



EMPLOYEE ENROLLMENT FORM



Please select a benefit design:

HMO PPO FLEX NET POS EPO

Instructions: Complete entire form. Please print using black ink. **Read all sections carefully. Incomplete or omitted information may affect your effective date and payment of claims.** Keep a copy of this form as Proof Of Application until you receive your ID card(s). If you have questions concerning this form, please contact your Employer.

Employer Information:	Company Name	Group No.	Effective Date
Employee Information:	Social Security Number	Employment Occupation / Title	Employee Type <input type="checkbox"/> Hourly <input type="checkbox"/> Salaried
	Work Telephone ()	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Do you have dependents other than spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many? _____
			Home Telephone ()

Below, list ONLY those persons that you wish to enroll in Health Net medical coverage. All enrollees must live or work within the Health Net service area. To enroll more than three children, please attach another form. If declining coverage for any dependent(s), complete the section on the back of this form labeled Declination of Coverage. **Note:** Any child(ren) aged 19 to 23 years old require(s) submission of proof of dependent status within 31 days of enrollment.

	Last Name	First Name	MI	Birth Date / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	For HMO, SELECT and ELECT Enrollees only. Medical Group/ Physician selection*			
SELF	Mailing Address		City	ZIP		PMG / IPA#	Medical Group Name	Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Street Address, if different from above		City	ZIP		PCP#	Physician Name (Last, First)		
SPOUSE	Last Name		First Name	MI	Birth Date / /		PMG / IPA#	Medical Group Name	Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Social Security Number	Address / Telephone (if different)		Date of marriage / /		PCP#	Physician Name (Last, First)		
CHILD	Last Name		First Name	MI	Birth Date / /		PMG / IPA#	Medical Group Name	Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Social Security Number	Address / Telephone (if different)		Full-time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No		PCP#	Physician Name (Last, First)		
CHILD	Last Name		First Name	MI	Birth Date / /		PMG / IPA#	Medical Group Name	Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Social Security Number	Address / Telephone (if different)		Full-time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No		PCP#	Physician Name (Last, First)		
CHILD	Last Name		First Name	MI	Birth Date / /		PMG / IPA#	Medical Group Name	Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Social Security Number	Address / Telephone (if different)		Full-time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No		PCP#	Physician Name (Last, First)		

* Review the Health Net Provider Directory and choose a medical group for yourself and each family member. Indicate number (PMG/IPA#) and name of the medical group. If the medical group you've selected has an "X" after the number (e.g., IPA 135X), be sure to indicate a Primary Care Physician (PCP) number and name for each person enrolling in that group.

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

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

DISABILITY INFORMATION SELECT, OPTIONS, ELECT, and FLEX NET enrollees: Do you believe that you or any family member for whom you are applying for coverage under Health Net and Health Net Life Insurance Company would be considered disabled according to the definitions of disability given on the back of this application? Yes No If yes, complete this section.

Name of Disabled Individual	Disabling Condition	Date Disability Began
-----------------------------	---------------------	-----------------------

OTHER HEALTH INSURANCE

Have you and/or any of your eligible family members been covered by other medical insurance within the last six (6) months? Yes No
 If yes, complete this section. Attach additional sheets if needed. This information is needed for coordination of benefits and to credit OPTIONS and FLEX NET enrollees who are subject to pre-existing conditions limitations for qualifying prior coverage. Health Net Life Insurance Company reserves the right to require proof of prior coverage and will assist you in obtaining this proof if needed.

Covered Person(s)	Coverage Through	Policy #	Carrier Name	Plan Type	Began	Ended
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)	<input type="checkbox"/> Current Employer <input type="checkbox"/> Previous Employer <input type="checkbox"/> Spouse's Employer <input type="checkbox"/> Other _____	Employer's Name		<input type="checkbox"/> Health <input type="checkbox"/> Other _____		If Applicable
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)	<input type="checkbox"/> Current Employer <input type="checkbox"/> Previous Employer <input type="checkbox"/> Spouse's Employer <input type="checkbox"/> Other _____	Employer's Name		<input type="checkbox"/> Health <input type="checkbox"/> Other _____		

Health Net SELECT and ELECT consist of HMO services provided by Health Net and insurance benefits underwritten by Health Net Life Insurance Company. FLEX NET and OPTIONS benefits are fully underwritten by Health Net Life Insurance Company. **Explanation of medical release authorization:** 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, designee or representative of Health Net, 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, or its agents, designees or representatives to disclose to a hospital, health care service plan, or self-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 as long as is necessary to enable Health Net to process claims.

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.

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

Employee Signature X	Date
--------------------------------	-------------

DECLINATION OF COVERAGE Complete this section ONLY if you are NOT enrolling ALL eligible dependents.

I am declining coverage for my: Spouse Child(ren) Spouse & Child(ren)

Reason:	<input type="checkbox"/> Other group health coverage	<input type="checkbox"/> Other _____
	<input type="checkbox"/> Individual health coverage	_____

I acknowledge that my employer has explained the available coverage's to me, and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll my dependent(s). I have made this decision voluntarily, and no one has tried to influence my decision to decline coverage. **By declining this group medical coverage I acknowledge that my dependents may have to wait up to 12 months from the date of this application to be enrolled in this group medical plan.**

Employee Signature (sign here only if declining coverage for eligible dependent(s))	Date
--	------

Disabling Conditions

If you or a family member were disabled as of the date of termination of coverage with a prior health insurer, and the loss of coverage was due to the termination of the employer's insurance policy, you may be entitled to an extension of health insurance 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 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 and family status.