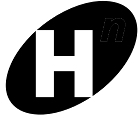

Health Net®

- ❑ New Hire
- ❑ Rehire
- ❑ Open Enrollment
- ❑ New Group
- ❑ Waiver of Coverage
- ❑ Coverage Termination
- ❑ Change Address/Name
  Reason________________________ (Explain)
- ❑ Add/Delete Dependent(s)
  Marriage/Divorce Date ______________
- ❑ On Cobra
  Cobra Eff. Date ______________
  Cobra End Date ______________
  Cobra Qualifying Event ______________

CHECK DESIRED PLANS

- ❑ HMO ______________ (Plan code)
- ❑ PPO ______________ (Plan code)
- ❑ POS ______________ (Plan code)
- ❑ DENTAL ______________ (Plan code)
- ❑ VISION ______________ (Plan code)

IMPORTANT: PLEASE PRINT ALL SECTIONS IN BLACK INK.

Customer Service 1-800-289-2818

1. YOUR EMPLOYER COMPLETES THIS SECTION

Company Name	Group Number	Plan Code	FT/Date of Hire	Effective Date

2. YOUR EMPLOYER COMPLETES THIS SECTION (IF APPLYING FOR GROUP LIFE)

Effective Date	Annual Salary	Occupation	Life Class	Life/AD&D Amount

3. YOU COMPLETE SECTIONS 3-8 Note: Even if you are declining coverage, you must complete Sections 3 and 9

Social Security Number	Last Name	First Name	M.I.

4. EMPLOYEE ADDRESS INFORMATION

Residence Mailing Address (Number, Street, Apartment)	City	State	Zip

Hours Worked	Job Title	E-mail address	Marital Status	Preferred Language
			❑ Single ❑ Married	❑ English ❑ Spanish

Home Telephone	Work Telephone	
( )	( )	Have you or any of your dependents ever been a Health Net member? ❑ Yes ❑ No Have you or any of your dependents waived Health Net coverage in the past 12 months? ❑ Yes ❑ No

NOTE: Please complete the entire enrollment form. This form cannot be processed if information is incomplete.

5. EMPLOYEE/DEPENDENT ENROLLMENT INFORMATION

Add	Change	Delete	Name / Address Last – First – M.I. Address – City – State – Zip (If Different from above)	Telephone Numbers (If Different from above)	Sex M / F	Date of Birth (Mo-Day-Yr)	Social Security Number	Primary Care Physician Selection (REQUIRED FOR HMO PLANS ONLY)	Established Patient Y = YES N = NO (REQUIRED FOR HMO PLANS ONLY)
			Employee	Home					
				Work					
			Spouse	Home					
				Work					
			Dependent	Home					
				Work					
			Dependent	Home					
				Work					
			Dependent	Home					
				Work					

6. GROUP TERM LIFE INSURANCE *(Attach separate sheet for additional or contingent beneficiaries)*

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

(If listing Secondary Beneficiary please attach a separate sheet indicating each beneficiary's name and the percentage payable to each beneficiary.)

WHITE - Health Net **GREEN - Health Net Life** **CANARY - Employer Group** **PINK - Health Net** **GOLDENROD - Employee copy (temporary I.D.)**

7. OTHER HEALTH INSURANCE

REQUIRED FOR ALL PLANS

Besides Health Net will you, or any member of your family covered under your plan, have other group or individual health insurance, including HMO or Medicare coverage? ❑ Yes If Yes, please complete the information below. ❑ No If No, please sign at signature and authorization line in section 8 below.

Failure to provide complete information may result in significant delay of claims processing. (Attach additional sheets if necessary)

Insurance Company Name:	Policyholder's Social Security Number:
Insurance Company Address:	___ ___ ___ — ___ ___ — ___ ___ ___ ___
Name of Policyholder:	Medicare Number:
Policy and Group Number:	Effective date - Medicare Part A:
Effective Date:	Effective Date - Medicare Part B:

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

Group Health Insurance: I hereby request enrollment in the Health Plan identified above and authorize deductions from my earnings (if applicable) in an amount to cover the premium. I understand that my signature indicates my acceptance of the terms, conditions and provisions of the applicable Evidence of Coverage or Certificate of Insurance under which I am covered and that the information I have entered above is true and correct. Health Net reserves the right to rescind or terminate coverage if any material misrepresentation is made in this Enrollment Application.

I, on behalf of myself and my dependents, authorize Health Net of Arizona, Inc. and/or Health Net Life Insurance Company, SafeHealth LIfe Insurance Company and the Fidelity entities, and their authorized employees, agents, independent contractors, and participating providers to release to and/or obtain from, said physician, practitioner, hospital, clinic, other medical or medically related facility, and/or employer who possess information about my or my eligible dependent(s)' care, treatment, including information about drugs, alcoholism, mental illness, AIDS or ARC, which Health Net requires or is obligated to provide pursuant to legal process, federal, state, or local law, to determine insurability or otherwise requires to administer coverage under this plan. Notwithstanding anything else herein, this authorization shall not apply to the release of information pertaining to HIV, AIDS or ARC to my employer without a separate authorization signed by me specifically for that purpose. This authorization expires 180 days from the date the authorization is signed as it relates to information regarding testing, diagnosis, treatment or other information related to AIDS, ARC or HIV. For all other purposes, this authorization shall be valid for 30 months unless this authorization is used for the purpose of collecting information in connection with a claim or benefits, in which case this authorization shall remain effective for the duration of my coverage by Health Net. I, or my authorized agent, am entitled to receive a copy of this authorization. A photocopy of this authorization is as valid as the original.

Group Term Life AD&D Insurance: I request coverage under my employer's group insurance plan as noted and also verify the accuracy of the employee section. Furthermore, I authorize my employer to deduct from my earnings any payments, if applicable, for this coverage.

Employee Signature ____ **Date** ______________

(Must sign if enrolling for Health and/or Life Coverage)

9. WAIVER OF HEALTH COVERAGE (Complete if DECLINING health coverage for yourself OR your dependents.)

I certify that the benefits of the plan have been thoroughly explained to me, and I am declining enrollment for: (check one)

❑ Myself and My Dependent(s) (if any) (list below)

❑ All My Dependent(s) (list below)

❑ My Spouse Only (list below)

❑ My Child(ren) Only (list below)

Spouse Name: ________________________________

Child(ren) Names: ________________________________

____

Reason(s) for declining coverage (check all that apply):

❑ I am covered under another group health plan offered by my spouse.
❑ I am covered under another individual health plan.
❑ I am covered under Champus, AHCCCS, I.H.S. or Medicare
❑ I have no other coverage
❑ My dependent(s) are covered under another group health plan offered by my spouse
❑ My dependent(s) are covered under another group health plan offered through their other parent or ex-spouse
❑ My dependent(s) are covered under another individual health plan.
❑ My dependent(s) are covered under Champus, AHCCS, I.H.S. or Medicare
❑ My dependent(s) have no other coverage

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, employer group anniversary date, or qualifying event.**

Notice of Special Enrollment Periods

I understand if I am declining enrollment for myself or my dependent(s), including my spouse, because of other health coverage, I may in the future be able to enroll myself and/or my dependent(s) in this group health coverage policy, provided that I request enrollment within 31 days after my other coverage ends. In addition, if I have a new dependent(s) as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependent(s), provided that I request enrollment within 31 days after the marriage, birth, adoption or placement of adoption.

(SIGN BELOW ONLY IF DECLINING COVERAGE FOR YOURSELF OR YOUR DEPENDENTS)

Employee Signature ____ **Date** ______________

(If signed in error, please cross out and initial)

WHITE - Health Net **GREEN - Health Net Life** **CANARY - Employer Group** **PINK - Health Net** **GOLDENROD - Employee copy (temporary I.D.)**

Health Net®

Notice of Insurance Information Practices:

Pursuant to Arizona law: Health Net and/or Health Net Life Insurance Company may collect personal information about you from other sources during the underwriting process. The information collected by Health Net and/or Health Net Life Insurance Company about you may, in certain circumstances, be disclosed to third parties without your authorization. You have the right to review information collected by Health Net and/or Health Net Life Insurance Company and correct erroneous information. A full description of your rights regarding the information collected by Health Net and/or Health Net Life Insurance Company is available upon request.

In Arizona, benefits are insured and/or administered by Health Net of Arizona, Inc. for HMO plans and Health Net Life Insurance Company for PPO plans and Life Insurance coverage. Health Net, Inc. is the parent company of both Health Net of Arizona, Inc., and Health Net Life Insurance Company.

Dental policies are underwritten and administered by SafeHealth Life Insurance Company (SafeHealth). Obligations of SafeHealth are not the obligations of nor guaranteed by Health Net, Inc. or its affiliates.

Vision plans are underwritten by Fidelity Security Life Insurance Company and serviced by EyeMed Vision Care, LLC (together, the "Fidelity entities"). Discounts on vision care services are made available by EyeMed. Obligations of the Fidelity entities are not the obligations of nor guaranteed by Health Net, Inc. or its affiliates.