



Enrollment *Request Form*

Employer name:	
Coverage effective date:	Employer group number <i>(Medical)</i> :

Important – Please print all sections in black ink. For the application to be valid, you must submit all applicable pages.

1. Select coverage

1a: Check the desired plan as offered by your employer: (Write the plan number next to the product.)

<input type="checkbox"/> HMO: _____	<input type="checkbox"/> EPO: _____
<input type="checkbox"/> HMO: PremierCare _____	<input type="checkbox"/> POS: Elect _____
<input type="checkbox"/> HMO: ExcelCare _____	<input type="checkbox"/> POS: Elect Open Access _____
<input type="checkbox"/> HMO: SmartCare _____	<input type="checkbox"/> POS: ExcelCare Elect Open Access _____
<input type="checkbox"/> HMO: Salud _____	<input type="checkbox"/> POS: Select _____
<input type="checkbox"/> PPO: _____	<input type="checkbox"/> Flex Net: _____

Reason for application:

Retiree Open Enrollment Loss of prior coverage date: _____

COBRA effective date: _____ Qualifying event: _____ Qualifying event date: _____

Add dependent Qualifying event: _____ Qualifying event date: _____

Reason for change:

Plan change Change address/name Delete dependent(s) (List names in Section 3.)

Other: _____

1b: Please provide your Medicare insurance information

<p>Please take out your red, white and blue Medicare card to complete this section.</p> <ul style="list-style-type: none"> • Fill out this information as it appears on your Medicare card. - OR - • Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board. 	<p>Name (as it appears on your Medicare card)</p> <p>_____</p> <p>Medicare number</p> <p>_____ - _____ - _____</p> <p>Is Entitled To Effective Date</p> <p>HOSPITAL (Part A) _____</p> <p>MEDICAL (Part B) _____</p> <p>You must have Medicare Part A and Part B to join a Medicare Advantage plan.</p>
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2. Retiree personal information

Last name:	First name:	MI:	Date of birth (MM/DD/YYYY):
Residence address:	City:	State:	ZIP:

Retiree name:

2. Retiree personal information (continued)

Mailing address (if different from residence): City: State: ZIP:

Home telephone #: () Social Security #: Email address:

Male Female Marital status: Single Married Domestic partner Medicare claim/HICN #:

Participating physician group/PPG #: Primary care physician/PCP #: N/A. I'm enrolling in a PPO or Flex Net plan.

Physician name (first, last): Is this your current MD? Yes No

Do you have other health coverage? If "Yes," please complete this section. Please fill out the following information to receive proper credit for **previous coverage** if, immediately prior to becoming eligible for this plan, you were covered under any public or private health care coverage (including Medi-Cal or individual coverage). According to federal laws, your employer or **former carrier** must provide you with a certificate that shows evidence of your prior coverage. We reserve the right to request a copy of this certificate.

Name: Prior coverage start date: ___/___/____ (M M / D D / Y Y Y Y)

Name and address of other insurance carrier:

Prior coverage end date: ___/___/____ (M M / D D / Y Y Y Y) Reason for ending coverage:

Group #/Policy ID #: Is this your primary coverage? Yes No Does it cover Medical? Yes No Medicare Part A Part B Part D

Are you enrolling dependents? Yes No If "Yes," complete and submit all pages of the form. If "No," and you are declining coverage for yourself or a

3. Family information (Please list all eligible family members to be enrolled. To add additional dependents, fill out the Health Net Dependent Information Form, and submit it along with this application.)

Dependent 1

Spouse Domestic partner Male Female Last name: First name: MI:

Residence address (Check here if same as employee): City: State: ZIP:

Date of birth (MM/DD/YYYY): Social Security #/Matricula ID #:

Coverage type: Medical Medicare Part A Medicare Part B Medicare Part D Medicare claim/HICN #: Participating physician group/PPG #: Primary care physician/PCP #:

3. Family information (continued)

Dependent 1 (continued)

Physician name (<i>first, last</i>):	Is this your current MD? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental HMO Provider ID # (<i>Complete only if electing Health Net Dental.</i>):
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Do you have other health care coverage? Yes No If "Yes," complete the following:
Name of insurance carrier: _____ Prior coverage start date: _____

Dependent 2

<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Last name:	First name:	MI:
Residence address (<input type="checkbox"/> <i>Check here if same as employee</i>):	City:	State:	ZIP:
Date of birth (MM/DD/YYYY):	Totally disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security #/Matricula ID #:	
Coverage type: <input type="checkbox"/> Medical <input type="checkbox"/> Medicare Part A <input type="checkbox"/> Medicare Part B <input type="checkbox"/> Medicare Part D	Medicare claim/ HICN #:	Participating physician group/PPG #:	
		Primary care physician/PCP #:	
Physician name (<i>first, last</i>):	Is this your current MD? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental HMO Provider ID # (<i>Complete only if electing Health Net Dental.</i>):	

Do you have other health care coverage? Yes No If "Yes," complete the following:
Name of insurance carrier: _____ Prior coverage start date: _____

4. Acceptance of coverage (Signature required.)

The use and disclosure of protected health information:

I acknowledge and understand that health care providers may disclose health information about me or my dependents to Health Net entities. Health Net entities use and may disclose this information for purposes of treatment, payment and health plan operations, including but not limited to, utilization management, quality improvement, and disease or case management programs. Health Net's Notice of Privacy Practices is included in the *Evidence of Coverage* or *Certificate of Insurance* for coverage underwritten by Health Net entities. I may also obtain a copy of this notice on the website at www.healthnet.com or through the Health Net Customer Contact Center.

Notice: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Acknowledgement and agreement: I understand and agree that by enrolling with or accepting services from the Health Net entities, I and any enrolled dependents are obligated to understand and abide by the terms, conditions and provisions of the plan contract or insurance policy. I have read and understand the terms of this application, and my signature below indicates that the information entered in this application is complete, true and correct to the best of my knowledge, and I accept these terms.

4. Acceptance of coverage (continued)

BINDING ARBITRATION AGREEMENT: I, the Applicant, understand and agree that any and all disputes between me (including any of my enrolled family members or heirs or personal representatives) and Health Net must be submitted to final and binding arbitration instead of a jury or court trial. This Agreement to arbitrate includes any disputes arising from or relating to the Evidence of Coverage or Certificate of Insurance or my Health Net membership or coverage, stated under any legal theory. This agreement to arbitrate any disputes applies even if other parties, such as health care providers or their agents or employees, are involved in the dispute. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties including Health Net are giving up their constitutional right to have their dispute decided in a court of law by a jury. I also understand that disputes that I may have with Health Net involving claims for medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) are also subject to final and binding arbitration. I understand that a more detailed arbitration provision is included in the Evidence of Coverage or Certificate of Insurance. Mandatory Arbitration may not apply to certain disputes if the Employer's plan is subject to ERISA, 29 U.S.C. §§ 1001-1461. My signature below indicates that I understand and agree with the terms of this Binding Arbitration Agreement and agree to submit any disputes to binding arbitration instead of a court of law.

Retiree signature: _____

Print retiree name: _____ Date: _____

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

Name: _____ Relationship to enrollee: _____

Address: _____ Phone number: (____) _____ - _____

Complete this section only if any coverage is to be declined by you.

<input type="checkbox"/> Declining medical coverage	Reason: <input type="checkbox"/> Other group coverage <input type="checkbox"/> Individual coverage <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other group coverage by another group (i.e., spouse's employer)
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The available coverages have been explained to me by my employer. I have been given the chance to apply for the available coverages. I have decided not to enroll myself and/or my dependent(s). **By declining coverage, I acknowledge that my dependents and I may have to wait to be enrolled until the next open enrollment period or qualifying event. Additionally, by signing below I certify that the reason I am declining coverage is accurate as indicated by the check marks above.**

Note: If you decline coverage for yourself or an eligible dependent because of coverage under other health insurance, you may be eligible for special enrollment rights if you or your dependent lose eligibility for that coverage. You must request special enrollment within 30 days of the loss of coverage or acquisition of a new dependent.

Employee signature: _____ Date: _____

(ONLY IF DECLINING COVERAGE: If signed in error, please cross out and initial.)

Medical Coordination of Benefits HMO health plans are offered by Health Net of California, Inc. Medical Coordination of Benefits health insurance plans are underwritten by Health Net Life Insurance Company.

In addition to the State of California nondiscrimination requirements (as described in benefit coverage documents), Health Net of California, Inc. and Health Net Life Insurance Company (Health Net) comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Health Net does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Health Net:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at:

Group Employer Applicants 1-800-522-0088 (TTY: 711)

Individual & Family Plan Applicants 1-877-609-8711 (TTY: 711)

If you believe that Health Net has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by calling the number above and telling them you need help filing a grievance; Health Net's Customer Contact Center is available to help you. You can also file a grievance by mail, fax or online at:

Health Net of California, Inc./Health Net Life Insurance Company Appeals & Grievances

PO Box 10348

Van Nuys, CA 91410-0348

Fax: 1-877-831-6019

Online: healthnet.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

English

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card, or employer group applicants please call 1-800-522-0088 (TTY: 711). Individual & Family Plan (IFP) applicants please call 1-877-609-8711 (TTY: 711). For more help: If you are enrolled in a PPO or EPO insurance policy from Health Net Life Insurance Company, call the CA Dept. of Insurance at 1-800-927-4357. If you are enrolled in an HMO or HSP plan from Health Net of California, Inc., call the DMHC Helpline at 1-888-HMO-2219.

Arabic

خدمات اللغة مجانية. يمكنك الحصول على مترجم فوري. ويمكنك الحصول على وثائق مقروءة لك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة الهوية، أو يرجى من مقدمي طلبات مجموعة أصحاب العمل الاتصال بمركز الاتصال 1-800-522-0088 (TTY: 711).. يرجى من مقدمي طلبات خطة الأفراد والعائلة (IFP) الاتصال على الرقم 1-877-609-8711 (TTY: 711). وللحصول على المساعدة: في حال كنت مسجلاً في بوليصة تأمين المنظمة المزودة المفضلة PPO أو المنظمة المزودة الحصرية EPO من Health Net Life Insurance Company ، اتصل على قسم التأمين في كاليفورنيا على الرقم 1-800-927-4357. في حال كنت مسجلاً في منظمة المحافظة على الصحة HMO أو خطة التوفير الصحية HSP من شركة Health Net of California, Inc. ، اتصل على خط المساعدة في قسم الرعاية الصحية المدارة DMHC على الرقم 1-888-HMO-2219.

Armenian

Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեզ համար ձեր լեզվով: Օգնության համար զանգահարեք մեզ ձեր ID քարտի վրա նշված հեռախոսահամարով, իսկ գործատուի խմբի դիմորդներին խնդրում ենք զանգահարել 1-800-522-0088 (TTY: 711) հեռախոսահամարով: Անհատական և Ընտանեկան Ծրագրի անդերեն հապավումը՝ (IFP) դիմորդներին խնդրում ենք զանգահարել 1-877-609-8711 (TTY: 711) հեռախոսահամարով: Լրացուցիչ օգնության համար, եթե անդամագրված եք Health Net Life Insurance Company-ի PPO կամ EPO ապահովագրությանը, զանգահարեք Կալիֆորնիայի Ապահովագրության բաժին՝ 1-800-927-4357 հեռախոսահամարով: Եթե անդամագրված եք Health Net of California, Inc.-ի HMO կամ HSP ծրագրին, զանգահարեք DMHC օգնության գիծ՝ 1-888-HMO-2219 հեռախոսահամարով:

Chinese

免費語言服務。您可使用口譯員。您可請人使用您的語言將文件內容唸給您聽，並請我們將有您語言版本的部分文件寄給您。如需協助，請致電您會員卡上所列的電話號碼與我們聯絡，僱主團體申請人請致電 1-800-522-0088 (TTY: 711)。個人與家庭計畫 (IFP) 申請人請致電 1-877-609-8711 (TTY: 711)。如需進一步協助：如果您透過 Health Net Life Insurance Company 投保 PPO 或 EPO 保單，請致電 1-800-927-4357 與加州保險局聯絡。如果您透過 Health Net of California, Inc. 投保 HMO 或 HSP 計畫，請致電 DMHC 協助專線 1-888-HMO-2219。

Hindi

बिना लागत की भाषा सेवाएँ। आप एक दुभाषिया प्राप्त कर सकते हैं। आपको दस्तावेज अपनी भाषा में पढ़ कर सुनाए जा सकते हैं। मदद के लिए, आपके आईडी कार्ड पर दिए गए सूचीबद्ध नंबर पर हमें कॉल करें, या नियोक्ता समूह आवेदक कृपया 1-800-522-0088 (TTY: 711) संपर्क केंद्र पर कॉल करें। कृपया व्यक्तिगत और पारिवारिक प्लैन (IFP) के आवेदक 1-877-609-8711 (TTY: 711) पर कॉल करें। अधिक मदद के लिए: यदि आप Health Net Life Insurance Company PPO या ईपीओ EPO बीमा पॉलिसी में नामांकित हैं, तो कैलिफोर्निया बीमा विभाग को 1-800-927-4357 पर कॉल करें। यदि आप Health Net of California, Inc., एचएमओ HMO या एचएसपी HSP प्लैन में नामांकित हैं, तो डीएमएचसी DMHC हेल्पलाइन के 1-888-HMO-2219 पर कॉल करें।

Hmong

Kev Pab Txhais Lus Dawb. Koj xav tau neeg txhais lus los tau. Koj xav tau neeg nyeem cov ntaub ntawv kom yog koj hom lus los tau xav tau kev pab, hu peb tau rau ntawm tus xov tooj nyob ntawm koj daim npav, los yog tias koj yog tus neeg tso npe xav tau kev pab kho mob los ntawm koj txoj hauj-lwm thov hu rau 1-800-522-0088 (TTY: 711). Yog koj yog tus tso npe xav tau kev pab kho mob rau Ib Tug Neeg & Tsev Neeg Individual & Family Plan (IFP) thov hu 1-877-609-8711 (TTY: 711). Xav tau kev pab ntxiv: Yog koj tau tsab ntawv tuav pov hwm PPO los yog EPO los ntawm Health Net Life Insurance Company, hu mus rau CA Dept. of Insurance ntawm 1-800-927-4357. Yog koj tau txoj kev pab kho mob HMO los yog HSP los ntawm Health Net of California, Inc., hu mus rau DMHC tus xov tooj pab Helpline ntawm 1-888-HMO-2219.

Japanese

無料の言語サービス。通訳をご利用いただけます。日本語で文書をお読みします。援助が必要な場合は、IDカードに記載されている番号までお電話いただくか、雇用主を通じた団体保険の申込者の方は、1-800-522-0088、(TTY: 711) までお電話ください。個人および家族向けプラン (IFP) の申込者の方は、1-877-609-8711 (TTY: 711) までお電話ください。さらに援助が必要な場合: Health Net Life Insurance CompanyのPPOまたはEPO保険ポリシーに加入されている方は、カリフォルニア州保険局 1-800-927-4357 まで電話でお問い合わせください。Health Net of California, Inc.のHMOまたはHSPに加入されている方は、DMHCヘルプライン 1-888-HMO-2219 まで電話でお問い合わせください。

Khmer

សេវាភាសាដោយឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ អ្នកអាចស្តាប់គេអានឯកសារឱ្យអ្នកនៅក្នុងភាសារបស់អ្នក។ សម្រាប់ជំនួយ សូមទាក់ទងយើងខ្ញុំតាមរយៈលេខទូរសព្ទដែលមាននៅលើកាតសម្គាល់ខ្លួនរបស់អ្នក ឬ បេក្ខជនក្រុមនិយោជក អាចទាក់ទងទៅមជ្ឈមណ្ឌលទំនាក់ទំនងពាណិជ្ជកម្មនៃក្រុមហ៊ុន 1-800-522-0088 (TTY: 711)។ បេក្ខជនផែនការគ្រួសារ និងបេក្ខជនផែនការបុគ្គល សូមទូរសព្ទទៅលេខ 1-877-609-8711 (TTY: 711)។ សម្រាប់ជំនួយបន្ថែម ៖ បើសិនអ្នកបានចុះ ឈ្មោះក្នុងគោលការណ៍ធានារ៉ាប់រង PPO ឬ EPO Health Net Life Insurance Company សូមទាក់ទងទៅនា យកដ្ឋានធានារ៉ាប់រង CA តាមរយៈទូរសព្ទលេខ 1-800-927-4357។ បើសិនអ្នកបានចុះឈ្មោះក្នុងផែនការ HMO ឬ HSP ពីក្រុមហ៊ុន Health Net នៃរដ្ឋកាលីហ្វ័រញ៉ា សូមទាក់ទងលេខទូរសព្ទជំនួយ DMHC ៖ 1-888-HMO-2219។

Korean

무료 언어 서비스, 통역 서비스를 받을 수 있습니다. 귀하가 구사하는 언어로 문서의 낭독 서비스를 받으실 수 있습니다. 도움이 필요하시면 보험 ID 카드에 수록된 번호로 전화하시거나 고용주 그룹 신청인의 경우 1-800-522-0088 (TTY: 711) 번으로 전화해 주십시오. Individual & Family Plan (IFP) 신청인의 경우, 1-877-609-8711 (TTY: 711) 번으로 전화해 주십시오. 추가 도움이 필요하시면, Health Net Life Insurance Company의 PPO 또는 EPO 보험에 가입되어 있으시면 캘리포니아 주 보험국에 1-800-927-4357번으로 전화해 주십시오. Health Net of California, Inc.의 HMO 또는 HSP 플랜에 가입되어 있으시면 DMHC 도움라인에 1-888-HMO-2219번으로 전화해 주십시오.

Navajo

Saad Bee Áká E'eyeed T'áá Jíík'e. Ata' halne'ígíí hóló. T'áá hó hazaad k'éhjí naaltsoos hach'í' wóltah. Shiká a'doowoł nínizingo naaltsoos bee néího'dólzíníígií bikáa'gi béésh bee hane'í bikáá' áajjí' hodiílnih éí doodaii' employer groupojí ninaaltsoos siłtsoozgo éí 1-800-522-0088 (TTY: 711). T'áá hó dóó ha'áłchíní bíł hak'é'ésti'ígíí ÍIFP wolyéhíígií éí kojí' hojilnih 1-877-609-8711 (TTY: 711). Shiká anáa'doowoł jinízingo: PPO éí doodaii' EPOojí Health Net Life Insurance Company wolyéhíjí béeso ách'ááqáh naa'nil biniiyé hwe'iina' bik'é'ésti'go éí CA Dept. of Insurance bich'í' hojilnih 1-800-927-4357. HMO éí doodaii' HSPojí Health Net of Californiaojí béeso ách'ááqáh naa'nil biniiyé hats'íís bik'é'ésti'go éí kojí' hojilnih DMHC Helpline 1-888-HMO-2219.

Persian (Farsi)

خدمات زبان به طور رایگان. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید که اسناد به زبان شما برایتان قرائت شوند. برای دریافت راهنمایی، با ما به شماره ای که روی کارت شناسایی شما درج شده تماس بگیرید، یا درخواست کنندگان گروه کارفرما لطفاً با مرکز تماس بازرگانی 1-800-522-0088 (TTY: 711) تماس بگیرید. درخواست کنندگان برنامه انفرادی یا خانواده (IFP) لطفاً با شماره 1-877-609-8711 (TTY: 711) تماس بگیرید. برای دریافت راهنمایی بیشتر: اگر در بیمه نامه PPO یا EPO از سوی Health Net Life Insurance Company عضویت دارید، با CA Dept. of Insurance به شماره 1-800-927-4357 تماس بگیرید. اگر در برنامه HMO یا HSP از سوی Health Net of California, Inc. عضویت دارید، با خط راهنمایی تلفنی DMHC به شماره 1-888-HMO-2219 تماس بگیرید.

Punjabi (Punjabi)

ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਤੋਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ਿਆ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ ਕਿਰਪਾ ਕਰਕੇ 1-800-522-0088 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਾਰਿਵਾਰਕ ਪਲੈਨ (IFP) ਦੇ ਆਵੇਦਕ ਕਿਰਪਾ ਕਰਕੇ 1-877-609-8711 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਵਧੇਰੀ ਮਦਦ ਲਈ: ਜੇ Health Net Life Insurance Company ਤੋਂ ਇੱਕ ਪ੍ਰਾਈਵੇਟ PPO ਜਾਂ ਈਓਪੀਏ EPO ਬੀਮਾ ਪਾਲਿਸੀ ਵਿੱਚ ਨਾਮਾਕਿਤ ਹੋ, ਤਾਂ ਕੈਲੀਫੋਰਨੀਆ ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ 1-800-927-4357 'ਤੇ ਕਾਲ ਕਰੋ। ਜੇ ਤੁਸੀਂ ਹੈਲਥ ਨੈੱਟ ਆਫ ਕੈਲੀਫੋਰਨੀਆ, ਇੱਕ ਤੋਂ ਇੱਕ ਐਚਐਮਓ HMO ਜਾਂ ਐਚਐਸਪੀ HSP ਪਲੈਨ ਵਿੱਚ ਨਾਮਾਕਿਤ ਹੋ ਤਾਂ ਡੀਐਮਐਚਸੀ DMHC ਹੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 'ਤੇ ਕਾਲ ਕਰੋ।

Russian

Бесплатная помощь переводчиков. Вы можете получить помощь устного переводчика. Вам могут прочитать документы в переводе на ваш родной язык. За помощью обращайтесь к нам по телефону, приведенному на вашей идентификационной карточке участника плана. Если вы хотите стать участником группового плана, предоставляемого работодателем, звоните в коммерческий контактный центр компании 1-800-522-0088 (TTY: 711). Если вы хотите стать участником плана для семей и частных лиц (IFP), звоните по телефону 1-877-609-8711 (TTY: 711). Дополнительная помощь: Если вы включены в полис PPO или EPO от страховой компании Health Net Life Insurance Company, звоните в Департамент страхования штата Калифорния CA Dept. of Insurance, телефон 1-800-927-4357. Если вы включены в план HMO или HSP от страховой компании Health Net of California, Inc., звоните по контактной линии Департамента управляемого медицинского обслуживания (DMHC), телефон 1-888-HMO-2219.

Spanish

Servicios de idiomas sin costo. Puede solicitar un intérprete. Puede obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación. Los solicitantes del grupo del empleador deben llamar al 1-800-522-0088 (TTY: 711). Los solicitantes de planes individuales y familiares deben llamar al 1-877-609-8711 (TTY: 711). Para obtener más ayuda, haga lo siguiente: Si está inscrito en una póliza de seguro PPO o EPO de Health Net Life Insurance Company, llame al Departamento de Seguros de California, al 1-800-927-4357. Si está inscrito en un plan HMO o HSP de Health Net of California, Inc., llame a la línea de ayuda del Departamento de Atención Médica Administrada, al 1-888-HMO-2219.

Tagalog

Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng isang interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo sa inyong wika. Para sa tulong, tawagan kami sa nakalistang numero sa inyong ID card, o para sa grupo ng mga aplikante ng employer, mangyaring tawagan ang 1-800-522-0088 (TTY: 711). Para sa mga aplikante ng Plano para sa Indibiduwal at Pamilya Individual & Family Plan, (IFP), mangyaring tawagan ang 1-877-609-8711 (TTY: 711). Para sa higit pang tulong: Kung nakatala kayo sa insurance policy ng PPO o EPO mula sa Health Net Life Insurance Company, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Kung nakatala kayo sa HMO o HSP na plan mula sa Health Net of California, Inc., tawagan ang Helpline ng DMHC sa 1-888-HMO-2219.

Thai

ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังเป็นภาษาของคุณได้ สำหรับความช่วยเหลือ โทรหาเราตามหมายเลขที่ให้ไว้บนบัตรประจำตัวของคุณ หรือ ผู้สมัครกลุ่มนายจ้าง กรุณาโทรหาศูนย์ติดต่อเชิงพาณิชย์ของ 1-800-522-0088 (TTY: 711) ผู้สมัครแผนบุคคลและครอบครัว Individual & Family Plan (IFP) กรุณาโทร 1-877-609-8711 (TTY: 711) สำหรับความช่วยเหลือเพิ่มเติม หากคุณสมัครทำกรมธรรม์ประกันภัย PPO หรือ EPO กับ Health Net Life Insurance Company โทรหากรมการประกันภัยรัฐแคลิฟอร์เนียได้ที่ 1-800-927-4357 หากคุณสมัครแผน HMO หรือ HSP กับ Health Net of California, Inc. โทรหาสายด่วนความช่วยเหลือของ DMHC ได้ที่ 1-888-HMO-2219.

Vietnamese

Các Dịch vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu cầu được đọc cho nghe tài liệu bằng ngôn ngữ của quý vị. Để nhận trợ giúp, hãy gọi cho chúng tôi theo số được liệt kê trên thẻ ID của quý vị, hoặc người nộp đơn vào chương trình theo nhóm của chủ sử dụng lao động vui lòng gọi 1-800-522-0088 (TTY: 711). Người nộp đơn thuộc Chương Trình Cá Nhân & Gia Đình viết tắt trong tiếng Anh là (IFP) vui lòng gọi số 1-877-609-8711 (TTY: 711). Để nhận thêm trợ giúp: Nếu quý vị đăng ký hợp đồng bảo hiểm PPO hoặc EPO từ Health Net Life Insurance Company, vui lòng gọi Sở Y Tế CA theo số 1-800-927-4357. Nếu quý vị đăng ký vào chương trình HMO hoặc HSP từ Health Net of California, Inc., vui lòng gọi Đường Dây Trợ Giúp DMHC theo số 1-888-HMO-2219.