

Group Name	Division	Group ID Number	Effective Date of Application (to be completed by the Benefits Administrator)
Reason for Application: <input type="checkbox"/> Open Enrollment <input type="checkbox"/> I have Health Net Dental/HNLIC dental coverage. I am adding Health Net Vision/HNLIC vision <input type="checkbox"/> I have Health Net Vision/HNLIC vision coverage. I am adding Health Net Dental/HNLIC dental			The Employer certifies that applicant meets all contractual eligibility requirements as defined in the Group Agreement or Policy.
<input type="checkbox"/> Terminate Employee <input type="checkbox"/> Terminate Dependent(s) listed below <input type="checkbox"/> Add Dependent(s) listed below <input type="checkbox"/> New Name (indicate below) Former Name: _____			
<input type="checkbox"/> New Address (indicate below) <input type="checkbox"/> New Hire/Newly Eligible - <input type="checkbox"/> Qualifying Event (reason) _____ Date of Hire or Qualifying Event ____/____/____			

Personal Information

Social Security Number	Last Name	First Name	M.I.	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth Month: [] [] Day: [] [] Year: [] [] [] []
Street Address	City (complete name)	State	Zip Code	Home Phone () ()	Work Phone () () Ext. Hours Worked Per Week

Benefit/Dependent Information

Check all new benefits requested

Relationship to Employee	Last Name (if different)	First Name	M.I.	Date of Birth	Sex M / F	*Over aged dependent Disabled Full-time Student	Dependent Add/Delete	Managed Vision	PPO Vision	Indemnity Vision	Dental PPO	Dental Indemnity	Dental DHMO	**Dental DHMO Office Selected	Existing Patient
Self								<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse				Month: [] [] Day: [] [] Year: [] [] [] []	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> add <input type="checkbox"/> delete	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Child				Month: [] [] Day: [] [] Year: [] [] [] []	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> add <input type="checkbox"/> delete	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Child				Month: [] [] Day: [] [] Year: [] [] [] []	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> add <input type="checkbox"/> delete	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Child				Month: [] [] Day: [] [] Year: [] [] [] []	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> add <input type="checkbox"/> delete	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No

* If you have a Dependent Child(ren) who is over 19 and is permanently disabled and dependent upon you for support, please provide the appropriate supporting documentation. Please see your Human Resources representative for details.

***If you have a Dependent Child(ren) between the ages of 19 and 24 who is a full-time student and a dependent as defined by the IRS, please provide the following information:**

School Name	Number of Credit hours (minimum of 12 hours)	School Start Date
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** New Employee and eligible Dependent(s) enrolling in a Dental HMO plan MUST indicate a dental office. If a dental office is not indicated, you and your Dependent(s) will be automatically assigned to an office selected by Health Net Dental.

IMPORTANT PROVISIONS:

Please read and retain with your personal records

Please read the consent for use and disclosure of Dental/Medical Information and the Binding Arbitration agreement below and indicate your agreement to these conditions.

Authorization to use or disclose dental/medical information: I consent, on my behalf and on behalf of my enrolled family members, to the use and disclosure of our dental/medical information by Health Net Dental/Health Net Vision/HNLIC for purposes of treatment, payment and plan operations. I understand that upon request, Health Net Dental/Health Net Vision/HNLIC will make available a copy of the statement describing their policies and procedures for preserving the confidentiality of dental/medical information.

Binding Arbitration: I understand and agree that, as set forth fully in the Health Net Dental/Health Net Vision Evidence of Coverage or HNLIC Policy/Certificate any and all disputes or disagreements between me (including any of my enrolled family members or heirs or personal representatives) and Health Net Dental/Health Net Vision/HNLIC regarding the construction, interpretation, performance or breach of the Evidence of Coverage or Policy/Certificate, or regarding other matters relating to or arising out of my Health Net Dental/Health Net Vision/HNLIC membership, whether stated in tort, contract or otherwise, and whether or not other parties such as employer groups, dental/vision/health care providers, or their agents or employees, are also involved, must be submitted to final and binding arbitration in lieu of a jury or court trial. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties, including Health Net Dental/Health Net Vision/HNLIC, are giving up their constitutional right to the extent permitted by law to have their dispute decided in a court of law before a jury. I also understand that disputes that I may have with Health Net Dental/Health Net Vision/HNLIC involving claims for dental/medical malpractice (that is, whether any dental/medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) are also subject to final and binding arbitration. A more detailed arbitration provision is included in the Evidence of Coverage or Policy/Certificate.

Authorization

If applicable, I hereby authorize payroll deduction. I understand that I must remain in the plan(s) indicated above throughout the duration of the Group Agreement or Policy. Should I choose not to enroll myself and/or my eligible Dependent(s) during the open enrollment period, I understand that I will be unable to enroll myself and/or my Dependent(s) until the next annual open enrollment period. My signature below confirms that I understand all agreements, including my agreement to submit disputes to binding arbitration. I have read and understand the terms on the reverse of this application, and my signature below indicates my acceptance of these terms and that the information I have entered above is true and correct. The Plan reserves the right to rescind or terminate coverage if any material misrepresentation is made in the Enrollment Application.

Employee Signature	Date
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IMPORTANT!

Please read and retain the goldenrod copy of this form with your personal records.

RIGHT OF REIMBURSEMENT: I, on my behalf and on behalf of my family member(s) listed on this Enrollment Application, hereby agree that in the event any services provided to me or my family member(s) and covered by Health Net Dental/Health Net Vision/HNLIC are the primary financial responsibility of another party, because of other coverage or by the act or omission of another person, I will fully inform Health Net Dental/Health Net Vision/HNLIC and will execute such assignments, liens or other documents which may be necessary to enable Health Net Dental/Health Net Vision/HNLIC to recover the value of services and supplies provided, in accordance with California law. I further agree that in the event I or any of my family member(s) collect benefits or damages from any other party who has primary responsibility for services provided by Health Net Dental/Health Net Vision/HNLIC, I will immediately reimburse Health Net Dental/Health Net Vision/HNLIC to the extent of services and supplies received, in accordance with California law.

HEALTH NET DENTAL/HEALTH NET VISION/HNLIC REQUIREMENTS: I, on my behalf and on behalf of my family member(s) listed on this Enrollment Application, agree to be bound by the benefits, copayments, deductibles, exclusions, limitations and other terms and conditions of the Group Agreement or Policy, and as the Group Agreement or Policy is amended.

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

For your protection, California law requires the following disclosure: 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.

* All references to "Health Net Dental/Health Net Vision/HNLIC" herein include the affiliates of Health Net Dental, Inc., Health Net Vision, Inc. and Health Net Life Insurance Company which underwrite or administer the coverage to which this Enrollment Application applies.