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

2010 HEALTH NET MEDICARE ADVANTAGE PLANS INDIVIDUAL ENROLLMENT FORM

Please follow these simple instructions to enroll in a Health Net Medicare Advantage Plan.

ARE YOU ELIGIBLE?

You are eligible to enroll in a Health Net Medicare Advantage Plan if:

- You are entitled to Medicare Part A (hospital insurance) and enrolled in Part B (medical insurance). For Dual Eligible Seniority Plus Amber I (HMO) and Seniority Plus Amber II (HMO), you need to be enrolled in Medi-Cal plans. For Health Net Seniority Plus Amber CHF (HMO), you must have been diagnosed with Congestive Heart Failure (CHF).
- You reside in one of the Health Net Medicare Advantage plan's 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.

Please fill out all 8 pages and 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 (HMO), Health Net Healthy Heart (HMO), and Salud con Health Net Medicare Advantage (HMO), call 1-800-977-6738 (TTY/TDD 1-800-929-9955).
- For Health Net Violet (PPO), call 1-800-579-9096 (TTY/TDD 1-800-929-9955).

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

Health Net Medicare Advantage Plans mailing address:

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

Material ID# M0004_2010_0127 (H0562, H5439)
CMS Approval (9/09)

Health Net®
MEDICARE PROGRAMS

HEALTH NET MEDICARE PROGRAMS
INDIVIDUAL ENROLLMENT FORM

Please contact Health Net if you need information in another language or format (Braille).

1. TO ENROLL IN HEALTH NET, PLEASE PROVIDE THE FOLLOWING INFORMATION

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 (HMO) (includes prescription drug coverage)

____ Health Net Healthy Heart Plan 1 (HMO) (includes prescription drug coverage)
__ LA, Orange, Riverside, San Bernardino __ Sacramento

____ Health Net Healthy Heart Plan 2 (HMO) (includes prescription drug coverage)
__ LA, Orange, Riverside, San Bernardino

____ Salud con Health Net Medicare Advantage (HMO) (includes prescription drug coverage)

____ Health Net Seniority Plus Green (HMO) (does not include prescription drug coverage)

____ Health Net Seniority Plus Ruby (HMO) (includes prescription drug coverage)

____ Health Net Seniority Plus Ruby Plan 1 (HMO) (includes prescription drug coverage)

____ Health Net Seniority Plus Ruby Plan 2 (HMO) (includes prescription drug coverage)
__ LA, Orange, Riverside, San Bernardino __ San Diego

____ Health Net Seniority Plus Ruby Plan 3 (HMO) (includes prescription drug coverage)

____ Health Net Seniority Plus Amber CHF (HMO) (Congestive Heart Failure)
(includes prescription drug coverage)

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

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

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

Please check if you would like to enroll in Optional Supplemental Benefits for an additional monthly premium:

☐ Optional Supplemental Package #1 $15 per month

☐ Optional Supplemental Package #2 $18 per month

☐ Optional Supplemental Package #4 $19 per month

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

Member last name:

White – Health Net Yellow – Writing Agent Pink – Member

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	Home Phone Number ( )	Alternate Phone Number (optional): ( )

Permanent Residence Street Address (P.O. Box is not allowed):		County:
City:	State:	ZIP Code:

E-mail Address (optional):

Mailing Address (if different from your Permanent Residence Street Address):
Street Address:

City:	State:	ZIP Code:

Emergency Contact (optional): _____ Relationship to You: _____
Phone Number: _____ E-mail Address (optional): _____

3. PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card

- OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Name: _____

Medicare Claim Number Sex ___

__ __ __ - __ __ - __ __ __ __ ___

Is Entitled To Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

4A. FOR HEALTH NET SENIORITY PLUS (HMO), HEALTH NET HEALTHY HEART (HMO), AND SALUD CON HEALTH NET MEDICARE ADVANTAGE (HMO) PLANS:

Provider Selection from a Health Net Medicare Advantage provider directory

Existing patient ☐ Yes ☐ No

Selected Health Net Participating Provider Group (PPG) Name	PPG ID #

Selected Primary Care Physician (PCP) Name	PCP ID #

4B. FOR HEALTH NET VIOLET (PPO) ONLY:

Primary Physician/Doctor Name _____

Please note: This information is optional and the physician name will not appear on your Health Net ID card. You are not limited to accessing services with this provider only.

5. PLEASE READ AND ANSWER THESE IMPORTANT QUESTIONS

1. Do you have End-Stage Renal Disease (ESRD)? ☐ Yes ☐ No
   If you answered "yes" to this question and you don't need regular dialysis any more, or if you have had a successful kidney transplant, **please attach a note or records** from your doctor showing you don't need dialysis or have had a successful kidney transplant.
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 (Medi-Cal) program? ☐ Yes ☐ No
   If yes, please provide your Medicaid (Medi-Cal) number: _____
5. Do you or your spouse work? ☐ Yes ☐ No
6. For Health Net Seniority Plus Amber CHF (HMO) plan only: Do you have congestive heart failure (CHF)? ☐ 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 ☐ Large Print ☐ Other: _____

Please contact Health Net at 1-800-977-6738 (Seniority Plus (HMO), Healthy Heart (HMO), and Salud con Health Net Medicare Advantage (HMO),) or 1-800-579-9096 (Health Net Violet (PPO) 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. TTY users should call 1-800-929-9955.

6. PAYING YOUR PLAN PREMIUM

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 you 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 benefit check each month.

You can pay your monthly plan premium by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

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 doesn't cover.

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

Please select a premium payment option:

☐ Get a bill each month.

☐ 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 benefit 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.)

7. PLEASE READ AND SIGN BELOW

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 membership rules as outlined in the Evidence of Coverage **(please read your Evidence of Coverage document when you get it to know what rules you must follow in order to receive coverage with Health Net).**

X _____ _____ _____

Signature | Date | Health Net Representative's signature

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

Name: _____

Address:

_____

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

Member last name:

White – Health Net Yellow – Writing Agent Pink – Member

8. ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

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 don't add or drop your prescription drug coverage (i.e. if you have Medicare prescription drug coverage you can only change to another plan with Medicare prescription drug coverage; if you don't have Medicare prescription drug coverage you can only change to another plan without Medicare 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, or I recently moved and this plan is a new option for me. I moved on (insert date) _____.

☐ I have both Medicare and Medicaid (Medi-Cal) or my state helps pay for my Medicare premiums.

☐ I get extra help paying for Medicare prescription drug coverage.

☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped getting extra help on (insert date) _____.

☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date) _____.

☐ I recently left a PACE program on (insert date) _____.

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.

☐ I am leaving employer or union coverage on (insert date) _____.

☐ 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. I returned to the U.S. on (insert date) _____.

☐ None of these statements apply to me.*

* Please contact Health Net at 1-800-977-6738 (Seniority Plus (HMO), Healthy Heart (HMO) and Salud con Health Net Medicare Advantage (HMO)) or 1-800-579-9096 (Health Net Violet PPO). 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.

Health Net Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment):_____

Requested Effective Date of Coverage: _____ Effective Date of Coverage: _____

Plan/Group ID: _____ Plan Code: _____ PCP Code: _____ PPG Code: _____

Batch Number: _____ Application Date: _____ Health Net Member ID: _____

EFT/Voided Check Received: Y / N Initial Payment Check Received: Y / N Faxed In: Y / N

Election Period (check one): ICEP/IEP: ___ OEP/New: ___ OEPI: ___ AEP: ___ SEP (type): _____

Application Pended due to: _____

Producer Name: _____ Phone #:_____ ID # _____

FMO/GA/Agency Name: _____ Phone #: _____ ID # _____

Sales Rep Name: _____ Phone #:_____ ID # _____

Producer Received Date: _____

Member last name:

White – Health Net Yellow – Writing Agent Pink – Member

STOP Please read this important section

If you currently have health coverage from an employer or union, joining Health Net could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Health Net. 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 isn't any 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 application, I agree to the following:

Health Net of California Inc. (HNCA) and Health Net Life Insurance Company (HNL) are Medicare Advantage plans and have a contract with the Federal government. I will need to keep my Medicare 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 don't 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.

Health Net serves a specific service area. If I move out of the area that Health Net serves, 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 Health Net, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Health Net when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

For Health Net Seniority Plus (HMO), Healthy Heart (HMO), and Salud con Health Net Medicare Advantage (HMO) plans only:

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

For Health Net Violet (PPO) plan only:

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

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

Release of information:

By joining this Medicare health plan, I acknowledge that Health Net 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 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 my behalf under the laws of the State where I live) 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 or by Medicare.

Note: This document is available in alternative formats.