Health Net®

Large Business Application

for Group Enrollment and Change

Medical and Life/AD&D insurance plans are provided by Health Net of California, Inc. and/or Health Net Life Insurance Company (together, "Health Net"). Dental HMO plans are provided by Dental Benefit Providers of California, Inc., and dental PPO and indemnity insurance plans are provided by Unimerica Life Insurance Company (together, "DBP"). Vision plans are provided by Fidelity Security Life Insurance Company and serviced by EyeMed Vision Care, LLC (together, "Fidelity").

Neither DBP nor Fidelity are affiliated with Health Net. Obligations under dental and vision plans are not the obligations of, and are not guaranteed by, Health Net.

Welcome to Health Net

Simple steps for completing the form:

1. Review the materials enclosed in your enrollment packet. Be sure that you understand the coverage options that are available to you by your employer.

2a. **If you are *declining* coverage** for yourself and/or your dependents, section 7 is required. Do not fill out any other sections.

2b. **If you are *accepting* coverage** for yourself and/or your dependents, sections 1, 2, 3, 5, and 8 are required.

The Affordable Care Act (ACA) requires Health Net to provide to the IRS confirmation of health care coverage for yourself, as the subscriber, and your covered dependents. The IRS uses this information to confirm each member has essential coverage. Please ensure that the Social Security number (SSN) is accurate for yourself and each dependent you are enrolling. For more information about the individual shared responsibility payment provision, go to http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision.

3. If you choose to enroll in the HMO, ExcelCare HMO, SmartCare HMO, Salud HMO y Más, Salud Mexico, Elect Open Access (EOA), Select POS, or Dental HMO plans, you must select your participating physician group (PPG), primary care physician (PCP) or dental provider. Be sure to fill in the names and numbers as they appear in Health Net's online ProviderSearch tool.

   Note: If you do not select a PPG, PCP and/or a dental provider, one will be selected for you.

4. If you choose to enroll in a PPO or EPO insurance plan, you are not required to select a PPG or PCP to enroll.

5. Make a copy of the completed application for your records. **If a correction is needed, cross out and initial each correction. Please do not use a white-out product.**

For administrative use only:	
Existing Business/Group PO Box 9103 Van Nuys, CA 91409-9103 www.healthnet.com	**New Business/Group** Please send all completed paperwork to your designated account executive or broker.

Health Net®

To be completed by employer	
Employer name:	
Requested effective date:	Employer group number *(medical)*:
Employee eligibility date *(new hire only)*: ☐ Same as hire date ☐ Other: _____	

Important: Please print all sections in black ink. You are entitled to see a *Summary of Benefits and Coverage* (SBC) before you choose a plan. Please contact your employer if you do not have the SBC for the plan you have selected.

1. Health plan information (Select coverage.)

HMO

☐ HMO ☐ SmartCare HMO[1] ☐ ExcelCare HMO[2] ☐ Salud HMO y Más[3] ☐ EOA ☐ ExcelCare EOA[2] ☐ Select POS
☐ EPO ☐ Other: _____

PPO

☐ PPO ☐ OOS PPO ☐ HSA-compatible PPO ☐ OOS HSA-compatible PPO ☐ Integrated HSA-compatible PPO
☐ Integrated HSA-compatible PPO (opt out) ☐ Integrated HRA-compatible PPO

Dental and Vision

☐ Dental (DHMO) ☐ Dental (DPPO) ☐ Vision (PPO)

2. Reason for application

☐ Plan change ☐ Change address/name ☐ Delete dependent ☐ Other: _____	☐ New hire ☐ Open Enrollment **Special Enrollment Period** Qualifying event date: ____/____/_____ Add dependent: _____	**COBRA** ☐ Effective date: ____/____/_____ Qualifying event: _____ Qualifying event date: ____/____/_____
	☐ Marriage ☐ Newborn/Adoption/Legal guardianship/Court order/Assumption of parent-child relationship ☐ Loss of prior coverage: ____/____/_____ ☐ Other (specify): _____	

3. Employee personal information

Last name:	First name:	MI:	☐ Male ☐ Female
Residence address:	City:	State:	ZIP:
Date of birth *(mm/dd/yyyy)*:	Social Security #/Matricular ID # (required for all applicants):	Job title:	
Telephone #: ( )	Work phone #: ( )	Email address:	
Date of hire: / /	Dept. #:	Marital status: ☐ Single ☐ Married ☐ Domestic partner	
I would prefer to receive communication and plan information in: ☐ English ☐ Spanish ☐ Chinese ☐ Korean			
Participating physician group:		Primary care physician:	
PPG/PCP enrollment ID # *(4-digit PPG and 6-digit PCP numbers)*:		Is this your current PCP? ☐ Yes ☐ No	
Dental HMO provider name:		Dental HMO provider ID #:	

[1]Available in all or parts of Los Angeles, Marin, Orange, Placer, Riverside, San Bernardino, San Diego, Santa Clara, and Santa Cruz counties.
[2]Available in all or parts of Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Francisco, Santa Clara, Stanislaus, and Ventura counties.
[3]Available in Orange County and select ZIP codes of Kern, Los Angeles, Riverside, San Diego, and San Bernardino counties.

Employee name: ______________________ | Last 4 digits of Social Security #: __ __ __ __

4. Family information – please list all eligible family members to be enrolled
(Attach additional sheets if necessary.)

Spouse/Domestic partner ☐ M ☐ F	Last name:	First name:		MI:
Residence address: ☐ Check here if same as subscriber		City:	State:	ZIP:
Date of birth *(mm/dd/yyyy)*:		Social Security #/Matricular ID # (required for all applicants):		
Participating physician group:		Primary care physician:		
PPG/PCP enrollment ID # *(4-digit PPG and 6-digit PCP numbers)*:		Is this your current PCP? ☐ Yes ☐ No		
Dental HMO provider name:		Dental HMO provider ID #:		

☐ Son ☐ Daughter	Disabled: ☐ Yes ☐ No	Last name:	First name:		MI:
Residence address: ☐ Check here if same as subscriber			City:	State:	ZIP:
Date of birth *(mm/dd/yyyy)*:			Social Security #/Matricular ID # (required for all applicants):		
Participating physician group:			Primary care physician:		
PPG/PCP enrollment ID # *(4-digit PPG and 6-digit PCP numbers)*:			Is this your current PCP? ☐ Yes ☐ No		
Dental HMO provider name:			Dental HMO provider ID #:		

☐ Son ☐ Daughter	Disabled: ☐ Yes ☐ No	Last name:	First name:		MI:
Residence address: ☐ Check here if same as subscriber			City:	State:	ZIP:
Date of birth *(mm/dd/yyyy)*:			Social Security #/Matricular ID # (required for all applicants):		
Participating physician group:			Primary care physician:		
PPG/PCP enrollment ID # *(4-digit PPG and 6-digit PCP numbers)*:			Is this your current PCP? ☐ Yes ☐ No		
Dental HMO provider name:			Dental HMO provider ID #:		

☐ Son ☐ Daughter	Disabled: ☐ Yes ☐ No	Last name:	First name:		MI:
Residence address: ☐ Check here if same as subscriber			City:	State:	ZIP:
Date of birth *(mm/dd/yyyy)*:			Social Security #/Matricular ID # (required for all applicants):		
Participating physician group:			Primary care physician:		
PPG/PCP enrollment ID # *(4-digit PPG and 6-digit PCP numbers)*:			Is this your current PCP? ☐ Yes ☐ No		
Dental HMO provider name:			Dental HMO provider ID #:		

Employee name: ______________________________ | Last 4 digits of Social Security #: __ __ __ __

5. Do you or your dependents have other health care coverage?

☐ No ☐ Yes If "Yes," please complete this section, including Medicare.

☐ Self	Name:		Name of other insurance carrier:		Prior coverage start date *(mm/dd/yy)*:	
Prior coverage end date *(mm/dd/yy)*:	Reason for ending coverage:		Group #/Policy ID #:	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:

☐ Spouse ☐ Domestic partner	Name:			Prior coverage start date *(mm/dd/yy)*:	
			Name of other insurance carrier:		
Prior coverage end date *(mm/dd/yy)*:	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? ☐ Yes ☐ No	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:

☐ Son ☐ Daughter	Name:		Name of other insurance carrier:		Prior coverage start date *(mm/dd/yy)*:	
Prior coverage end date *(mm/dd/yy)*:	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? ☐ Yes ☐ No	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:

☐ Son ☐ Daughter	Name:		Name of other insurance carrier:		Prior coverage start date *(mm/dd/yy)*:	
Prior coverage end date *(mm/dd/yy)*:	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? ☐ Yes ☐ No	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:

☐ Son ☐ Daughter	Name:		Name of other insurance carrier:		Prior coverage start date *(mm/dd/yy)*:	
Prior coverage end date *(mm/dd/yy)*:	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? ☐ Yes ☐ No	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:

6. Group term life insurance, if applicable *(Attach separate sheet for additional or contingent beneficiaries.)*

Life/AD&D coverage: ☐ Yes ☐ No

Life beneficiary *(full name)*:	Relationship:	%
Life beneficiary *(full name)*:	Relationship:	%
Life beneficiary *(full name)*:	Relationship:	%
Life beneficiary *(full name)*:	Relationship:	%

Employee name: _____ Last 4 digits of Social Security #: __ __ __ __

7. Declination of coverage *(Complete this section if any coverage is being declined by you or your eligible dependents.)*

Employee personal information

Last name:	First name:	MI:	Social Security #/Matricular ID #:

Declining medical coverage for:
☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent(s)
Name(s): _____

Reason: ☐ Other group coverage through this employer ☐ Individual coverage
☐ Other group coverage by another group *(i.e., spouse's employer)*
☐ Other: _____

Declining dental coverage for:
☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent(s)
Name(s): _____

Reason: ☐ Other group coverage through this employer ☐ Individual coverage
☐ Other group coverage by another group *(i.e., spouse's employer)*
☐ Other: _____

Declining vision coverage for:
☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent(s)
Name(s): _____

Reason: ☐ Other group coverage through this employer ☐ Individual coverage
☐ Other group coverage by another group *(i.e., spouse's employer)*
☐ Other: _____

IF YOU ARE DECLINING COVERAGE – STOP AND READ CAREFULLY

I have decided to decline coverage for myself and/or my dependent(s). I acknowledge that my dependents and I may have to wait to be enrolled until the next annual Open Enrollment Period or Special Enrollment Period due to a qualifying event. The available coverages have been explained to me by my employer, and I have been given the chance to apply for the available coverages. Additionally, by signing below, I certify that the reason I am declining coverage is accurate as indicated by the check marks above.

Employee signature: _____ **Date:** _____

(Sign only if declining coverage. If signed in error, please cross out and initial.)

8. Acceptance of coverage *(Signature required.)*

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

ACKNOWLEDGMENT AND AGREEMENT: I understand and agree that by enrolling with or accepting services from Health Net, DBP and/or Fidelity, I and any enrolled dependents are obligated to understand and abide by the terms, conditions and provisions of the Plan Contract or Insurance Policy.[4] 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 information and belief, and I accept these terms.

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.

Employee signature: _____ **Date:** _____

(Sign only if accepting coverage. If signed in error, please cross out and initial.)

[4] "Plan Contract" refers to the Health Net of California, Inc. and/or Dental Benefit Providers of California, Inc. Group Service Agreement and Evidence of Coverage; "Insurance Policy" refers to Health Net Life Insurance Company, Unimerica Life Insurance Company, and/or Fidelity Security Life Insurance Company Group Policy and Certificate of Insurance.