Health Net

Date: ___________

Dear Applicant:

The enclosed health insurance application is being returned to you for the following reason(s):

Employee Information:

__ Social Security Number __ Address/Phone # __ Job Title

__ Employment Status __ Marital/Dependent Status __ Other __________

Enrollment Information:

__ Name, Social Security number, date of marriage, and date of birth for yourself and all dependents covered under the insurance plan

__ Student Status/Verification for dependent(s)

__ Name of the Medical Group / Physician selected for you and all dependents covered under the insurance plan

Life Insurance:

__ Beneficiary Name(s) and Relationship

Disability Information:

__ Yes/No (If yes, please complete this section)

Other Health Insurance:

__ Yes/No (If yes, please complete this section)

Coverage Declination (Complete this section if declining coverage for any dependents):

__ Person(s) Declined __ Reason Declined __ Signature and Date

Signature:

__ Employee Signature and Date

Please return the completed form(s) promptly. **Delay may result in coverage being denied**. Fax to (714) 953-6987. If you have any questions, please call (866) 358-9456.

Thank you,

Contractor's Choice

A *CHOICE* Administrators Program