Health Net®
MEDICARE PROGRAMS

2016 Medicare Advantage Short Enrollment
Request Form

Name of Plan You are Enrolling In:

Health Net Healthy Heart (HMO) (includes prescription drug coverage)

☐ Alameda, Stanislaus	$163 per month
☐ Fresno	$0 per month
☐ Los Angeles, Orange	$20 per month
☐ Placer, Sacramento	$167 per month
☐ Riverside, San Bernardino	$30 per month
☐ San Diego	$0 per month
☐ San Francisco	$127 per month
☐ Yolo	$107 per month

Health Net Gold Select (HMO) (includes prescription drug coverage)

☐ Los Angeles, Orange	$0 per month
☐ Riverside, San Bernardino	$0 per month

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

☐ Alameda, Placer, Sacramento, Sonoma, Stanislaus	$139 per month
☐ Los Angeles, Riverside, San Bernardino	$0 per month

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

☐ Kern	$0 per month
☐ Santa Clara	$221 per month
☐ Sonoma	$200 per month

Health Net Ruby Select (HMO) (includes prescription drug coverage)

☐ Placer, Sacramento	$0 per month
☐ San Francisco	$0 per month
☐ Yolo	$0 per month

Health Net Seniority Plus Sapphire (HMO) (includes prescription drug coverage)

☐ Los Angeles, Orange, San Diego	$31 per month
☐ Kern, Riverside, San Bernardino	$31 per month

Health Net Jade (HMO SNP)[1] (Cardiovascular Disorders, Chronic Heart Failure (CHF), Diabetes) (includes prescription drug coverage)

☐ Kern, Los Angeles, Orange	$0 per month

Health Net Seniority Plus Amber I (HMO SNP)[1] (All Dual Eligible beneficiaries enrolled in Medicare and Medi-Cal) (includes prescription drug coverage)

☐ Kern, Los Angeles, Orange, Riverside, San Bernardino $31* per month

Health Net Seniority Plus Amber II (HMO SNP)[1] (Full Dual Eligible beneficiaries enrolled in Medicare and Medi-Cal) (includes prescription drug coverage)

☐ Fresno, Los Angeles, Orange, San Diego, San Francisco $31* per month

☐ Kern, Riverside, San Bernardino, Tulare $31* per month

*Actual premium based on Low Income Subsidy status.

[1]You must meet specific enrollment criteria to enroll in this plan.

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

☐ Optional Supplemental Buy-Up #1: $22 per month

☐ Optional Supplemental Buy-Up #2: $32 per month

☐ Optional Supplemental Buy-Up #6: $27 per month

☐ Optional Supplemental Buy-Up #8: $18 per month

☐ Optional Supplemental Buy-Up #9: $12 per month

Monthly plan premium amount (including optional supplemental package premium amount):

$_____ Requested effective date: __ __/__ __/__ __ __ __

Name: _____	**Medicare number:** _____ (Note: may use "member number" instead of "Medicare number".)
Home phone number:	
Permanent street address (PO Box is not allowed):	

City:	County:	State:	ZIP code:

Mailing address (only if different from your permanent street address):

Street Address: City: State: ZIP code:

Please fill out the following:

I am currently a member of the _____ plan in Health Net of California, Inc. with a monthly premium of $ _____.

I would like to change to the _____ plan in Health Net of California, Inc. I understand that this plan has different health benefits and a monthly premium of $ _____.

Name of chosen primary care physician (PCP), clinic or health center:

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

Please contact Health Net at 1-800-977-6738 if you need information in another format or language than what is listed above. Our office hours are: From October 1 through February 14, 8:00 a.m. to 8:00 p.m., 7 days a week, excluding certain holidays. However, after February 14, your call will be handled by our automated phone system on weekends and certain holidays. TTY users should call 711.

Your Plan Premium

If we determine that you owe a late enrollment penalty (or if you currently have 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 pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. Do NOT pay Health Net the Part D-IRMAA.

You can pay your monthly plan premium (including any late enrollment penalty you have or may owe) by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the Railroad Retirement Board. Do NOT pay Health Net the Part D-IRMAA.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, 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 won't have a coverage gap or a late enrollment penalty. Many people qualify 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 for this benefit. 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

☐ Electronic Funds Transfer (EFT)

☐ Automatic deduction from your monthly Social Security or RRB benefit check. (The Social Security deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Please Read This Important Information

Please Read and Sign Below

Health Net of California, Inc. is a plan that has a contract with the Federal government.

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 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 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 people with Medicare aren't covered under Medicare while out of the country, except for limited coverage near the U.S. border.

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.**

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 from Medicare.

Signature:	**Today's date:**

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

Name: _____

Address: _____

Phone number: (_ _ _) _ _ _ - _ _ _ _

Relationship to enrollee: _____

OFFICE USE ONLY:

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

Plan ID #: _____

Effective date of coverage: _____

ICEP/IEP: _____AEP: _____ SEP (type): _____ Not eligible: _____

Health Net Sales Representative / Authorized Agent

(Individual sales representative/agent who completed the application.)

Agent type (select one): ☐ Authorized agent ☐ Health Net employee

Complete section - or - place printed label here:

Sales rep / Agent name: _____ **Health Net ID #**_____

Sales rep / Agent NPN #: _____

Agency / FMO affiliation: _____ **Health Net ID #**_____

(If applicable)

This information must match your approved Health Net licensing records.

Agent phone: (__ __ __) __ __ __ - __ __ __ __ Email: _____

Agency / FMO phone: (__ __ __) __ __ __ - __ __ __ __

(If applicable)

Sales representative/Authorized agent application receipt date: __ __ / __ __ /__ __ __ __

(Applications must be received at Health Net within 1 calendar day of this date.)

Application receipt location:

☐ Appointment ☐ Sales event ☐ Walk-in ☐ Other (specify): _____

Provider information for HMO plans

PCP name: _____ PCP ID: __ __ __ __ __ __

PPG name: _____ PPG ID: __ __ __ __

Is PCP/PPG selected accepted for the plan chosen? ☐ Yes ☐ No

Current patient? ☐ Yes ☐ No

White – Health Net Yellow – Member