

SMALL BUSINESS EMPLOYEE ENROLLMENT FORM

Welcome to Health Net Small Business Plans.



Post Office Box 9103
Van Nuys, California 91409-9103
www.healthnet.com

If you have any questions or need assistance completing this form, please contact the
Small Business Plan Member Services Department at **1-800-361-3366**.
For Salud con Health Net, call **1-800-331-1777**.

PPO, EPO, Flex Net and Group Term Life and AD&D benefits are fully underwritten by Health Net Life Insurance Company.

Health Net of California, Inc. is a subsidiary of Health Net, Inc.



CHECK DESIRED PLAN

- New Enrollment
- New Hire
- Rehire/Re-Enrollee
- Late Enrollment
- Cobra Eff. Date _____
- Qualifying Event _____
- Date of Event _____
- Change Coverage (Loss of coverage)
- Add Dependent
- Change Dependent

- HMO
- HMO Variable Copay
- ELECT Open Access
- SELECT 3-Tier POS
- PPO
- FLEX NET (Out of Area)
- LIFE & AD&D
- Salud con Health Net PPO
- Salud con Health Net EPO
- Salud con Health Net HMO
- Salud con Health Net Mexico

IMPORTANT: PLEASE PRINT ALL SECTIONS IN BLACK INK.

1 YOUR EMPLOYER COMPLETES THIS SECTION

Company Name	Group Number	FT/Date of Hire	Effective Date
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2 YOUR EMPLOYER COMPLETES THIS SECTION (IF APPLYING FOR GROUP LIFE AD&D)

Effective Date	Annual Salary	Occupation	Life Class	Life/AD&D Amount
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3 YOU COMPLETE SECTIONS 3-9 Note: Even if you are declining coverage, you must complete Sections 3 and 9

Last Name	First Name	M.I.	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partnership (affidavit attached)
Social Security Number	Employment Status <input type="checkbox"/> Salaried <input type="checkbox"/> Hourly	Job Title	
Residence Mailing Address (Number, Street, Apartment, City)			State Zip
Home Telephone () ()	Work Telephone () ()	E-mail address	Have you or any of your dependents ever been a Health Net member? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you or any of your dependents waived Health Net coverage in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No

NOTE: Please complete the entire enrollment form. This form cannot be processed if information is incomplete. Dependents age 19 up to 23rd birthday require proof of full-time student status or permanent disability status within 31 days of enrollment.

4 EMPLOYEE/DEPENDENT ENROLLMENT INFORMATION

Please list eligible applicants to be enrolled below, HMO, ELECT Open Access and SELECT 3-Tier (POS) members must reside within the geographic service area established by Health Net to assure reasonable access to care. If you have more than three dependents, please attach an additional Enrollment Form.

If applying for HMO, ELECT Open Access and SELECT 3-Tier (POS) please choose a Physician group within 15-30 mile radius of residence or job site for each member of your family by entering the names and numbers in the appropriate area below. For a listing of physicians you may visit our website at www.healthnet.com, or review the Health Net Small Business Plans Provider Directory. You may choose a different Physician group and Primary Care Physician for each family member. If the group you've selected has an "X" after the number (e.g., IPA 135X), indicate a Primary Care Physician for yourself and each family member enrolling in that group. **Questions? Call Health Net Member Services at 1-800-361-3366 or for Salud con Health Net 1-800-331-1777.**

Name / Address Last - First - M.I. Address - City - State - Zip (If Different)	Telephone Numbers (If Different)	Relationship	Sex M / F	Date of Birth (Mo-Day-Yr)	Social Security Number	Review the Health Net Provider Directory and choose a Participating Physician Group and Primary Care Physician for each family member.	For HMO, ELECT Open Access and SELECT POS Plans Only	
							Physician Group and Primary Care Physician NAME AND ID NUMBER	Existing Patient Y = YES N = NO
	Home	SELF				Disabled <input type="checkbox"/> Full-time Student <input type="checkbox"/> Over 50% support <input type="checkbox"/>		
	Work							
	Home	SPOUSE				Disabled <input type="checkbox"/> Full-time Student <input type="checkbox"/> Over 50% support <input type="checkbox"/>		
	Work							
	Home	DEPENDENT				Disabled <input type="checkbox"/> Full-time Student <input type="checkbox"/> Over 50% support <input type="checkbox"/>		
	Work							
	Home	DEPENDENT				Disabled <input type="checkbox"/> Full-time Student <input type="checkbox"/> Over 50% support <input type="checkbox"/>		
	Work							

5 GROUP TERM LIFE INSURANCE If Applicable (Attach separate sheet for additional or contingent beneficiaries)

Life coverage Yes No If yes, I am applying for Basic Life/AD&D \$ _____ Dependent Life \$ _____

Life Beneficiary (Full Name)	Relationship	%
Life Beneficiary (Full Name)	Relationship	%

6 DISABILITY INFORMATION

1. Do you believe that you or any family member for whom you are applying for coverage would be considered totally disabled according to the definitions of disability given on the back of this application?

Yes No If yes, who? _____

Disabling Condition(s) _____ Date Disability Commenced _____

7 OTHER HEALTH INSURANCE

- Is anyone listed in Section 4 on previous page eligible for Medicare? Yes No If yes, who? _____
- Are you or have you and/or any of your eligible family members been covered by other medical coverage within the last six months?
 Yes No If yes, complete the section below. Please list all current or prior medical coverage. **Failure to provide complete information may result in significant delay of claims processing.** (Attach additional sheets if necessary)

Covered Person's Name Last – First – M.I.	Policy Holder Name(s)	Insurance Company Name(s)	Type of Coverage	Policy No.	Effective Date	Termination Date
			<input type="checkbox"/> Health <input type="checkbox"/> Other _____			(If Applicable)
			<input type="checkbox"/> Health <input type="checkbox"/> Other _____			

Coverage under PPO, EPO or Flex Net may be subject to pre-existing condition limitations for certain enrollees. Please see the back of this form for additional information.

8 ACCEPTANCE OF COVERAGE (The following authorization must be signed if you are applying for coverage.)

Explanation of Authorization to Obtain or Release Medical Information: The authorization below to obtain and release medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act, effective January 1, 1980, Section 56 et seq. of the California Civil Code. Your cooperation is requested. **Authorization to Obtain or Release Medical Information:** I hereby authorize my physician, health care practitioner, hospital, clinic or other medically related facility to furnish an agent, designees or representatives of Health Net or Health Net Life, any and all records pertaining to medical history, services rendered or treatment given to anyone enrolled hereunder, or added hereunder for purpose of review, investigation, or evaluation of an application or a claim. I authorize Health Net, Health Net Life, or its agents, designees or representatives to disclose to a hospital or health care service plan, insurer, any such medical information obtained if such disclosure is necessary to allow the processing of any claim. This authorization shall become effective immediately and shall remain in effect for up to 30 months from the date the authorization is signed. You, or a person authorized to act on your behalf, is

entitled to receive a copy of the authorization form.

Arbitration Agreement: I understand that any dispute or controversy, except medical malpractice, that may arise regarding the performance, interpretation or breach of the agreement between myself (and / or any enrolled family member) and Health Net, Health Net Life Insurance Company or any Participating Medical Group / Independent Physicians Association, whether arising in contract, tort or otherwise, must be submitted to arbitration in lieu of a jury or court trial.

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

For your protection, California law requires the following to appear on this form. Any person who knowingly presents 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.

Please sign and date this application below. Your signature indicates that you have completed all requested information as accurately as possible and that you have read the Plan information and understand all agreements, including your agreement to submit disputes to binding arbitration.

Employee Signature _____ Date _____

9 DECLINATION OF COVERAGE (Complete this section if any coverage is to be declined by you or your eligible dependents.)

I certify that the reason I am declining enrollment is: (check, as applicable)

- I am covered under another group health benefit plan offered to my spouse.
- I am covered under another group health benefit plan offered by my EMPLOYER.
- I am covered under an Individual health plan
- I am declining for my spouse, name: _____
- I am declining for my child/children, name(s): _____, _____, _____

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.**

Employee Signature _____ Date _____
 (ONLY IF DECLINING COVERAGE; If signed in error, please cross out and initial)

10 ETHNICITY (Voluntary)

If available, I would prefer to receive materials in the following language _____.

The following information is voluntary. By indicating your ethnicity you are helping us to better serve your needs.

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> American/Alaskan Native | <input type="checkbox"/> Filipino | <input type="checkbox"/> Korean |
| <input type="checkbox"/> Black/African-American (Non-Hispanic) | <input type="checkbox"/> Hispanic/Latino | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Caucasian (Non-Hispanic/White) | <input type="checkbox"/> Japanese | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Chinese | | |

Welcome to Health Net. Please complete these temporary Enrollment Information Cards and keep until you receive your permanent ID card.



ENROLLMENT INFORMATION CARD

Name _____ Effective Date _____

Employer Name _____

Medical Group Name/Number _____

Doctor _____ Phone _____

HMO HMO Variable Copay ELECT OA SELECT 3-Tier POS PPO
 FLEX NET (Out of Area) SCHN PPO SCHN HMO SCHN EPO
 SCHN Mexico Call Health Net at 1-800-361-3366 or 1-800-331-1777.



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Preexisting Conditions and Creditable Coverage - Your coverage under this benefit plan may be subject to preexisting condition limitations for a maximum period of six months from the effective date of your enrollment. In accordance with state and federal law, Health Net will credit any prior coverage that you document at the time you apply to enroll in PPO, EPO or FLEX NET, provided the prior coverage qualifies as "creditable coverage" as defined under federal and state law. Creditable coverage will be applied to offset (in part or whole) the pre-existing condition limitation, which may apply to your coverage under this policy. If you're unable to provide documentation of bona fide creditable coverage at enrollment time, Health Net may provide assistance in obtaining the necessary documentation upon request. Note: Prior coverage which is interrupted by a period of 63 days (or 181 days if coverage through employment has ended) or more does not qualify as creditable coverage.

Disabling Conditions

If you or a family member were disabled as of the date of termination of coverage with a prior health insurer, you may be entitled to an extension of health benefits according to California Insurance Code § 10128. Under this law, the prior insurer retains responsibility until whichever of the following occurs first: (a) the member is no longer totally disabled; (b) the Maximum benefits of the prior insurer's coverage are paid; or (c) a period of 12 consecutive months has passed since the date coverage ended with the prior insurer.

Total disability, as it relates to the law described above, means: Employee: when, as a result of bodily injury or disease, the employee is unable to engage in any employment or occupation for which he or she is or becomes qualified for by reason of education, training or experience and is not, in fact, engaged in any employment or occupation for wage or profit. Family member: when the family member is prevented from performing all regular and customary activities usual for a person of that age.

Please answer the questions as completely as possible to avoid delay in the processing of your application.

ENROLLMENT INFORMATION CARD

Additional Enrollees Covered

Name _____
 Doctor _____ Phone _____
 Name _____
 Doctor _____ Phone _____
 Name _____
 Doctor _____ Phone _____

Coverage shall not begin until acceptance of your application by Health Net or Health Net Life Insurance Company. Upon acceptance of your application, Health Net shall be bonded by the terms of the Agreement and any Amendments thereto.

ENROLLMENT INFORMATION CARD

Additional Enrollees Covered

Name _____
 Doctor _____ Phone _____
 Name _____
 Doctor _____ Phone _____
 Name _____
 Doctor _____ Phone _____

Coverage shall not begin until acceptance of your application by Health Net or Health Net Life Insurance Company. Upon acceptance of your application, Health Net shall be bonded by the terms of the Agreement and any Amendments thereto.

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 complete these
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