



Health Net®

TO BE COMPLETED BY EMPLOYER	
Employer name:	
Requested effective date:	Employer group number (medical):
Employee eligibility date (new hire only):	
<input type="checkbox"/> Same as hired date <input type="checkbox"/> 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 (All medical plans include pediatric dental and vision coverage.)

FULL HMO NETWORK ¹			SMARTCARE HMO NETWORK ²		
Platinum <input type="checkbox"/> \$10 <input type="checkbox"/> \$20 <input type="checkbox"/> \$30	Gold <input type="checkbox"/> \$30 <input type="checkbox"/> \$35 <input type="checkbox"/> \$40 <input type="checkbox"/> \$50	Silver <input type="checkbox"/> \$50	Platinum <input type="checkbox"/> \$10 <input type="checkbox"/> \$20 <input type="checkbox"/> \$30	Gold <input type="checkbox"/> \$30 <input type="checkbox"/> \$35 <input type="checkbox"/> \$40 <input type="checkbox"/> \$50	Silver <input type="checkbox"/> \$50
WHOLECARE HMO NETWORK ¹			SALUD HMO Y MÁS NETWORK ³		
Platinum <input type="checkbox"/> \$10 <input type="checkbox"/> \$20 <input type="checkbox"/> \$30	Gold <input type="checkbox"/> \$30 <input type="checkbox"/> \$35 <input type="checkbox"/> \$40 <input type="checkbox"/> \$50	Silver <input type="checkbox"/> \$50	Platinum <input type="checkbox"/> \$10 <input type="checkbox"/> \$20 <input type="checkbox"/> \$30	Gold <input type="checkbox"/> \$30 <input type="checkbox"/> \$35 <input type="checkbox"/> \$40 <input type="checkbox"/> \$50	Silver <input type="checkbox"/> \$50
COMMUNITYCARE HMO NETWORK ⁴					
Silver <input type="checkbox"/> \$50		Bronze <input type="checkbox"/> CommunityCare Bronze 60 HMO 6300/65 + Child Dental			
PURECARE HSP NETWORK ¹					
<input type="checkbox"/> PureCare Platinum 90 HSP 0/15 + Child Dental <input type="checkbox"/> PureCare Gold 80 HSP 250/25 + Child Dental			<input type="checkbox"/> PureCare Silver 70 HSP 2250/50 + Child Dental <input type="checkbox"/> PureCare Bronze 60 HSP 6300/65 + Child Dental		
FULL PPO NETWORK			ENHANCEDCARE PPO NETWORK ⁵		
<input type="checkbox"/> Platinum 90 PPO 0/15 + Child Dental <input type="checkbox"/> Platinum 90 PPO 250/15 + Child Dental Alt <input type="checkbox"/> Gold 80 PPO 0/30 + Child Dental Alt <input type="checkbox"/> Gold 80 PPO 250/25 + Child Dental <input type="checkbox"/> Gold 80 PPO 500/20 + Child Dental Alt <input type="checkbox"/> Gold 80 PPO 1000/30 + Child Dental Alt <input type="checkbox"/> Gold 80 Value PPO 750/15 + Child Dental Alt <input type="checkbox"/> Silver 70 PPO 2250/50 + Child Dental <input type="checkbox"/> Silver 70 PPO 2250/55 + Child Dental Alt <input type="checkbox"/> Silver 70 HDHP PPO 1400/40% + Child Dental Alt <input type="checkbox"/> Silver 70 Value PPO 1700/50 + Child Dental Alt <input type="checkbox"/> Bronze 60 PPO 6300/65 + Child Dental <input type="checkbox"/> Bronze 60 HDHP PPO 5600/20% + Child Dental Alt			<input type="checkbox"/> EnhancedCare Platinum 90 PPO 250/15 + Child Dental Alt <input type="checkbox"/> EnhancedCare Gold 80 PPO 0/30 + Child Dental Alt <input type="checkbox"/> EnhancedCare Gold 80 PPO 500/20 + Child Dental Alt <input type="checkbox"/> EnhancedCare Gold 80 PPO 1000/30 + Child Dental Alt <input type="checkbox"/> EnhancedCare Gold 80 Value PPO 750/15 + Child Dental Alt <input type="checkbox"/> EnhancedCare Silver 70 PPO 2250/55 + Child Dental Alt <input type="checkbox"/> EnhancedCare Silver 70 HDHP PPO 1400/40% + Child Dental Alt <input type="checkbox"/> EnhancedCare Silver 70 Value PPO 1700/50 + Child Dental Alt <input type="checkbox"/> EnhancedCare Bronze 60 HDHP PPO 5600/20% + Child Dental Alt		
OTHER PLAN(S):					

DENTAL (DHMO)	DENTAL (DPPO)	VISION (PPO)
<input type="checkbox"/> HN Plus 150 <input type="checkbox"/> HN Plus 225	<input type="checkbox"/> Classic 5 1500 (w/ortho) <input type="checkbox"/> Essential 2 1000 <input type="checkbox"/> Essential 6 1500 <input type="checkbox"/> Classic 4 1500 <input type="checkbox"/> Essential 5 1500 (w/ortho)	<input type="checkbox"/> Elite 1010-1 <input type="checkbox"/> Supreme 010-2 <input type="checkbox"/> Preferred 1025-2 <input type="checkbox"/> Preferred 1025-3 <input type="checkbox"/> Preferred Value 10-3 <input type="checkbox"/> Plus 20-1 <input type="checkbox"/> Exam Only

2. Reason for application

<input type="checkbox"/> Plan change <input type="checkbox"/> Change address/name <input type="checkbox"/> Delete dependent (list names below) <input type="checkbox"/> Other: _____	<input type="checkbox"/> New hire <input type="checkbox"/> Open Enrollment Special Enrollment Period Qualifying event date: ____/____/____	<input type="checkbox"/> COBRA ⁶ Effective date: ____/____/____ Qualifying event: _____ Qualifying event date: ____/____/____
	Add dependent: <input type="checkbox"/> Marriage <input type="checkbox"/> Newborn/Adoption/Legal guardianship/Court order/Assumption of parent-child relationship <input type="checkbox"/> Loss of prior coverage <input type="checkbox"/> Domestic partnership <input type="checkbox"/> Other (specify): _____	

Employee name: _____

Last 4 digits of Social Security #/TIN: _____

3. EMPLOYEE PERSONAL INFORMATION

Last name:		First name:		MI:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Residence address:					
City:			State:	ZIP:	County:
Date of birth (mm/dd/yyyy):		Social Security #/TIN/Matricular ID #:		Job title:	
Telephone #: ()		Work phone #: ()		Email address:	
Date of hire: / /		Dept. #:		Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic partner	
If available, I would prefer to receive communication and plan information in Spanish: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Participating physician group:			Primary care physician:		
PPG/PCP Enrollment ID # (4-digit PPG and 6-digit PCP numbers):			Is this your current PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Dental HMO provider name:			Dental HMO provider ID #:		

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

Spouse/Domestic partner <input type="checkbox"/> M <input type="checkbox"/> F		Last name:		First name:		MI:
Residence address: <input type="checkbox"/> Check here if same as subscriber						
City:					State:	ZIP:
Date of birth (mm/dd/yyyy):			Social Security #/TIN/Matricular ID #:			
Participating physician group:			Primary care physician:			
PPG/PCP Enrollment ID # (4-digit PPG and 6-digit PCP numbers):			Is this your current PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Dental HMO provider name:			Dental HMO provider ID #:			

<input type="checkbox"/> Son <input type="checkbox"/> Daughter		Last name:		First name:		MI:
Residence address: <input type="checkbox"/> Check here if same as subscriber						
City:					State:	ZIP:
Date of birth (mm/dd/yyyy):			Social Security #/TIN/Matricular ID #:			
Participating physician group:			Primary care physician:			
PPG/PCP Enrollment ID # (4-digit PPG and 6-digit PCP numbers):			Is this your current PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Dental HMO provider name:			Dental HMO provider ID #:			

Employee name: _____

Last 4 digits of Social Security #/TIN: _____

4. Family information, please list all eligible family members to be enrolled. (continued)

(Attach additional sheets if necessary.)

<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Last name:	First name:	MI:
Residence address: <input type="checkbox"/> Check here if same as subscriber			
City:		State:	ZIP:
Date of birth (mm/dd/yyyy):		Social Security #/TIN/Matricular ID #:	
Participating physician group:		Primary care physician:	
PPG/PCP Enrollment ID # (4-digit PPG and 6-digit PCP numbers):		Is this your current PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dental HMO provider name:		Dental HMO provider ID #:	

<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Last name:	First name:	MI:
Residence address: <input type="checkbox"/> Check here if same as subscriber			
City:		State:	ZIP:
Date of birth (mm/dd/yyyy):		Social Security #/TIN/Matricular ID #:	
Participating physician group:		Primary care physician:	
PPG/PCP Enrollment ID # (4-digit PPG and 6-digit PCP numbers):		Is this your current PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dental HMO provider name:		Dental HMO provider ID #:	

5. Do you or your dependents have other health care coverage? No Yes If "Yes," please complete this section including Medicare.

<input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicare: <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare claim/HICN #:
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner	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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does it cover? Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare: <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare claim/HICN #:
<input type="checkbox"/> Son <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does it cover? Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare: <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare claim/HICN #:
<input type="checkbox"/> Son <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does it cover? Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare: <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare claim/HICN #:
<input type="checkbox"/> Son <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does it cover? Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare: <input type="checkbox"/> Part A <input type="checkbox"/> 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:	%

¹Available in all or parts of Alameda, Contra Costa, El Dorado, Fresno, Kern, Kings, Los Angeles, Madera, Marin, Merced, Napa, Nevada, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare, Ventura, and Yolo counties.²Available in all or parts of Los Angeles, Orange, Riverside, San Diego, San Bernardino, Santa Clara, and Santa Cruz counties.³Available in Orange County and select ZIP codes of Kern, Los Angeles, Riverside, San Diego, and San Bernardino counties.⁴Available in Los Angeles, Orange and San Diego counties.⁵Available in Los Angeles County.⁶Provide the effective date COBRA first began, whether you were eligible for a total of 18 months or 36 months of COBRA (including Cal-COBRA).

"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 Group Policy and Certificate of Insurance.

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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner <input type="checkbox"/> Dependent(s) Name(s): _____		Reason: <input type="checkbox"/> Other group coverage through this employer <input type="checkbox"/> Individual coverage <input type="checkbox"/> Other group coverage by another group (<i>i.e., spouse's employer</i>) <input type="checkbox"/> Other: _____	
Declining dental coverage for: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner <input type="checkbox"/> Dependent(s) Name(s): _____		Reason: <input type="checkbox"/> Other group coverage through this employer <input type="checkbox"/> Individual coverage <input type="checkbox"/> Other group coverage by another group (<i>i.e., spouse's employer</i>) <input type="checkbox"/> Other: _____	
Declining vision coverage for: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner <input type="checkbox"/> Dependent(s) Name(s): _____		Reason: <input type="checkbox"/> Other group coverage through this employer <input type="checkbox"/> Individual coverage <input type="checkbox"/> Other group coverage by another group (<i>i.e., spouse's employer</i>) <input type="checkbox"/> 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, to the best of my knowledge or belief, 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 and/or DBP 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 represent that 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 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, except disputes concerning adverse benefit determinations as defined in 45 CFR 147.136, arising from or relating to the *Evidence of Coverage or Certificate of Insurance* or my Health Net coverage, must be submitted to individual, final and binding arbitration instead of a jury or court trial, and that I am waiving all rights to class arbitration. This agreement to arbitrate 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, except disputes concerning adverse benefit determinations, 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, except disputes concerning adverse benefit determinations, 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.)