plus Amber I (All Dual Eligible beneficiaries enrolled in Medicare and Medi-Cal) (includes prescription drug coverage)

____ Health Net Seniority Plus Amber II (Full Benefit Dual Eligible beneficiaries enrolled in Medicare and Medi-Cal) (includes prescription drug coverage)

____ Health Net Options Plus Violet (PPO) (includes prescription drug coverage)

____ Optional Supplemental Benefits Package Plan #__________ for an additional monthly plan premium of $__________

Monthly Plan Premium Amount $________ **Requested Effective Date ________**

2. TELL US ABOUT YOURSELF

LAST Name:	FIRST Name:	Middle Initial:	☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex: ☐ M ☐ F	Social Security Number: (providing this information is optional)	Home Phone Number: ( )
Permanent Residence Street Address:			County:
City:		State:	ZIP Code:
E-mail Address:			
Mailing Address (if different from your Permanent Residence Street Address): Street Address:			
City:		State:	ZIP Code:

Emergency Contact: ______________________________ Relationship to You: ____________________

Phone Number: __________________________ E-mail Address: ______________________________

3. YOUR MEDICARE INFORMATION

Your Medicare # (from red, white & blue Medicare card)	Entitlement: Part A Hospital date: ______________ Part B Medical date: ______________

Member last name:

White – Medicare Files Yellow – Medicare Programs Pink – Member

4. FOR SENIORITY PLUS AND HEALTHY HEART PLANS ONLY

Provider Selection from a Health Net Medicare Programs provider directory Existing patient ☐ Yes ☐ No

Selected Health Net Participating Provider Group (PPG) Name	PPG ID #
Selected Primary Care Physician (PCP) Name	PCP ID #

5. PLEASE READ AND ANSWER THESE IMPORTANT QUESTIONS

1. Do you have End Stage Renal Disease (ESRD)? ☐ Yes ☐ No
2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

   Will you have other prescription drug coverage in addition to Health Net? ☐ Yes ☐ No
   If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

   Name of other coverage: ____________ ID# for this coverage: ____________ Group# for this coverage: ____________
3. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
   If "yes" please provide the following information:

   Name of Institution: ____________

   Address & Phone Number of Institution (number and street): ____________
4. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No
   If yes, please provide your Medicaid number: ____________
5. Do you or your spouse work? ☐ Yes ☐ No

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:

☐ Spanish ☐ Chinese ☐ Other: ____________

Please contact Health Net at 1-800-977-6738 (Seniority Plus and Healthy Heart) or 1-800-579-9096 (Health Net Options Plus). TTY users should call 1-800-929-9955 if you need information in another format or language other than what is listed above. Our office hours are 8:00 a.m. – 8:00 p.m., 7 days a week.

6. YOUR PLAN PREMIUM OPTIONS

Skip this section if you have selected a $0 premium MA-PD plan and do not owe a late enrollment penalty. If we determine that you owe a late enrollment penalty, we need to know how would prefer to pay it. You can pay by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security Check each month.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover.

If you don't select a payment option, you will receive a bill each month.

Please select a premium payment option:

☐ Receive a bill

☐ Electronic funds transfer (EFT) from your bank account each month. Please complete an Automatic Bank Draft form and provide a voided check if your checking account is to be used.

☐ Automatic deduction from your monthly Social Security benefits check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point of withholding begins.)

Member last name:

White – Medicare Files Yellow – Medicare Programs Pink – Member

7. PLEASE READ THIS IMPORTANT INFORMATION AND SIGN

I understand that my signature on this enrollment form certifies that I have read and understand the information contained on **both sides** of this form. I agree to abide by Health Net Medicare Programs membership rules as outlined in the Evidence of Coverage **(please read your Evidence of Coverage document to know what rules you must follow in order to receive coverage with Health Net Medicare Programs).**

X ______________________________________ ____________ ______________________________

Signature of Enrollee | Date | Health Net Medicare Programs Representative's signature

If you are the authorized representative, you must provide the following information:

Name: ____

Address:

____

Phone Number: (___) _____ - _______ **Relationship to Enrollee:** ____________________

8. PLEASE READ THIS IMPORTANT INFORMATION AND SIGN

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. In addition, you can join a Medicare Advantage plan during the open enrollment period between January 1 and March 31 of each year, as long as you do not change your prescription drug coverage. Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.
- ☐ I recently moved outside of the service area for my current plan.
- ☐ I recently moved and this plan is a new option for me.
- ☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- ☐ I receive extra help paying for Medicare prescription drug coverage.
- ☐ I am no longer eligible for extra help paying for my Medicare prescription drugs.
- ☐ I live in or recently moved out of a Long Term Care Facility (for example, a nursing home or long term care facility).
- ☐ I recently left a PACE program.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's)
- ☐ I am leaving employer or union coverage.
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ I recently returned to the United States after living permanently outside of the U.S.
- ☐ None of these statements apply to me.*

* Please contact Health Net at 1-800-977-6738 (Seniority Plus and Healthy Heart) or 1-800-579-9096 (Health Net Options Plus). TTY users should call 1-800-929-9955 to see if you are eligible to enroll. We are open 8 am – 8 pm, 7 days a week.

Authorized Agent Use Only:

Broker Name:____________________ Broker Phone #:______________ Broker HN ID#:__________

GA/FMO Name:____________________ GA/FMO Phone #:______________ GA/FMO HN ID#:__________

Health Net Rep Name:______________ Health Net Rep Phone #:__________ Health Net Rep ID#__________

HN ENROLLMENT SERVICES ONLY	Group #	Election type
Correction of Member information (PPG, PCP, etc.)		

Member last name:

White – Medicare Files   Yellow – Medicare Programs   Pink – Member

Please read this important section

If you currently have health coverage from an employer or union, joining Health Net Medicare Programs could affect your employer or union health benefits. If you have health coverage from an employer or union, joining Health Net Medicare Programs may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please read below

By completing this enrollment form, I agree to the following:

Health Net of California Inc. (HNCA) and Health Net Life Insurance Company (HNL) is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Parts A and B. I can be in only one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future I understand that if I do not have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: November 15 – December 31 of every year), or under certain special circumstances.

HNCA and HNL serves a specific service area. If I move out of the area that HNCA or HNL serve, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of HNCA or HNL, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from HNCA or HNL when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

For Health Net Seniority Plus and Healthy Heart plans only:

I understand that beginning on the date Health Net Seniority Plus or Healthy Heart coverage begins, I must get all of my health care from Health Net Seniority Plus or Healthy Heart, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by Health Net Seniority Plus or Healthy Heart and other services contained in my Health Net Seniority Plus or Healthy Heart Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, ***NEITHER MEDICARE NOR HEALTH NET SENIORITY PLUS OR HEALTHY HEART WILL PAY FOR THE SERVICES.***

For Health Net Options Plus plan only:

I understand that beginning on the date Health Net Options Plus coverage begins, using services in-network can cost less than using services out-of-network, with the exception of emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Health Net Options Plus provides reimbursement for all covered benefits, even if received out of network. Services authorized by Health Net Options Plus and other services contained in my Health Net Options Plus Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, ***NEITHER MEDICARE NOR HEALTH NET OPTIONS PLUS WILL PAY FOR THE SERVICES.***

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Health Net Medicare Programs, he/she may be compensated based on my enrollment in Health Net Medicare Programs.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

By joining this plan, I attest that I am not receiving any financial support from my current or former employer group or union (or my spouse's current or former employer group or union) intended for the purchase of medical services or medical coverage, prescription drugs or prescription drug coverage or to pay for, in whole or in part, my enrollment in a Medicare Advantage or Medicare drug plan.

Release of information

By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Health Net Medicare Programs will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Health Net Medicare Programs or by Medicare.

Note: This document is available in alternative formats.