Health Net®

INSTRUCTIONS FOR COMPLETING YOUR INDIVIDUAL & FAMILY PLAN ENROLLMENT APPLICATION

You may use this Application to apply for any of the available Health Net health insurance plans and Individual Term Life Insurance. HMO plans are provided by Health Net of California, Inc. PPO plans and term life insurance coverage are underwritten by Health Net Life Insurance Company.

IMPORTANT: Can you read this form? If not, we can have somebody help you read it. You may also be able to get this form written in your language. For free help, please call right away at 800-909-3447, option 2.

IMPORTANTE: ¿Puede leer este formulario? De no ser así, podemos hacer que alguien le ayude a leerlo. También puede obtener este formulario escrito en su idioma. Para obtener ayuda sin costo, llame inmediatamente al 800-909-3447, opción 2.

重要資訊：您是否能閱讀此文件?如果您無法閱讀，我們將請專人協助您。我們也能以您使用的語言翻譯此份文件。請立即致電 800-909-3447，再按 2，洽詢免費服務。

Please print clearly using black or blue ink.

Please see Part VII if applicant does not read/write English. The Individual & Family Enrollment Application is available in Chinese and Spanish language versions.

THE APPLICATION MUST BE COMPLETED BY THE APPLICANT. NEITHER THE BROKER NOR ANY OTHER PERSON MAY COMPLETE THE STATEMENT OF HEALTH OR SIGN THE APPLICATION AND AGREEMENT ON BEHALF OF THE APPLICANT(S).

- Fully complete the Application to avoid a return of the Application and delay in processing.
- Give complete name, address, and phone number of all doctors indicated in Part V(b).
- If approved, this Application will become part of your Plan Contract or Insurance Policy.

Corrections to answers can be made by drawing a straight line through the incorrect answer and printing the correct response above the lined out answer. Applicant must then initial and date the correction.

If you have questions or are not sure how to answer a question, call your broker/agent, or Health Net, toll free at (800) 909-3447, option 2.

PART I, A, B, C:

- Effective dates can be the 1st of the month for HMO plans or the 1st and 15th for PPO Plans.
- Select the reason for the Application.
- Select requested Billing Type.

Health Net offers three payment modes: Monthly by check; Monthly by Automatic Bank Draft (ABD); Monthly by Repetitive Credit Card. If you prefer to pay by ABD or Credit Card, please complete the Pay Option Form on page 23.

- One Application can be used for family members that want to apply for separate plans. Part II is for the primary applicant; use Part III to choose plan options for other applicants. Family members that choose separate plans will be billed "Subscriber" rates. See Monthly Rate Guide for rates.

PLUS OPTION

A Health Net "Plus" plan is a Health Net HMO or PPO plan with Health Net Dental and Vision coverage included. The "Plus" indicates the addition of the optional coverage. Please refer to the Monthly Rate Guide for rates. If you are applying for HMO Plus, you must select an HMO Dentist. Go to www.healthnet.com to find a listing of participating dentists.

PART V, STATEMENT OF HEALTH

Each applicant applying for coverage must complete a separate Statement of Health. The Application contains 3 Statement of Health questionnaires. If additional questionnaires are needed, please request the additional copies from your broker/agent or call (800) 909-3447, option 2.

Please read and complete the required *Authorization for Use or Disclosure of Information for Enrollment* when applying for health coverage.

PREMIUM PAYMENT

Ask your broker/agent for monthly rates or refer to the Monthly Rate Guide.

Checks should be made payable to Health Net. Submit your completed and signed Application to:

Health Net
P.O. Box 1150
Rancho Cordova, CA 95741-1150

Your new health insurance coverage with Health Net will be in force when all of the following events take place:

1. The Application has been approved for issuance by the Underwriting Department.
2. The first full premium has been paid and received by Health Net.
3. Coverage will become effective based upon the effective date that you selected, subject to underwriting approval. Once approved, the effective date will not be changed without proof of other existing coverage.
4. **Do not terminate any existing coverage until you have been notified that your Health Net coverage is in effect.**

Health Net®

INDIVIDUAL & FAMILY ENROLLMENT APPLICATION

Application must be typed or completed in blue or black ink. **THE APPLICATION MUST BE COMPLETED BY THE APPLICANT. NEITHER BROKER NOR ANY OTHER PERSON MAY COMPLETE THE STATEMENT OF HEALTH OR SIGN THIS APPLICATION AND AGREEMENT ON BEHALF OF THE APPLICANT. The Statement of Health can be completed by the applicant for minor dependents.**

Please see Part VII if applicant does not read/write English. The Individual & Family Enrollment Application is available in Chinese and Spanish language versions.

IMPORTANT: Can you read this form? If not, we can have somebody help you read it. You may also be able to get this form written in your language. For free help, please call right away at 800-909-3447, option 2.

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PART I. TELL US WHO YOU ARE ENROLLING AND SELECT THE PRODUCT:

A. REQUESTED EFFECTIVE DATE

☐ **1st of the month.**

Please note date: _____/01/_____

☐ **15th of the month** ***(PPO coverage only)***

Please note date: _____/15/_____

B. REASON FOR APPLICATION

Family type

☐ Subscriber ☐ Subscriber & Spouse/Domestic Partner* ☐ Subscriber & Child ☐ Subscriber & Children
☐ Family: Subscriber, Spouse/Domestic Partner and Child(ren)*
**Please circle spouse or Domestic Partner*

Enrollment type

☐ New Enrollment ☐ Change Plan** ☐ Add Dependent ***Member ID number (listed on your ID card):* _____

C. BILLING OPTIONS

Please select a billing option. This billing option does not apply to Term Life, which is billed and administered separately.

First Premium Payment (select one)

☐ Automated Bank Draft (Please complete the Simple Pay Option section.)
☐ Pay by Check (Please include completed check and send with Application. Amount must match monthly premium.)
☐ Credit card (Please complete the credit card section.)

Monthly Premium Payments (select one, includes first month's premium)

☐ Automated Bank Draft (Please complete the Simple Pay Option section.)
☐ Monthly Bill
☐ Credit card (Please complete the credit card section.)

D. COVERAGE CHOICES

Health Net offers the following coverage options:

1. Single Coverage: if you are applying for coverage just for yourself, complete Part II.

2. Family Coverage (applicant plus one or more dependents): for family coverage, you need to fill out both Parts II and III.

With family coverage, you have the option of enrolling in the same plan or choosing different plans for different family members. Please note that when each family member chooses a different plan, Subscriber rates will apply to each family member. To specify different plans for different family members be sure to write the plan name you are choosing for each family member in the spaces provided in Part III.

Primary Applicant's Social Security Number

☐☐☐ ☐☐ ☐☐☐☐

Primary Applicant Name: _____

PART II. PRIMARY APPLICANT

If you are applying for coverage with a spouse or domestic partner who is younger, indicating him or her as the Primary Applicant may qualify you for a more favorable rate. If you choose different plans for you and a spouse/domestic partner, "Subscriber" rates will apply.

STEP 1: Choose your plan

PPO* – HEALTH NET LIFE INSURANCE COMPANY: *(1st and 15th of the month effective dates)*

☐ **NetFirst** *with* ☐ Generic Rx *or* ☐ Combo Rx

☐ **ValueNet** ☐ **BalanceNet**

HSA (Compatible Plans) ☐ Optimum Advantage HSA 2500 ☐ Optimum Advantage HSA 4500

If you have applied for Individual PPO coverage and do not meet the underwriting requirements for preferred premiums for the PPO plan for which you applied, Health Net may elect to offer you our **Modified Issue PPO option**. The Modified offer may be a plan that will have **a rate that is 20% or 50% higher** than the standard rate for which you applied. You will be automatically enrolled unless otherwise specified. Please check this box if you do not want to be automatically enrolled into the **Modified Issue PPO option**.

☐ **NO, do not enroll me in the Modified Issue PPO option**

HMO – HEALTH NET OF CALIFORNIA: *(1st of the month effective dates)* ☐ HMO 15 ☐ HMO 40

☐ **Add – Term Life Insurance Coverage underwritten by Health Net Life Insurance Company – (Part VI (page 18), must be completed.)**

☐ **Add – Dental and Vision Plus – If you are selecting different medical plans for each family member and noting these choices in Part III, please also note in Part III which family members you wish to enroll in Dental and Vision Plus.**

Primary Dentist Number (HMO plans only): _____

STEP 2: Tell us about yourself

Primary Applicant's Last Name	First Name	MI	☐ Male ☐ Female
Home Address			
City	State	ZIP	County applicant resides in
Billing Address (if you want your bill sent to an address different from your home address; only your bill will be sent to this address)			
Home Phone Number ( )	Work Phone Number ( )	Email address	
Primary Applicant's Birth Date (mo/day/year) / /	Place of Birth	Primary Applicant's Social Security Number - -	
Height	Weight (lbs)	Primary Care Physician ID # (if applicable)	Current Patient ☐ Yes ☐ No / Physician Group ID#

In the past 6 months, have you been a resident of the United States? ☐ Yes ☐ No

If no, where was your last residence?

Type of Business:	Occupation:	Salary Range (optional):
☐ Self Employed/Consultant ☐ Unemployed (between jobs) ☐ Professional/Management ☐ Student ☐ Retired ☐ Employed (Non-managerial) ☐ Other:		☐ $18,000–30,000 ☐ $60,001–75,000 ☐ $30,001–45,000 ☐ $75,001–90,000 ☐ $45,001–60,000 ☐ $90,001+

Would you be interested in other Health Net or affiliated entities, products and services? ☐ Yes ☐ No

May we contact you by email? ☐ Yes ☐ No

If yes, a Health Net representative or Authorized Agent will contact you.

How did you hear about Health Net's Individual and Family coverage?

☐ Radio ☐ Mail ☐ Billboard ☐ Newspaper ☐ Yellow Pages ☐ Broker ☐ Internet ☐ Other: _____

Primary Applicant's Social Security Number

Primary Applicant Name: _____

PART III. FAMILY MEMBER(S) TO BE ENROLLED

1. List all eligible family members to be enrolled other than you. If a listed family member's last name is different from yours, please explain on a separate sheet of paper.
2. For Domestic Partner coverage all requirements for eligibility, as required by the applicable laws of the State of California, must be met and a joint Declaration of Domestic Partnership must be filed with the California Secretary of State.
3. How to make different plan choices:
   a. If you wish to choose different medical and dental/vision (Plus) coverage for each family member, please complete the dental/vision (Plus) coverage questions.*
   b. Health Net bills to only one address per Subscriber. Therefore, to be processed under one Subscriber, all family members must be billed to the same address.
   c. If you are applying for HMO coverage, you must select a Physician Group and Primary Care Physician. You may choose the same or different Physician Group and Primary Care Physician for each family member you are enrolling. If you do not select a Primary Care Physician, one will be selected for you within your regional area.
   d. For Plus (dental/vision) coverage with an HMO Plan, please provide the dentist number for the HMO dentist you've chosen. You may choose a different dentist per family member. If you do not select a dental office, one will be selected for you in your area.
   e. See Part VI to enroll in Supplemental Term Life Insurance.

Relation	Last Name First Name MI	Social Security Number	Date of Birth	Place of Birth	Height/ Weight (lbs.)	Primary Care Physician ID (HMO only)
☐ Husband ☐ Wife ☐ Spouse/ Domestic Partner						

Current Patient	Physician Group ID # (HMO only)	Medical plan choice for each family member if different*	Add Dental and Vision Plus (if yes, and HMO please note Primary Dentist #)
☐ Yes ☐ No			☐ Yes ☐ No Primary Dentist Number: _____

Relation	Last Name First Name MI	Social Security Number	Date of Birth	Place of Birth	Height/ Weight (lbs.)	Primary Care Physician ID (HMO only)
☐ Son ☐ Daughter	Child 1					

Current Patient	Physician Group ID # (HMO only)	Medical plan choice for each family member if different*	Add Dental and Vision Plus (if yes, and HMO please note Primary Dentist #)
☐ Yes ☐ No			☐ Yes ☐ No Primary Dentist Number: _____

Full Time Student?	Units carried	Name of School
☐ Yes ☐ No		

Relation	Last Name First Name MI	Social Security Number	Date of Birth	Place of Birth	Height/ Weight (lbs.)	Primary Care Physician ID (HMO only)
☐ Son ☐ Daughter	Child 2					

Current Patient	Physician Group ID # (HMO only)	Medical plan choice for each family member if different*	Add Dental and Vision Plus (if yes, and HMO please note Primary Dentist #)
☐ Yes ☐ No			☐ Yes ☐ No Primary Dentist Number: _____

Full Time Student?	Units carried	Name of School
☐ Yes ☐ No		

Relation	Last Name First Name MI	Social Security Number	Date of Birth	Place of Birth	Height/ Weight (lbs.)	Primary Care Physician ID (HMO only)
☐ Son ☐ Daughter	Child 3					

Current Patient	Physician Group ID # (HMO only)	Medical plan choice for each family member if different*	Add Dental and Vision Plus (if yes, and HMO please note Primary Dentist #)
☐ Yes ☐ No			☐ Yes ☐ No Primary Dentist Number: _____

Full Time Student?	Units carried	Name of School
☐ Yes ☐ No		

For additional dependents please attach another sheet with the requested information.
*Subscriber rates apply when you enroll each family member in a different medical plan.

Primary Applicant's Social Security Number

Primary Applicant Name: _____

PART IV. PRIOR HEALTH COVERAGE.

A. During the previous 63 days, have you been covered by health insurance? ☐ Yes ☐ No

If "Yes," Current Carrier: _____ Effective date: _____ Expected termination date: _____

☐ Individual & Family HMO ☐ Group HMO
☐ Individual & Family PPO ☐ Group PPO
☐ Disability, Short Term or Interim ☐ Other: _____

B. Has anyone on this Application been covered under a Health Net of California Plan or Health Net Life Insurance Company Policy in the last 5 years? ☐ Yes ☐ No

If "Yes," former Health Net Member name: _____

Group Number (listed on your ID card): _____

Member ID Number (listed on your ID card): _____

C. **HIPAA Guaranteed Issue Coverage**

If you do not qualify for the Individual HMO or PPO plans, you may be considered for coverage under the HIPAA Guaranteed Issue plans. The HIPAA Guaranteed Issue plans do not require medical underwriting and the rates are higher compared to the other Individual Plans. If you qualify for coverage under the HIPAA Guaranteed Issue plans please request the complete benefit details and rates for those plans. To be eligible for HIPAA Guaranteed Issue coverage, you must meet every condition below.

1. Have you had a total of at least 18 months of health care coverage (including COBRA or Cal-COBRA, if applicable) without more than a 63-day break (excluding any employer imposed waiting periods) in coverage? Please note that you must apply for HIPAA coverage within the 63-day break after your group health care coverage (including COBRA or Cal-COBRA, if applicable) ended. ☐ Yes ☐ No
2. Was your most recent coverage through a group health plan (COBRA and Cal-COBRA are considered group coverage)? ☐ Yes ☐ No
3. Currently are you eligible for coverage under a group health plan, Medicare or Medicaid? ☐ Yes ☐ No
   (If yes, you are not eligible for HIPAA coverage.)
4. Was your most recent coverage terminated because of nonpayment or fraud? ☐ Yes ☐ No
5. Were you eligible under COBRA or Cal-COBRA? ☐ Yes ☐ No

   Yes, start date: _____ end date: _____

   If Yes, did you accept and use up all benefits that were available? ☐ Yes ☐ No

   If No, please explain: _____

D. While I understand that I am applying for an Individual Plan, if I do not qualify for the Individual Plans, I would like to be considered for coverage under HIPAA. HIPAA does not require eligibility. I understand that no underwriting is required and rates may be higher than for the Individual Plans. If I qualify, please offer the HIPAA coverage and send complete details regarding my options and rates. ☐ Yes ☐ No

Primary Applicant's Social Security Number

Primary Applicant Name: _____

PART V. (A) STATEMENT OF HEALTH – All questions must be answered.

A SEPARATE STATEMENT OF HEALTH MUST BE COMPLETED FOR EACH FAMILY MEMBER APPLYING FOR COVERAGE. If you require additional Statement of Health questionnaires please contact the Health Net Broker who represents you or call Health Net at 1-800-909-3447, option 2. Please answer all questions "Yes" or "No." **IF "YES," PLEASE CIRCLE THE SPECIFIC CONDITIONS and complete Part V (B).** For the purposes of this Statement of Health, a health care provider or practitioner is any health care professional capable of rendering any kind of health care service.

Applicants for HIPAA only coverage should complete the Health Net HIPAA Enrollment Application. See Part IV for HIPAA eligibility information and how to obtain information regarding HIPAA coverage, including the HIPAA Enrollment Application. HIPAA law guarantees coverage and applicants for HIPAA only are not required to complete a Statement of Health.

NOTICE: You must provide truthful and complete answers to the following questions to the best of your ability. Even if you currently have health coverage or had prior coverage with Health Net, you must fully disclose and answer all health history questions. We are relying on the information you provide to determine whether you are eligible for coverage. During the first 24 months you are covered, we have the right to review all of your medical records to verify the accuracy of your information. If coverage is issued, we may not later rescind coverage unless we have made reasonable efforts to complete medical underwriting and resolved all reasonable questions arising from written information submitted by you on or with this Application before issuing coverage, except that any willful nondisclosure or misrepresentation in the Application of a material fact is also cause for disenrollment and rescission of the Plan Contract. If we rescind coverage, we may revoke your coverage as if it never existed and you will lose health benefits including coverage for treatment already received. This means that we may recover from you any amounts paid from the original date of coverage. For additional information regarding rescission of membership, see Part IX, Conditions of Enrollment.

1)	During the past 12 months have you seen a health care provider(s) or practitioner(s), had a physical exam, laboratory test(s), EKG, X-ray(s), MRI, CT scan, PET, EEG, CAT scan, sonogram, ultrasound, mammogram, biopsy, colonoscopy, endoscopy, upper GI tests or series, urine test, or blood test(s) (other than an HIV test)?	☐ Yes	☐ No
2)	Within the past 2 years, have you consulted with a health care provider(s) or practitioner(s) for, or been diagnosed with, or been treated for any of the following:		
	A. Bursitis, arthritis, gout, muscle or tendon pain?	☐ Yes	☐ No
	B. Chest pain, pneumonia, shortness of breath, pain or difficulty breathing, sleep apnea, or difficult chewing or swallowing?	☐ Yes	☐ No
	C. Acne, rosacea, psoriasis or keratosis, or eczema?	☐ Yes	☐ No
	D. Jaundice, chronic diarrhea, unintentional or unexplained weight loss?	☐ Yes	☐ No
	E. Dizziness?	☐ Yes	☐ No
	F. Recurrent or chronic pain (including back pain)?	☐ Yes	☐ No
	G. Cataracts, ear infection (otitis), sinusitis, deviated nasal septum, TMJ (temporomandibular joint disorder), tonsillitis, or allergies?	☐ Yes	☐ No
	H. Asthma? If "Yes," have you been hospitalized or been to an emergency room in the past 24 months?	☐ Yes ☐ Yes	☐ No ☐ No
	If "Yes," have you received any adrenaline or epinephrine injections?	☐ Yes	☐ No
	I. Thyroid disorder?	☐ Yes	☐ No
3)	During the past 5 years, have you consulted a health care provider(s) or practitioner(s), for any condition or symptom for which a diagnosis has not been established?	☐ Yes	☐ No
4)	During the past 5 years, have you consulted a health care provider(s) or practitioner(s) for any condition or symptom for which you have not been made aware of the cause or diagnosis?	☐ Yes	☐ No
5)	During the past 5 years, have you consulted a health care provider(s) or practitioner(s) for any condition or symptom for which you have been advised to have diagnostic test(s), treatment(s), surgery or hospitalization?	☐ Yes	☐ No
6)	Are you waiting for the results of any diagnostic tests?	☐ Yes	☐ No
7)	During the past 5 years, have you received Medicare benefits or any other disability benefits as a result of disability or chronic illness or condition?	☐ Yes	☐ No

Primary Applicant's Social Security Number

Primary Applicant Name: _____

PART V. (A) STATEMENT OF HEALTH (continued)

8)	Within the last 5 years, have you consulted with a health care provider(s) or practitioner(s) for, or been diagnosed with, or been treated for any of the following:		
	A. High or low blood pressure, hypertension, high cholesterol, phlebitis, Raynaud's disease, calf pain when walking, loss of consciousness, seizure disorder, headaches, anemia, varicose veins, or paralysis?	☐ Yes	☐ No
	B. Pyelonephritis, kidney stones, or kidney, bladder, or urinary tract disorder(s)?	☐ Yes	☐ No
	C. Genital herpes, HPV (Human Papilloma Virus), genital or anal warts, or any other sexually transmitted disease?	☐ Yes	☐ No
	D. Carpal tunnel syndrome, osteopenia, osteoporosis, or muscle/bone/tendon/joint/vertebral disc injury or disorder(s)?	☐ Yes	☐ No
	E. Pancreatitis, ulcers, spastic colitis, hemorrhoids, hernia or gallbladder, liver, stomach, intestines, or esophagus disorder(s)?	☐ Yes	☐ No
	F. Cyst(s), lump(s), or tumor(s) in any part of the body?	☐ Yes	☐ No
	G. Nervous, mental, emotional or behavioral disorder or panic attack(s)?	☐ Yes	☐ No
	H. Anxiety, depression, Epstein-Barr virus, chronic fatigue syndrome, attention deficit disorder, or ADHD?	☐ Yes	☐ No
	I. Developmental delay, premature birth, club foot, cleft lip or palate?	☐ Yes	☐ No
	J. Glaucoma, cataracts or retinal degeneration?	☐ Yes	☐ No
	K. Male reproductive system: disorder of the prostate, infections, impotency, sexual dysfunction, or male reproductive system disorder(s)?	☐ Yes	☐ No
	L. Female reproductive system: disorder of the breast, repeated breast biopsy, bleeding/drainage from the nipple, fibroid tumors, menstruation disorders, abnormal Pap test, infections, abnormal bleeding, endometriosis, disorder of the ovaries, or female reproductive system disorder(s)?	☐ Yes	☐ No
9)	Have you ever consulted with a health care provider(s) or practitioner(s) for, or been diagnosed with, or been treated for any of the following:		
	A. Manic depression, bipolar disorder, schizophrenia, obsessive compulsive disorder, suicide attempt, or eating disorder?	☐ Yes	☐ No
	B. Cancer, melanoma, leukemia, bone marrow transplant, Kaposi's sarcoma, Hodgkin's disease, enlarged lymph nodes, or any other malignancy?	☐ Yes	☐ No
	C. Cerebral palsy, Alzheimer's disease, Parkinson's disease, stroke, or brain or nervous system disorder(s)?	☐ Yes	☐ No
	D. Heart attack, angina, heart murmur, heart valve replacement, irregular heart beat, palpitations, peripheral vascular disease, blood clot, poor circulation, pacemaker, shunt, heart disease, heart valve disorder, or heart, cardiovascular, or circulatory disorder(s)?	☐ Yes	☐ No
	E. Emphysema, chronic obstructive pulmonary disease (COPD), pneumocystis carinii pneumonia, cystic fibrosis, tuberculosis or coughing up blood?	☐ Yes	☐ No
	F. Colitis, ulcerative colitis, Crohn's disease, cirrhosis, liver disease, hepatitis, or gastric bypass surgery?	☐ Yes	☐ No
	G. Infertility (infertility is defined as either (1) the presence of a demonstrated condition recognized by a licensed physician and surgeon as a cause of infertility, or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception)?	☐ Yes	☐ No
	H. Ankylosing spondylitis, spondylosis, herniated, ruptured or bulging disc, rheumatoid arthritis, sclerodoma, joint replacement, or fixation device(s) (pins, plates, rods)?	☐ Yes	☐ No
	I. Amyotrophic lateral sclerosis (ALS), Lou Gehrig's disease, multiple sclerosis, muscular dystrophy, Down's syndrome, or any congenital disorder?	☐ Yes	☐ No
	J. Diabetes, adrenal disorder, lupus, endocrine or metabolic disorder?	☐ Yes	☐ No
	K. Alcoholism, alcohol or substance abuse/dependency?	☐ Yes	☐ No

Primary Applicant's Social Security Number

	L. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? (Note: California law prohibits an HIV test from being required or used by health care service plans or insurance companies as a condition of obtaining coverage.)	☐ Yes	☐ No
	M. Breast implants, reconstructive or cosmetic surgery, or any other prosthesis or implant?	☐ Yes	☐ No
	N. Hemophilia or blood or bleeding disorder(s)?	☐ Yes	☐ No
	O. Organ transplant?	☐ Yes	☐ No
10)	During the past 12 months, have you had a physical injury or experienced reoccurring pain or symptoms that have not been evaluated by a licensed health care provider or practitioner or for which you plan to have evaluated by a licensed health care provider or practitioner?	☐ Yes	☐ No
11)	Within the past two years, have you visited or consulted a physician, psychiatrist, chiropractor, physician assistant, nurse practitioner, physical therapist, or other licensed health care provider or practitioner that has not been disclosed elsewhere on this Application?	☐ Yes	☐ No
12)	Are you currently taking prescription medication? If "Yes," please complete Part V (B).	☐ Yes	☐ No
13)	Have you been prescribed or taken any prescription medication during the past 12 months?	☐ Yes	☐ No
14)	During the past 12 months, have you smoked cigarettes, cigars, pipes, or used chewing tobacco?	☐ Yes	☐ No
15)	Do you consume alcoholic beverages? If "Yes," please indicate the number of alcoholic beverages you consume weekly (a beverage is 12 ounces of beer, 6 ounces of wine, 1 ounce of liquor): _____	☐ Yes	☐ No
16)	During the past 5 years have you received counseling or been a member of a support group related to alcohol or substance abuse?	☐ Yes	☐ No
17)	During the past 5 years have you been convicted of driving under the influence of alcohol or any controlled substance and as a consequence been required to receive counseling or attend a support group or class related to driving under the influence of alcohol or any controlled substance?	☐ Yes	☐ No
	MALE APPLICANT ONLY		
18)	Are you expecting a child with anyone, even if the mother is not listed on this Application?	☐ Yes	☐ No
19)	Has your spouse, even if not listed on this Application, performed a home pregnancy test during the previous 90 days, which has indicated she was pregnant?	☐ Yes	☐ No
	FEMALE APPLICANT ONLY		
20)	Are you currently pregnant?	☐ Yes	☐ No
21)	During the previous 90 days, have you performed a home pregnancy test which indicated you were pregnant?	☐ Yes	☐ No
22)	A. Have you had a menstrual period in each of the last six months, including within the last 30 days? If "No," please explain: *(attach additional pages as needed to provide complete information)* _____ _____	☐ Yes	☐ No
	B. (i) Have you had a pelvic exam? If "Yes," date of last pelvic exam (Mo/Dy/Yr): _____	☐ Yes	☐ No
	(ii) Have you had a Pap smear? If "Yes," date of last Pap smear (Mo/Dy/Yr): _____	☐ Yes	☐ No
	(iii) Were the results of the exam(s) normal? If "No," please explain: *(attach additional pages as needed to provide complete information)* _____	☐ Yes	☐ No

Primary Applicant's Social Security Number

Primary Applicant Name: _____

PART V. (B) STATEMENT OF HEALTH (continued) – If you answered "Yes" to any questions in Part V (A) (except questions 14, 15, 22(A) and 22(B) (iii) please identify the question number and explain in FULL DETAIL below. If additional space is necessary, please attach extra pages.

Question Number	Diagnosis, condition, treatment or recommendation	Still under treatment?	Dates of treatment or Hospitalization (Mo/Yr) Began	Ended	Full name, address & telephone number of every health care provider or practitioner, clinic, hospital or any other medical facility (include ZIP code)
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			

DOCTOR'S VISITS – Please provide information regarding the last health care provider or practitioner visit or physical examination. If additional space is necessary, please attach extra pages.

Date of visit	Reason for visit	Result of visit	Full name, address & telephone number of every health care provider or practitioner, clinic, hospital or any other medical facility (include ZIP code)

MEDICATIONS – Please list all prescription medications you are currently taking. If additional space is necessary, please attach extra pages.

Condition	Name of Medication	Prescribing Physician	Most Recent Refill Date	Strength (No. of milligrams)	Dosage & Frequency (How many pills and how often taken?)	Number of refills per year

Primary Applicant's Social Security Number

Dependent 1 Applicant Name: _____

PART V. (A) STATEMENT OF HEALTH – All questions must be answered.

A SEPARATE STATEMENT OF HEALTH MUST BE COMPLETED FOR EACH FAMILY MEMBER APPLYING FOR COVERAGE. If you require additional Statement of Health questionnaires please contact the Health Net Broker who represents you or call Health Net at 1-800-909-3447, option 2. Please answer all questions "Yes" or "No." **IF "YES," PLEASE CIRCLE THE SPECIFIC CONDITIONS and complete Part V (B).** For the purposes of this Statement of Health, a health care provider or practitioner is any health care professional capable of rendering any kind of health care service.

Applicants for HIPAA only coverage should complete the Health Net HIPAA Enrollment Application. See Part IV for HIPAA eligibility information and how to obtain information regarding HIPAA coverage, including the HIPAA Enrollment Application. HIPAA law guarantees coverage and applicants for HIPAA only are not required to complete a Statement of Health.

NOTICE: You must provide truthful and complete answers to the following questions to the best of your ability. Even if you currently have health coverage or had prior coverage with Health Net, you must fully disclose and answer all health history questions. We are relying on the information you provide to determine whether you are eligible for coverage. During the first 24 months you are covered, we have the right to review all of your medical records to verify the accuracy of your information. If coverage is issued, we may not later rescind coverage unless we have made reasonable efforts to complete medical underwriting and resolved all reasonable questions arising from written information submitted by you on or with this Application before issuing coverage, except that any willful nondisclosure or misrepresentation in the Application of a material fact is also cause for disenrollment and rescission of the Plan Contract. If we rescind coverage, we may revoke your coverage as if it never existed and you will lose health benefits including coverage for treatment already received. This means that we may recover from you any amounts paid from the original date of coverage. For additional information regarding rescission of membership, see Part IX, Conditions of Enrollment.

1)	During the past 12 months have you seen a health care provider(s) or practitioner(s), had a physical exam, laboratory test(s), EKG, X-ray(s), MRI, CT scan, PET, EEG, CAT scan, sonogram, ultrasound, mammogram, biopsy, colonoscopy, endoscopy, upper GI tests or series, urine test, or blood test(s) (other than an HIV test)?	☐ Yes	☐ No
2)	Within the past 2 years, have you consulted with a health care provider(s) or practitioner(s) for, or been diagnosed with, or been treated for any of the following:		
	A. Bursitis, arthritis, gout, muscle or tendon pain?	☐ Yes	☐ No
	B. Chest pain, pneumonia, shortness of breath, pain or difficulty breathing, sleep apnea, or difficult chewing or swallowing?	☐ Yes	☐ No
	C. Acne, rosacea, psoriasis or keratosis, or eczema?	☐ Yes	☐ No
	D. Jaundice, chronic diarrhea, unintentional or unexplained weight loss?	☐ Yes	☐ No
	E. Dizziness?	☐ Yes	☐ No
	F. Recurrent or chronic pain (including back pain)?	☐ Yes	☐ No
	G. Cataracts, ear infection (otitis), sinusitis, deviated nasal septum, TMJ (temporomandibular joint disorder), tonsillitis, or allergies?	☐ Yes	☐ No
	H. Asthma? If "Yes," have you been hospitalized or been to an emergency room in the past 24 months?	☐ Yes ☐ Yes	☐ No ☐ No
	If "Yes," have you received any adrenaline or epinephrine injections?	☐ Yes	☐ No
	I. Thyroid disorder?	☐ Yes	☐ No
3)	During the past 5 years, have you consulted a health care provider(s) or practitioner(s), for any condition or symptom for which a diagnosis has not been established?	☐ Yes	☐ No
4)	During the past 5 years, have you consulted a health care provider(s) or practitioner(s) for any condition or symptom for which you have not been made aware of the cause or diagnosis?	☐ Yes	☐ No
5)	During the past 5 years, have you consulted a health care provider(s) or practitioner(s) for any condition or symptom for which you have been advised to have diagnostic test(s), treatment(s), surgery or hospitalization?	☐ Yes	☐ No
6)	Are you waiting for the results of any diagnostic tests?	☐ Yes	☐ No
7)	During the past 5 years, have you received Medicare benefits or any other disability benefits as a result of disability or chronic illness or condition?	☐ Yes	☐ No

Primary Applicant's Social Security Number

Dependent 1 Applicant Name: _____

PART V. (A) STATEMENT OF HEALTH (continued)

8)	Within the last 5 years, have you consulted with a health care provider(s) or practitioner(s) for, or been diagnosed with, or been treated for any of the following:		
	A. High or low blood pressure, hypertension, high cholesterol, phlebitis, Raynaud's disease, calf pain when walking, loss of consciousness, seizure disorder, headaches, anemia, varicose veins, or paralysis?	☐ Yes	☐ No
	B. Pyelonephritis, kidney stones, or kidney, bladder, or urinary tract disorder(s)?	☐ Yes	☐ No
	C. Genital herpes, HPV (Human Papilloma Virus), genital or anal warts, or any other sexually transmitted disease?	☐ Yes	☐ No
	D. Carpal tunnel syndrome, osteopenia, osteoporosis, or muscle/bone/tendon/joint/vertebral disc injury or disorder(s)?	☐ Yes	☐ No
	E. Pancreatitis, ulcers, spastic colitis, hemorrhoids, hernia or gallbladder, liver, stomach, intestines, or esophagus disorder(s)?	☐ Yes	☐ No
	F. Cyst(s), lump(s), or tumor(s) in any part of the body?	☐ Yes	☐ No
	G. Nervous, mental, emotional or behavioral disorder or panic attack(s)?	☐ Yes	☐ No
	H. Anxiety, depression, Epstein-Barr virus, chronic fatigue syndrome, attention deficit disorder, or ADHD?	☐ Yes	☐ No
	I. Developmental delay, premature birth, club foot, cleft lip or palate?	☐ Yes	☐ No
	J. Glaucoma, cataracts or retinal degeneration?	☐ Yes	☐ No
	K. Male reproductive system: disorder of the prostate, infections, impotency, sexual dysfunction, or male reproductive system disorder(s)?	☐ Yes	☐ No
	L. Female reproductive system: disorder of the breast, repeated breast biopsy, bleeding/drainage from the nipple, fibroid tumors, menstruation disorders, abnormal Pap test, infections, abnormal bleeding, endometriosis, disorder of the ovaries, or female reproductive system disorder(s)?	☐ Yes	☐ No
9)	Have you ever consulted with a health care provider(s) or practitioner(s) for, or been diagnosed with, or been treated for any of the following:		
	A. Manic depression, bipolar disorder, schizophrenia, obsessive compulsive disorder, suicide attempt, or eating disorder?	☐ Yes	☐ No
	B. Cancer, melanoma, leukemia, bone marrow transplant, Kaposi's sarcoma, Hodgkin's disease, enlarged lymph nodes, or any other malignancy?	☐ Yes	☐ No
	C. Cerebral palsy, Alzheimer's disease, Parkinson's disease, stroke, or brain or nervous system disorder(s)?	☐ Yes	☐ No
	D. Heart attack, angina, heart murmur, heart valve replacement, irregular heart beat, palpitations, peripheral vascular disease, blood clot, poor circulation, pacemaker, shunt, heart disease, heart valve disorder, or heart, cardiovascular, or circulatory disorder(s)?	☐ Yes	☐ No
	E. Emphysema, chronic obstructive pulmonary disease (COPD), pneumocystis carinii pneumonia, cystic fibrosis, tuberculosis or coughing up blood?	☐ Yes	☐ No
	F. Colitis, ulcerative colitis, Crohn's disease, cirrhosis, liver disease, hepatitis, or gastric bypass surgery?	☐ Yes	☐ No
	G. Infertility (infertility is defined as either (1) the presence of a demonstrated condition recognized by a licensed physician and surgeon as a cause of infertility, or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception)?	☐ Yes	☐ No
	H. Ankylosing spondylitis, spondylosis, herniated, ruptured or bulging disc, rheumatoid arthritis, sclerodoma, joint replacement, or fixation device(s) (pins, plates, rods)?	☐ Yes	☐ No
	I. Amyotrophic lateral sclerosis (ALS), Lou Gehrig's disease, multiple sclerosis, muscular dystrophy, Down's syndrome, or any congenital disorder?	☐ Yes	☐ No
	J. Diabetes, adrenal disorder, lupus, endocrine or metabolic disorder?	☐ Yes	☐ No
	K. Alcoholism, alcohol or substance abuse/dependency?	☐ Yes	☐ No

Primary Applicant's Social Security Number

	L. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? (Note: California law prohibits an HIV test from being required or used by health care service plans or insurance companies as a condition of obtaining coverage.)	☐ Yes	☐ No
	M. Breast implants, reconstructive or cosmetic surgery, or any other prosthesis or implant?	☐ Yes	☐ No
	N. Hemophilia or blood or bleeding disorder(s)?	☐ Yes	☐ No
	O. Organ transplant?	☐ Yes	☐ No
10)	During the past 12 months, have you had a physical injury or experienced reoccurring pain or symptoms that have not been evaluated by a licensed health care provider or practitioner or for which you plan to have evaluated by a licensed health care provider or practitioner?	☐ Yes	☐ No
11)	Within the past two years, have you visited or consulted a physician, psychiatrist, chiropractor, physician assistant, nurse practitioner, physical therapist, or other licensed health care provider or practitioner that has not been disclosed elsewhere on this Application?	☐ Yes	☐ No
12)	Are you currently taking prescription medication? If "Yes," please complete Part V (B).	☐ Yes	☐ No
13)	Have you been prescribed or taken any prescription medication during the past 12 months?	☐ Yes	☐ No
14)	During the past 12 months, have you smoked cigarettes, cigars, pipes, or used chewing tobacco?	☐ Yes	☐ No
15)	Do you consume alcoholic beverages? If "Yes," please indicate the number of alcoholic beverages you consume weekly (a beverage is 12 ounces of beer, 6 ounces of wine, 1 ounce of liquor): _____	☐ Yes	☐ No
16)	During the past 5 years have you received counseling or been a member of a support group related to alcohol or substance abuse?	☐ Yes	☐ No
17)	During the past 5 years have you been convicted of driving under the influence of alcohol or any controlled substance and as a consequence been required to receive counseling or attend a support group or class related to driving under the influence of alcohol or any controlled substance?	☐ Yes	☐ No
	MALE APPLICANT ONLY		
18)	Are you expecting a child with anyone, even if the mother is not listed on this Application?	☐ Yes	☐ No
19)	Has your spouse, even if not listed on this Application, performed a home pregnancy test during the previous 90 days, which has indicated she was pregnant?	☐ Yes	☐ No
	FEMALE APPLICANT ONLY		
20)	Are you currently pregnant?	☐ Yes	☐ No
21)	During the previous 90 days, have you performed a home pregnancy test which indicated you were pregnant?	☐ Yes	☐ No
22)	A. Have you had a menstrual period in each of the last six months, including within the last 30 days? If "No," please explain: *(attach additional pages as needed to provide complete information)* _____ _____	☐ Yes	☐ No
	B. (i) Have you had a pelvic exam? If "Yes," date of last pelvic exam (Mo/Dy/Yr): _____	☐ Yes	☐ No
	(ii) Have you had a Pap smear? If "Yes," date of last Pap smear (Mo/Dy/Yr): _____	☐ Yes	☐ No
	(iii) Were the results of the exam(s) normal? If "No," please explain: *(attach additional pages as needed to provide complete information)* _____	☐ Yes	☐ No

Primary Applicant's Social Security Number

☐☐☐ ☐☐ ☐☐☐☐

Dependent 1 Applicant Name: _____

PART V. (B) STATEMENT OF HEALTH (continued) – If you answered "Yes" to any questions in Part V (A) (except questions 14, 15, 22(A) and 22(B) (iii) please identify the question number and explain in FULL DETAIL below. If additional space is necessary, please attach extra pages.

Question Number	Diagnosis, condition, treatment or recommendation?	Still under treatment?	Dates of treatment or Hospitalization (Mo/Yr) Began	Ended	Full name, address & telephone number of every health care provider or practitioner, clinic, hospital or any other medical facility (include ZIP code)
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			

DOCTOR'S VISITS – Please provide information regarding the last health care provider or practitioner visit or physical examination. If additional space is necessary, please attach extra pages.

Date of visit	Reason for visit	Result of visit	Full name, address & telephone number of every health care provider or practitioner, clinic, hospital or any other medical facility (include ZIP code)

MEDICATIONS – Please list all prescription medications you are currently taking. If additional space is necessary, please attach extra pages.

Condition	Name of Medication	Prescribing Physician	Most Recent Refill Date	Strength (No. of milligrams)	Dosage & Frequency (How many pills and how often taken?)	Number of refills per year

Primary Applicant's Social Security Number

Dependent 2 Applicant Name: _____

PART V. (A) STATEMENT OF HEALTH – All questions must be answered.

A SEPARATE STATEMENT OF HEALTH MUST BE COMPLETED FOR EACH FAMILY MEMBER APPLYING FOR COVERAGE. If you require additional Statement of Health questionnaires please contact the Health Net Broker who represents you or call Health Net at 1-800-909-3447, option 2. Please answer all questions "Yes" or "No." **IF "YES," PLEASE CIRCLE THE SPECIFIC CONDITIONS and complete Part V (B).** For the purposes of this Statement of Health, a health care provider or practitioner is any health care professional capable of rendering any kind of health care service.

Applicants for HIPAA only coverage should complete the Health Net HIPAA Enrollment Application. See Part IV for HIPAA eligibility information and how to obtain information regarding HIPAA coverage, including the HIPAA Enrollment Application. HIPAA law guarantees coverage and applicants for HIPAA only are not required to complete a Statement of Health.

NOTICE: You must provide truthful and complete answers to the following questions to the best of your ability. Even if you currently have health coverage or had prior coverage with Health Net, you must fully disclose and answer all health history questions. We are relying on the information you provide to determine whether you are eligible for coverage. During the first 24 months you are covered, we have the right to review all of your medical records to verify the accuracy of your information. If coverage is issued, we may not later rescind coverage unless we have made reasonable efforts to complete medical underwriting and resolved all reasonable questions arising from written information submitted by you on or with this Application before issuing coverage, except that any willful nondisclosure or misrepresentation in the Application of a material fact is also cause for disenrollment and rescission of the Plan Contract. If we rescind coverage, we may revoke your coverage as if it never existed and you will lose health benefits including coverage for treatment already received. This means that we may recover from you any amounts paid from the original date of coverage. For additional information regarding rescission of membership, see Part IX, Conditions of Enrollment.

1)	During the past 12 months have you seen a health care provider(s) or practitioner(s), had a physical exam, laboratory test(s), EKG, X-ray(s), MRI, CT scan, PET, EEG, CAT scan, sonogram, ultrasound, mammogram, biopsy, colonoscopy, endoscopy, upper GI tests or series, urine test, or blood test(s) (other than an HIV test)?	☐ Yes	☐ No
2)	Within the past 2 years, have you consulted with a health care provider(s) or practitioner(s) for, or been diagnosed with, or been treated for any of the following:		
	A. Bursitis, arthritis, gout, muscle or tendon pain?	☐ Yes	☐ No
	B. Chest pain, pneumonia, shortness of breath, pain or difficulty breathing, sleep apnea, or difficult chewing or swallowing?	☐ Yes	☐ No
	C. Acne, rosacea, psoriasis or keratosis, or eczema?	☐ Yes	☐ No
	D. Jaundice, chronic diarrhea, unintentional or unexplained weight loss?	☐ Yes	☐ No
	E. Dizziness?	☐ Yes	☐ No
	F. Recurrent or chronic pain (including back pain)?	☐ Yes	☐ No
	G. Cataracts, ear infection (otitis), sinusitis, deviated nasal septum, TMJ (temporomandibular joint disorder), tonsillitis, or allergies?	☐ Yes	☐ No
	H. Asthma? If "Yes," have you been hospitalized or been to an emergency room in the past 24 months?	☐ Yes ☐ Yes	☐ No ☐ No
	If "Yes," have you received any adrenaline or epinephrine injections?	☐ Yes	☐ No
	I. Thyroid disorder?	☐ Yes	☐ No
3)	During the past 5 years, have you consulted a health care provider(s) or practitioner(s), for any condition or symptom for which a diagnosis has not been established?	☐ Yes	☐ No
4)	During the past 5 years, have you consulted a health care provider(s) or practitioner(s) for any condition or symptom for which you have not been made aware of the cause or diagnosis?	☐ Yes	☐ No
5)	During the past 5 years, have you consulted a health care provider(s) or practitioner(s) for any condition or symptom for which you have been advised to have diagnostic test(s), treatment(s), surgery or hospitalization?	☐ Yes	☐ No
6)	Are you waiting for the results of any diagnostic tests?	☐ Yes	☐ No
7)	During the past 5 years, have you received Medicare benefits or any other disability benefits as a result of disability or chronic illness or condition?	☐ Yes	☐ No

Primary Applicant's Social Security Number

Dependent 2 Applicant Name: _____

PART V. (A) STATEMENT OF HEALTH (continued)

8)	Within the last 5 years, have you consulted with a health care provider(s) or practitioner(s) for, or been diagnosed with, or been treated for any of the following:		
	A. High or low blood pressure, hypertension, high cholesterol, phlebitis, Raynaud's disease, calf pain when walking, loss of consciousness, seizure disorder, headaches, anemia, varicose veins, or paralysis?	☐ Yes	☐ No
	B. Pyelonephritis, kidney stones, or kidney, bladder, or urinary tract disorder(s)?	☐ Yes	☐ No
	C. Genital herpes, HPV (Human Papilloma Virus), genital or anal warts, or any other sexually transmitted disease?	☐ Yes	☐ No
	D. Carpal tunnel syndrome, osteopenia, osteoporosis, or muscle/bone/tendon/joint/vertebral disc injury or disorder(s)?	☐ Yes	☐ No
	E. Pancreatitis, ulcers, spastic colitis, hemorrhoids, hernia or gallbladder, liver, stomach, intestines, or esophagus disorder(s)?	☐ Yes	☐ No
	F. Cyst(s), lump(s), or tumor(s) in any part of the body?	☐ Yes	☐ No
	G. Nervous, mental, emotional or behavioral disorder or panic attack(s)?	☐ Yes	☐ No
	H. Anxiety, depression, Epstein-Barr virus, chronic fatigue syndrome, attention deficit disorder, or ADHD?	☐ Yes	☐ No
	I. Developmental delay, premature birth, club foot, cleft lip or palate?	☐ Yes	☐ No
	J. Glaucoma, cataracts or retinal degeneration?	☐ Yes	☐ No
	K. Male reproductive system: disorder of the prostate, infections, impotency, sexual dysfunction, or male reproductive system disorder(s)?	☐ Yes	☐ No
	L. Female reproductive system: disorder of the breast, repeated breast biopsy, bleeding/drainage from the nipple, fibroid tumors, menstruation disorders, abnormal Pap test, infections, abnormal bleeding, endometriosis, disorder of the ovaries, or female reproductive system disorder(s)?	☐ Yes	☐ No
9)	Have you ever consulted with a health care provider(s) or practitioner(s) for, or been diagnosed with, or been treated for any of the following:		
	A. Manic depression, bipolar disorder, schizophrenia, obsessive compulsive disorder, suicide attempt, or eating disorder?	☐ Yes	☐ No
	B. Cancer, melanoma, leukemia, bone marrow transplant, Kaposi's sarcoma, Hodgkin's disease, enlarged lymph nodes, or any other malignancy?	☐ Yes	☐ No
	C. Cerebral palsy, Alzheimer's disease, Parkinson's disease, stroke, or brain or nervous system disorder(s)?	☐ Yes	☐ No
	D. Heart attack, angina, heart murmur, heart valve replacement, irregular heart beat, palpitations, peripheral vascular disease, blood clot, poor circulation, pacemaker, shunt, heart disease, heart valve disorder, or heart, cardiovascular, or circulatory disorder(s)?	☐ Yes	☐ No
	E. Emphysema, chronic obstructive pulmonary disease (COPD), pneumocystis carinii pneumonia, cystic fibrosis, tuberculosis or coughing up blood?	☐ Yes	☐ No
	F. Colitis, ulcerative colitis, Crohn's disease, cirrhosis, liver disease, hepatitis, or gastric bypass surgery?	☐ Yes	☐ No
	G. Infertility (infertility is defined as either (1) the presence of a demonstrated condition recognized by a licensed physician and surgeon as a cause of infertility, or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception)?	☐ Yes	☐ No
	H. Ankylosing spondylitis, spondylosis, herniated, ruptured or bulging disc, rheumatoid arthritis, sclerodoma, joint replacement, or fixation device(s) (pins, plates, rods)?	☐ Yes	☐ No
	I. Amyotrophic lateral sclerosis (ALS), Lou Gehrig's disease, multiple sclerosis, muscular dystrophy, Down's syndrome, or any congenital disorder?	☐ Yes	☐ No
	J. Diabetes, adrenal disorder, lupus, endocrine or metabolic disorder?	☐ Yes	☐ No
	K. Alcoholism, alcohol or substance abuse/dependency?	☐ Yes	☐ No

Primary Applicant's Social Security Number

Dependent 2 Applicant Name: _____

PART V. (A) STATEMENT OF HEALTH (continued)

	L. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? (Note: California law prohibits an HIV test from being required or used by health care service plans or insurance companies as a condition of obtaining coverage.)	☐ Yes	☐ No
	M. Breast implants, reconstructive or cosmetic surgery, or any other prosthesis or implant?	☐ Yes	☐ No
	N. Hemophilia or blood or bleeding disorder(s)?	☐ Yes	☐ No
	O. Organ transplant?	☐ Yes	☐ No
10)	During the past 12 months, have you had a physical injury or experienced reoccurring pain or symptoms that have not been evaluated by a licensed health care provider or practitioner or for which you plan to have evaluated by a licensed health care provider or practitioner?	☐ Yes	☐ No
11)	Within the past two years, have you visited or consulted a physician, psychiatrist, chiropractor, physician assistant, nurse practitioner, physical therapist, or other licensed health care provider or practitioner that has not been disclosed elsewhere on this Application?	☐ Yes	☐ No
12)	Are you currently taking prescription medication? If "Yes," please complete Part V (B).	☐ Yes	☐ No
13)	Have you been prescribed or taken any prescription medication during the past 12 months?	☐ Yes	☐ No
14)	During the past 12 months, have you smoked cigarettes, cigars, pipes, or used chewing tobacco?	☐ Yes	☐ No
15)	Do you consume alcoholic beverages? If "Yes," please indicate the number of alcoholic beverages you consume weekly (a beverage is 12 ounces of beer, 6 ounces of wine, 1 ounce of liquor): _____	☐ Yes	☐ No
16)	During the past 5 years have you received counseling or been a member of a support group related to alcohol or substance abuse?	☐ Yes	☐ No
17)	During the past 5 years have you been convicted of driving under the influence of alcohol or any controlled substance and as a consequence been required to receive counseling or attend a support group or class related to driving under the influence of alcohol or any controlled substance?	☐ Yes	☐ No
	MALE APPLICANT ONLY		
18)	Are you expecting a child with anyone, even if the mother is not listed on this Application?	☐ Yes	☐ No
19)	Has your spouse, even if not listed on this Application, performed a home pregnancy test during the previous 90 days, which has indicated she was pregnant?	☐ Yes	☐ No
	FEMALE APPLICANT ONLY		
20)	Are you currently pregnant?	☐ Yes	☐ No
21)	During the previous 90 days, have you performed a home pregnancy test which indicated you were pregnant?	☐ Yes	☐ No
22)	A. Have you had a menstrual period in each of the last six months, including within the last 30 days? If "No," please explain: *(attach additional pages as needed to provide complete information)* _____ _____	☐ Yes	☐ No
	B. (i) Have you had a pelvic exam? If "Yes," date of last pelvic exam (Mo/Dy/Yr): _____	☐ Yes	☐ No
	(ii) Have you had a Pap smear? If "Yes," date of last Pap smear (Mo/Dy/Yr): _____	☐ Yes	☐ No
	(iii) Were the results of the exam(s) normal? If "No," please explain: *(attach additional pages as needed to provide complete information)* _____	☐ Yes	☐ No

Primary Applicant's Social Security Number

☐☐☐ ☐☐ ☐☐☐☐

Dependent 2 Applicant Name: _____

PART V. (B) STATEMENT OF HEALTH (continued) – If you answered "Yes" to any questions in Part V (A) (except questions 14, 15, 22(A) and 22(B) (iii) please identify the question number and explain in FULL DETAIL below. If additional space is necessary, please attach extra pages.

Question Number	Diagnosis, condition, treatment or recommendation?	Still under treatment?	Dates of treatment or Hospitalization (Mo/Yr) Began	Ended	Full name, address & telephone number of every health care provider or practitioner, clinic, hospital or any other medical facility (include ZIP code)
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			

DOCTOR'S VISITS – Please provide information regarding the last health care provider or practitioner visit or physical examination. If additional space is necessary, please attach extra pages.

Date of visit	Reason for visit	Result of visit	Full name, address & telephone number of every health care provider or practitioner, clinic, hospital or any other medical facility (include ZIP code)

MEDICATIONS – Please list all prescription medications you are currently taking. If additional space is necessary, please attach extra pages.

Condition	Name of Medication	Prescribing Physician	Most Recent Refill Date	Strength (No. of milligrams)	Dosage & Frequency (How many pills and how often taken?)	Number of refills per year

Primary Applicant's Social Security Number

Primary Applicant Name: _____

PART VI. INDIVIDUAL TERM LIFE INSURANCE – Underwritten by Health Net Life Insurance Company – Complete this section only if you wish to apply for life insurance coverage. Life Insurance coverage is different and separate from the Individual HMO or PPO Health Care Coverage previously discussed in this Application.

The Primary Applicant and/or any dependents that are approved for a Health Net HMO or PPO medical plan will also qualify for Term Life coverage. Applicants under the age of one year and Applicants being offered Modified Issue or HIPAA plans are ineligible for Life Insurance. Coverage is optional and can be purchased at an additional charge.

This insurance also is not intended to replace any Life Insurance Policy currently in force. If you would like supplemental Term Life coverage:
1. Please list all family members applying for Term Life Insurance Coverage (available for ages 1-64).
2. Life insurance requires an additional premium. You will be billed for the premium after enrollment is confirmed by Health Net.
3. Complete the beneficiary information. You can have one or more beneficiaries. If you have more than one, the percentages must add up to 100%.

Name of Family Member/Full Name	Relationship to Primary Applicant	Birthdate (mo/day/year)	Amount
	Self		☐ $10,000 ☐ $40,000 ☐ $20,000 ☐ $50,000 ☐ $30,000

Beneficiary Name	Beneficiary Relationship	Percentage*
1)		
2)		
3)		

Signature of Applicant	Date

Name of Family Member/Full Name	Relationship to Primary Applicant	Birthdate (mo/day/year)	Amount
	Spouse/Domestic Partner		☐ $10,000 ☐ $40,000 ☐ $20,000 ☐ $50,000 ☐ $30,000

Beneficiary Name	Beneficiary Relationship	Percentage*
1)		
2)		
3)		

Signature of Spouse/Domestic Partner	Date

Name of Family Member/Full Name	Relationship to Primary Applicant	Birthdate (mo/day/year)	Amount
	Dependent		☐ $10,000 Max amount for children age 1-17 ☐ $20,000 ☐ $40,000 ☐ $30,000 ☐ $50,000

Beneficiary Name	Beneficiary Relationship	Percentage*
1)		
2)		
3)		

Signature of Dependent 18 years of age or older	Date

*The percentage for all beneficiaries must total 100%.

Primary Applicant's Social Security Number

Primary Applicant Name: _____

Name of Family Member/Full Name	Relationship to Primary Applicant	Birthdate (mo/day/year)	Amount
	Dependent		☐ $10,000 Max amount for children age 1-17 ☐ $20,000 ☐ $40,000 ☐ $30,000 ☐ $50,000

Beneficiary Name	Beneficiary Relationship	Percentage*
1)		
2)		
3)		

Signature of Dependent 18 years of age or older	Date

Name of Family Member/Full Name	Relationship to Primary Applicant	Birthdate (mo/day/year)	Amount
	Dependent		☐ $10,000 Max amount for children age 1-17 ☐ $20,000 ☐ $40,000 ☐ $30,000 ☐ $50,000

Beneficiary Name	Beneficiary Relationship	Percentage*
1)		
2)		
3)		

Signature of Dependent 18 years of age or older	Date

*The percentage for all beneficiaries must total 100%.

PART VII. INDIVIDUAL & FAMILY PLANS EXCEPTION TO STANDARD ENROLLMENT – STATEMENT OF ACCOUNTABILITY.

IMPORTANT: Can you read this form? If not, we can have somebody help you read it. You may also be able to get this form written in your language. For free help, please call right away at 800-909-3447, option 2.

IMPORTANTE: ¿Puede leer este formulario? De no ser así, podemos hacer que alguien le ayude a leerlo. También puede obtener este formulario escrito en su idioma. Para obtener ayuda sin costo, llame inmediatamente al 800-909-3447, opción 2.

重要資訊：您是否能閱讀此文件?如果您無法閱讀，我們將請專人協助您。我們也能以您使用的語言翻譯此份文件。請立即致電 800-909-3447，再按 2，洽詢免費服務。

Instructions for Part VII: The following process is to be used when the Applicant cannot complete the Application because he/she cannot read, write and/or speak the language of the Application. Health Net requires that if you need assistance in completing this Application, you must employ the services of a qualified interpreter. Please contact Health Net at 800-909-3447, option 2 for information about qualified interpreter services and how to obtain them. This form must be submitted with the Individual & Family Enrollment Application when applicable.

I, _____ was assisted in the completion of this Application by a qualified interpreter authorized by Health Net because I:

☐ Do not read the language of this Application ☐ Do not speak the language of this Application ☐ Do not write the language of this Application

☐ Other (explain)_____

A qualified interpreter assisted me with the completion of: ☐ The entire Application ☐ The Statement of Health

☐ Other (explain)_____

A qualified interpreter read this Application to me in the following language: _____

SIGNATURE of APPLICANT	Today's Date
Date Application was interpreted	Time Application was interpreted
Qualified interpreter number	

Primary Applicant's Social Security Number

PART VIII. APPLICANT'S AGENT/BROKER INFORMATION – Complete agent/broker name and address is necessary for correspondence to be sent to the agent/broker.

Instructions for Part VIII: The following form is to be completed by the applicant's broker (if applicable).

Health Net Broker ID: _____

Name (Print) _____ Phone number _____

Address _____ Fax number _____

_____ Email address _____

_____ _____

Applicant's Broker Signature/Number (Required) **Date signed (Required)**

Broker Certification

I _____ (Name of Broker)

(NOTE: You must select the appropriate box. You may only select one box.)

(_____) did not assist the applicant(s) in any way in completing or submitting this application. All information was completed by the applicant(s) with no assistance or advice of any kind from me. I understand that, if any portion of this statement by me is false, I may be subject to civil penalties, including but not limited to a fine of up to $10,000.

OR

(_____) assisted the applicant(s) in submitting this application. All information in the health questionnaire(s) was completed by the applicant(s). I advised the applicant(s) that he or she should answer all questions completely and truthfully and that no information requested on the application should be withheld. I explained that withholding information could result in rescission or cancellation of coverage in the future. The applicant(s) indicated to me that he or she understood these instructions and warnings. To the best of my knowledge, the information on the application is complete and accurate. I understand that, if any portion of this statement by me is false, I may be subject to civil penalties, including but not limited to a fine of up to $10,000.

Please answer all questions 1 through 4:

1) **Who filled out and completed the application form?** _____

2) Did you personally witness the applicant(s) sign the application? ☐ Yes ☐ No

3) Did you review the application after the applicant(s) signed it? ☐ Yes ☐ No

4) Are you aware of any information, including but not limited to medical history, not disclosed in this application that might have a bearing on the risk? ☐ Yes ☐ No

If "Yes," please explain: _____

PART IX. CONDITIONS OF ENROLLMENT.

GENERAL CONDITIONS: Health Net reserves the right to reject any Application for enrollment. Health Net may selectively accept the Applicant or only a dependent(s). There is no coverage unless this Application is accepted by Health Net's Underwriting Department and a Notice of Acceptance is issued to the Applicant even though you paid money to Health Net for the first month's premium. Cashing your check does not mean your Application is approved. If rejected, your money will be returned to you. No other department, officer, agent or employee of Health Net is authorized to grant enrollment. The Applicant's broker or agent cannot grant approval, change terms or waive requirements of this Application. Health Net may require that you take a medical examination and you will be responsible for payment of any related fees in such event. This Application and all medical information or examination reports shall become a part of the Plan Contract or Insurance Policy.

Family Members who are covered under another Health Net Individual plan are not eligible for coverage hereunder. Should a Family Member enrolling for coverage, become covered under another Health Net Individual plan at a later date, his or her coverage under this plan will terminate on the effective date of coverage under the other Health Net Individual plan.

RESCISSION OF MEMBERSHIP FOR MEMBERS OF HEALTH NET OF CALIFORNIA INC.'S INDIVIDUAL HMO PLANS: Health Net of California, Inc. is a health care service plan licensed and regulated under California's Knox Keene Act (California Health & Safety Code section 1340, et seq.). Health Net's Individual HMO plans are provided by Health Net of California, Inc. Health Net of California, Inc. may not rescind a Plan Contract unless it has made reasonable efforts to complete medical underwriting and resolve all reasonable questions arising from written information submitted by the Subscriber (or by you or by the applicant) on or with this Application before issuing a Plan Contract, except that any willful nondisclosure or misrepresentation in the Application of a material fact is also cause for disenrollment and rescission of the Plan Contract. If this Plan Contract is rescinded, Health Net may revoke the Subscriber's (or your or the applicant's) coverage as if it never existed and the Subscriber (or you or the applicant) will lose health

benefits including coverage for treatment already received. This means that Health Net of California, Inc. may recover from the Subscriber (or from you or from the applicant) any amounts paid under the Plan Contract from the original date of coverage. If the Plan Contract is rescinded, Health Net of California, Inc. shall have no liability for the provision of coverage under the Plan Contract. By signing this Application, the Subscriber (or you or the applicant) represent that all responses to the Statement of Health are true, complete and accurate, to the best of the Subscriber's (or your or the applicant's) knowledge, and that should Health Net of California, Inc. accept the Subscriber's (or your or the applicant's) Application, the Application will become part of the Plan Contract between Health Net of California, Inc. and the Subscriber (or you or the applicant). By signing this Application you further agree to comply with the terms of the Plan Contract. If the Plan Contract is rescinded, Health Net of California, Inc. will provide a written notice that will explain the basis of the decision and the Subscriber's (or your or the applicant's) appeal rights. If the Plan Contract is rescinded, Health Net of California, Inc. will refund all premium amounts paid by the Subscriber (or you or the applicant), less any medical expenses paid by Health Net of California, Inc. on behalf of the Subscriber (or you or the applicant).

RESCISSION OF MEMBERSHIP FOR HEALTH NET LIFE INSURANCE COMPANY INDIVIDUAL PPO PLANS: Health Net Life Insurance Company ("HNL") is an Insurance Company licensed and regulated under the California Insurance Code. HNL underwrites Individual PPO health insurance plans. HNL will undertake reasonable steps to complete medical underwriting and resolve all reasonable questions arising from the written information you have submitted on or with your Application before issuing an Insurance Policy. However, intentional or unintentional nondisclosure or misstatement of material facts in written information you have submitted on or with your Application materials may be cause for disenrollment and rescission of the Insurance Policy and HNL may recoup from the Policyholder (or from You or from the applicant) any amounts paid under the Insurance Policy obtained as a result of such nondisclosure or misstatement of material facts. In addition, if a Policyholder makes an intentional or unintentional nondisclosure, misstatement or omission of material facts in written information submitted on or with the Application as to the Policyholder's or Family Member's health status or history, HNL shall have no liability for the provision of coverage under the Insurance Policy. By signing this Application, you represent that all responses to the Statement of health are true, complete and accurate and that should your Application be accepted by HNL, the Application will become part of the contract between HNL and yourself. By signing this Application you further represent and agree to abide by the terms of the contract. Should the contract be rescinded, HNL will provide a written notice that will explain the basis of the decision and your appeals rights. HNL will refund all amounts paid by you, less any medical expenses that HNL paid.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: I acknowledge and understand that health care providers may disclose health information about me or my dependents to Health Net. Health Net uses and may disclose this information for purposes of treatment, payment and health plan operations, including but not limited to, utilization management, quality improvement, disease or case management programs. Health Net's Notice of Privacy Practices is included in the Plan Contract and Insurance Policy, and that I may also obtain a copy of this Notice on the website at www.healthnet.com or through Health Net Customer Contact Center. Authorization for use and disclosure of protected health information shall be valid for a period of 24 months from the date of my signature below.

IF SOLE APPLICANT IS A MINOR: If the sole Applicant under this Application is under 18 years of age, the Applicant's parent or legal guardian must sign as such. By signing, he or she does hereby agree to be legally responsible for the accuracy of information in this Application and for payments of premiums. If such responsible party is not the natural parent of the Applicant, copies of the court papers authorizing guardianship must be submitted with this Application.

IF APPLICANT CANNOT READ THE LANGUAGE OF THIS APPLICATION: If an Applicant does not read the language of this Application and an interpreter assisted with the completion of the Application, the Applicant must sign and submit the **Statement of Accountability** (see PART VII of this Application "Individual & Family Plans Exception to Standard Enrollment – Statement of Accountability").

Primary Applicant's Social Security Number

PART X. IMPORTANT PROVISIONS.

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

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health care services plans or insurance companies as a condition of obtaining coverage.

ACKNOWLEDGEMENT AND AGREEMENT: I, the applicant, understand and agree that by enrolling with or accepting services from Health Net, I and any enrolled dependents shall comply with the terms, conditions and provisions of the Plan Contract or Insurance Policy. I, the applicant, 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, and I accept these terms.

BINDING ARBITRATION: I, the applicant, understand and agree that any and all disputes or disagreements between me (including any of my enrolled family members or heirs or personal representatives) and Health Net regarding the construction, interpretation, performance or breach of the Health Net Plan Contract or Insurance Policy, or regarding other matters relating to or arising out of my Health Net membership, whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or employees, are also involved, must be submitted to final and binding arbitration in lieu of a jury or court trial. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties, including Health Net, are giving up their constitutional right to the extent permitted by law to have their dispute decided in a court of law before 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. A more detailed arbitration provision is included in the Plan Contract or Insurance Policy. My signature below indicates that I understand the terms of this Binding Arbitration Clause and agree to submit disputes to binding arbitration.

APPLICANT OR PARENT OR LEGAL GUARDIAN'S SIGNATURE IF APPLICANT IS UNDER 18 YEARS OLD	Date Signed
SPOUSE/DOMESTIC PARTNER'S SIGNATURE	Date Signed
SIGNATURE OF APPLICANT'S DEPENDENT (age 18 or older)	Date Signed
SIGNATURE OF APPLICANT'S DEPENDENT (age 18 or older)	Date Signed

The Application and this Arbitration Clause must be signed by the Applicant. The applicant must personally sign his/her name in ink and agree to comply with the Arbitration Clause and the terms, conditions and provisions of the Application and the Plan Contract or Insurance Policy in order for this Application to be processed. For this Application to be considered, neither Broker nor any other person may sign this Application and Arbitration Clause.

Make personal check payable to "Health Net." Return Completed Application to:
Health Net Individual & Family Enrollment, Post Office Box 1150 Rancho Cordova, California 95741–1150

You may submit a photocopy or facsimile of the Application and Authorizations. Health Net recommends that you retain a copy of this Application and Authorizations for your records.

All references to "Health Net" herein include the affiliates and subsidiaries of Health Net which underwrite or administer the coverage to which this Enrollment Application applies. "Plan Contract" refers to the Health Net of California, Inc. Combined Plan Contract and Evidence of Coverage; "Insurance Policy" refers to Health Net Life Insurance Company Explanation of Your Insurance Plan, Health Net PPO Policy.

Health Net®

Primary Applicant's Social Security Number

HEALTH NET'S PAY OPTION – MONTHLY AUTOMATIC PAYMENT FOR INDIVIDUAL & FAMILY PLANS AND CALIFORNIA FARM BUREAU MEMBER'S HEALTH INSURANCE PROGRAM

SIMPLE PAYMENT OPTION (Automatic Bank Draft) ☐ First month's payment ☐ Monthly premium payment

Monthly premium charge can be withdrawn directly from your personal checking or savings account. The premium will be withdrawn from your bank account about ten days in advance of the due date. Please select your account type: ☐ Checking ☐ Savings

Account Holder's Social Security Number	Transit Routing Number (9-digits)	Account Number

Bank Name	State

As a convenience, I request and authorize Health Net to pay and charge to the above account checks drawn on that account by and payable to the order of **"Health Net"** provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the Premium withdrawn from my account will be for the future bill period plus any past due balances and my first month's withdraw maybe for multiple periods if I did not submit a check or due to the timing of the set up. I agree that Health Net's rights in respect to each such check shall be the same as if it were a check written to Health Net and signed personally by me. This authority is to remain in effect until revoked by me in writing and until Health Net actually receives such notice, I agree that Health Net shall be fully protected in honoring any such check. ***(Note: A 30-day notice is required to discontinue this service due to the time required to initiate this change with your bank.)***

Automatic Bank Draft (ABD) transmissions are withdrawn from your bank approximately the 20th of every month, for the following month's premium. It can take upwards of 6 weeks to process an ABD request. Therefore, your premium should be submitted with your request for ABD.

I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, I will be charged a $25 service charge for each occurrence. I understand Health Net shall be under no liability whatsoever even though such dishonor may result in the forfeiture of health coverage.

SIGNATURE of ACCOUNT HOLDER (Required to Process)	Date

CREDIT CARD ☐ First month's payment ☐ Monthly premium payment

Monthly premium charge can be charged directly to your credit card account. The premium will be charged to your credit card account approximately ten days in advance of the due date. Your card will be charged for the first month's premium on the day your Application is approved by underwriting.

First Name (as on card)	Middle (as on card)	Last Name (as on card)	Card Type ☐ Visa ☐ MasterCard

Account Number 16-digits (complete)	Expiration Date (MM/YYYY)	Cardholder's email address

Billing Address	City	State	**ZIP**[1]

As a convenience, I request and authorize Health Net Life Insurance Company ("Health Net") to charge my credit card account identified above for the payment of my initial premium and/or my monthly premium. I understand that the Premium charged to my account will be for the future bill period plus any past due balances and that my first month's withdraw / charge may be for multiple periods depending upon date of approval and the bill period. This authority is to remain in effect until revoked by me in writing and until Health Net actually receives such notice, I agree that Health Net shall be fully protected in honoring any such charge. ***(Note: A 30-day notice is required to discontinue this service due to the time required to initiate this change with your credit card company.)*** I further agree that if my credit card is declined for payment, whether with or without cause and whether intentionally or inadvertently, I will be charged a $25 service charge for each occurrence. Credit card account will be charged approximately the 20th of every month, for the following month's premium.

SIGNATURE of CREDIT CARD ACCOUNT HOLDER (Required to Process)	Date

[1]The ZIP code must match the cardholder's address otherwise the credit card cannot be processed.

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION FOR ENROLLMENT

Please detach and keep this copy for your records.

Information regarding your insurability will be treated as confidential. Health Net or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Health Net, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION FOR ENROLLMENT

This authorization for use or disclosure of personal health information is being requested by Health Net to comply with the terms of federal HIPAA regulations, 45 C.F.R. § 164.508. A copy of this form is as valid as the original.

THIS AUTHORIZATION FORM MUST BE COMPLETED IN ORDER TO ENABLE HEALTH NET TO UNDERWRITE YOUR COVERAGE. THE ENROLLMENT PROCESS CANNOT BE COMPLETED WITHOUT YOUR EXPRESS AUTHORIZATION WHICH IS MORE FULLY DESCRIBED BELOW. THIS FORM MUST BE SIGNED BY THE APPLICANT AND EACH ADULT FAMILY MEMBER APPLYING FOR COVERAGE (including dependents age 18 and over).

APPLICANT AND FAMILY MEMBERS REQUESTING ENROLLMENT:

Applicant Name	Social Security Number
Spouse Name	Social Security Number
Dependent (age 18 or older)	Social Security Number
Dependent (age 18 or older)	Social Security Number

I, _____, _____
applicant (print name) spouse (print name)

_____, _____
adult dependent (print name) adult dependent (print name)

hereby authorize the use or disclosure of personal health information as described below.

Additional adult dependents may be listed below.

As the (applicant) parent, I, (print name) _____, authorize the use or disclosure of personal health information about my minor dependent(s), age 17 and under, as described below:

_____, _____, _____
(print dependent[s'] name[s])

_____, _____, _____

1. Person(s) or group of persons authorized to disclose the information to Health Net include:
   - Any medical professional, hospital, or other health care facility, clinic, pharmacy, insurer or health benefit plan administrator, Medicare or Medicaid, MIB, Inc., ("MIB"), or any other health care provider or health plan that has medical information about me or my dependent(s);
   - Health care providers or health plans indicated in my application for coverage or on my dependents' applications for coverage, or identified by me during a health history interview in regard to myself or my dependent(s), or identified by me or my dependent(s) to my agent, or any other healthcare provider or health plan referred to in my medical records or my dependent's(s') medical records.

Information regarding your insurability will be treated as confidential. Health Net or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866 692-6901 (TTY 866 346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Health Net, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

2. I authorize the following person(s) or group of persons to receive the information disclosed by one of the persons or organizations listed in paragraph 1 above, and to use that information and the information included on my application for coverage to underwrite and rate the health plan coverage for which I have applied:
   - Health Net and its affiliates including, but not limited to, its agents, underwriting operations, including independent contractors who have executed Business Associates contracts to conduct underwriting activities on behalf of Health Net or do post enrollment review of any information for determination whether policy should be rescinded for misrepresentation, who have agreed to safeguard protected health information from unauthorized disclosure, claims operations, legal representatives, its Medical Director or his/her designees, and its sales and

marketing operations. I understand that Health Net may condition my or my dependent's(s') enrollment in the health plan on my signing this Authorization and initialing this paragraph 2.

Applicant _____ Spouse _____ Dependent _____ Dependent _____

3. Description of the information that may be used or disclosed includes: All health information pertaining to me or my minor dependent(s), if applicable, related to the diagnosis, treatment or prognosis with respect to any physical, accident, illness, medical or mental condition, including but not limited to, alcohol abuse, substance abuse, mental or emotional disorders, AIDS (Acquired Immune Deficiency Syndrome), or ARC (AIDS-Related Complex), except psychotherapy notes, and any other related information, including but not limited to, the information provided on my application.
4. I understand that if this Authorization is for disclosures to someone other than Health Net, personal health information disclosed may be subject to re-disclosure by the recipient, in which case it would no longer be protected by federal Privacy Rules. However, Health Net is subject to federal Privacy Rules and any information Health Net receives is protected by these Rules.
5. I understand that my enrollment in Health Net's health plan may be conditioned on my signing this Authorization and initialing paragraph 2. I understand that I may refuse to initial paragraph 2 of this Authorization, and that such refusal could affect my enrollment in the health plan or eligibility for benefits under the health plan.
6. If the person completing this Authorization is the personal representative of the applicant or dependent, describe your authority to act on this person's behalf.

_____

_____

_____

7. As described in the "Notice of Privacy Practices," I understand that I may revoke this Authorization in writing at any time, except to the extent that action has been taken by Health Net and its subsidiaries and affiliates in reliance on this Authorization. I may send a written and dated revocation to Health Net to: Health Net Privacy Office, 21650 Oxnard Street, Ste. 2211, Woodland Hills, CA 91367. Health Net's "Notice of Privacy Practices" is available on the Health Net website at www.healthnet.com or will be provided to me in writing upon request.
8. I understand that either I am, or my personal representative is, entitled to receive a copy of my signed Authorization and by my signature below, I acknowledge that I have been provided with a copy.
9. This authorization will become effective immediately and shall remain valid for thirty (30) months from the date the authorization form is signed as to Health Net's determination on enrollment.

SIGNATURES (REQUIRED IN INK)

Applicant's Signature	Date Signed
Spouse's Signature	Date Signed
Signature of Applicant's Dependent (age 18 or older)	Date Signed
Signature of Applicant's Dependent (age 18 or older)	Date Signed
Personal Representative's Name, if applicable (Print)	Date Signed
Personal Representative's Signature	Date Signed

PLEASE RETURN THIS FORM TO:

Health Net Individual & Family Plans
P.O. Box 1150
Rancho Cordova, CA 95741-1150

Health Net®

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card. Individual and Family Plan (IFP) applicants please call 800-909-3447, option 2. For more help call the CA Dept. of Insurance at 1-800-927-4357 if you are enrolling in a PPO plan. If you are enrolling in a HMO plan, call the DMHC Helpline at 1-888-HMO-2219.
English

Servicios de Idiomas Sin Costo. Usted puede solicitar un intérprete. Puede solicitar que una persona le lea los documentos y que algunos se le envíen en su idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación. Los solicitantes de Plan Individual y Familiar (IFP, por sus siglas en inglés), deben llamar al 800-909-3447, opción 2. Para obtener ayuda adicional llame al Departamento de Seguros de California al 1-800-927-4357, si desea inscribirse en un plan PPO. Si usted se inscribe en un plan HMO, llame a la Línea de ayuda de DMHC, al 1-888-HMO-2219.
Spanish

免費語言服務。您可以取得口譯員服務。我們可以把文件朗讀給您聽，部分文件可以翻譯成您的語言並寄送給您。如需協助，請撥打您會員卡上所列的電話號碼。個人和家庭計畫 (IFP) 或申請人請撥 800-909-3447，按 2。欲投保首選醫師 / 醫療組織 (PPO) 計畫，請致電 1-800-927-4357 與加州保險部聯絡，詢求額外協助。欲投保管理式醫療組織 (HMO) 計畫，請撥加州醫療保健計畫管理局 (DMHC) 協助專線， 電話 1-888-HMO-2219。
Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch và được người khác đọc giúp các tài liệu bằng ngôn ngữ của quý vị. Để được giúp đỡ, xin gọi chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị. Những người muốn xin bảo hiểm của Chương Trình Bảo Hiểm Cá Nhân và Gia Đình (IFP), xin gọi số 800-909-3447, bấm số 2. Để được giúp đỡ thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357 nếu quý vị muốn tham gia một chương trình PPO. Nếu quý vị đang tham gia một chương trình HMO, xin gọi Đường Dây Trợ Giúp của DMHC tại số 1-888-HMO-2219.
Vietnamese

무료 언어 지원 서비스. 무료 통역사 서비스 및 여러분에게 편한 언어로 서류 낭독 서비스를 받을 수 있습니다. 도움이 필요하신 분은 본인의 ID 카드상에 적힌 안내 번호로 전화해 주십시오. 개인 및 가족 플랜 (IFP) 가입 신청자님은 안내번호 800-909-3447번, 옵션 2를 이용해 주십시오. PPO 플랜에 가입하신 경우, 더 많은 도움이 필요하신 분은 캘리포니아 보험 담당국 안내번호 1-800-927-4357번으로 문의하십시오. HMO 플랜에 가입하신 경우, DMHC (보건관리부) 헬프라인, 안내번호 1-888-HMO-2219번으로 문의하십시오.
Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa iyong wika ang mga dokumento. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card. Para sa Individual and Family Plan (IFP) applicants, mangyaring tumawag sa 800-909-3447, opsyon 2. Para sa karagdagang tulong, tumawag sa CA Dept. of Insurance sa 1-800-927-4357 kung ikaw ay nag-eenroll sa isang PPO plan. Kung ikaw ay nag-eenroll sa isang HMO plan, tawagan ang DMHC Helpline sa 1-888-HMO-2219.
Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար ձեր լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված համարով: Անհատական և Ընտանեկան Ծրագրի (Individual and Family Plan/IFP) դիմորդներից խնդրվում է զանգահարել 800-909-3447 համարով, ընտրանք 2: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք, եթե գրանցվում եք PPO ծրագրում: Եթե գրանցվում եք HMO ծրագրում, 1-888-HMO-2219 համարով զանգահարեք DMHC-ի Օգնության գծին:
Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и вам могут прочесть документы на вашем языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте. Участники планов индивидуального или семейного страхования (Individual and Family Plan, IFP): пожалуйста, звоните по номеру 800-909-3447, добавочный 2. Если вы участвуете в плане системы предпочтительного выбора (Preferred Provider Organization, PPO), для получения дополнительной помощи звоните в Департамент страхования штата Калифорния по телефону 1-800-927-4357. Если вы состоите в плане организаций медицинского обслуживания (Health Maintenance Organizations, HMO), пожалуйста, звоните в горячую линию Департамента организованного медицинского обслуживания (DMHC) по телефону 1-888-HMO-2219.
Russian

無料の言語サービス。日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号までお問い合わせください。個人・家族プラン (IFP)への加入申込の方は、800-909-3447（ダイアル後 2 を選択）までお問い合わせください。更なるお問い合わせ事項がある場合、PPO プランにご加入の方は、カリフォルニア州保険庁、1-800-927-4357 までご連絡ください。HMOプランにご加入 の方は、カリフォルニア州管理医療庁 (DMHC) の相談窓口、1-888-466-2219 までご連絡ください。
Japanese

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی برخوردار شده و بگوئید مدارک به زبان خودتان برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است تماس بگیرید. متقاضیان «طرح افراد و خانواده ها» (IFP) لطفاً به شماره 800-909-3447 گزینه 2 تلفن کنند. برای دریافت کمک بیشتر، به اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تلفن کنید اگر در یک طرح PPO ثبت نام میکنید. اگر در یک طرح HMO ثبت نام میکنید، به خط کمکی DMHC به شماره 1-888-HMO-2219 تلفن کنید.
Farsi

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ। ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਪਲਾਨ (IFP) ਅਰਜ਼ੀਦਾਤਾ ਕਿਰਪਾ ਕਰਕੇ 800-909-3447, ਔਪਸ਼ਨ 2 ਤੇ ਫੋਨ ਕਰੋ। ਜੇ ਤੁਸੀਂ ਕਿਸੇ PPO ਪਲਾਨ ਲਈ ਨਾਂ ਲਿਖਵਾ ਰਹੇ ਹੋ ਤਾਂ ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫੋਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਜੇ ਤੁਸੀਂ ਕਿਸੇ HMO ਪਲਾਨ ਲਈ ਨਾਂ ਲਿਖਵਾ ਰਹੇ ਹੋ ਤਾਂ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਮੈਨੇਜਡ ਹੈਲਥ ਕੇਅਰ (DMHC) ਦੀ ਹੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ।
Punjabi

ការបកប្រែភាសាដោយឥតអស់ថ្លៃ ។ អ្នកអាចទទួលអ្នកបកប្រែភាសា និងឲ្យគេអានឯកសារជូនអ្នកជាភាសាខ្មែរបាន ។ សំរាប់ជំនួយ សូមទូរស័ព្ទមកយើង តាមលេខមានកត់នៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក ។ គំរោងបុគ្គលម្នាក់ៗ និងជាគ្រួសារ (IFP) សូមទូរស័ព្ទ ទៅលេខ 800-909-3447 ចុចជំរើសទី 2 ។ សំរាប់ជំនួយថែមទៀត សូមទូរស័ព្ទទៅ ក្រសួងធានារ៉ាប់រងកាលីហ្វ័រនីញ៉ា តាមលេខ 1-800-927-4357 បើសិនជាអ្នកកំពុងតែចុះឈ្មោះក្នុងគំរោង PPO ។ បើសិនជាអ្នកកំពុងតែចុះឈ្មោះក្នុងគំរោង HMO សូមទូរស័ព្ទ ទៅខ្សែជំនួយ DMHC តាមលេខ 1-888-HMO-2219 ។
Khmer

Cov Kev Pab Txhais Lus Uas Tsis Tau Them Nqi. Yuav muaj ib tug neeg txhais lus thiab nyeem cov ntawv ua koj hom lus rau koj. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID. Cov neeg thov kev pab hauv pawg Tus Kheej thiab Tsev Neeg (Individual and Family Plan [IFP]) thov hu rau 800-909-3447, xaiv nqe 2. Yog xav tau kev pab ntxiv hu rau CA Lub Caj Meem Fai Saib Xyuas Txog Kev Tswj Txoj Kev Kho Mob (Dept. of Insurance) ntawm 1-800-927-4357 yog hais tias koj koom rau hauv ib qho kev pab los ntawm PPO. Yog hais tias koj koom rau hauv ib qho kev pab los ntawm HMO, hu rau DMHC Tus Xov Tooj Muab Kev Pab ntawm 1-888-HMO-2219.
Hmong

ບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າ. ທ່ານສາມາດໄດ້ຮັບບໍລິການແປພາສາແລະມີຜູ້ອ່ານເອກກະສານໃຫ້ທ່ານຟັງເປັນພາສາ
ຂອງທ່ານເອງ. ເພື່ອຈະໄດ້ຮັບຄວາມຊ່ວຍເຫລືອ, ໃຫ້ໂທຫາພວກເຮົາຕາມໝາຍເລກທີ່ລະບຸໄວ້ໃນບັດປະກັນໄພຂອງ
ທ່ານ. ຜູ້ຂໍເອົາແຜນການ Individual and Family Plan (IFP) ຂໍໃຫ້ໂທຕາມໝາຍເລກ 800-909-3447 ແລ້ວເລືອກ
ຂໍ້ທີ 2. ຖ້າຫາກທ່ານກຳລັງຈະລົງທະບຽນແຜນການ PPO, ໃຫ້ໂທໄປຫາກົມປະກັນໄພແຫ່ງລັດຄາລິຟໍເນຍຕາມ
ໝາຍເລກ 1-800-927-4357 ເພື່ອຈະໄດ້ຮັບຄວາມຊ່ວຍເຫລືອເພີ່ມຕື່ມ. ຖ້າຫາກ
ທ່ານກຳລັງຈະລົງທະບຽນແຜນການ HMO, ໃຫ້ໂທຕາມສາຍດ່ວນ DMHC ຕາມໝາຍເລກ 1-888-HMO-2219.
Laotian

خدمات لغوية بدون تكلفة. يمكنك الاستعانة بمترجم وطلب قراءة الوثائق لك بلغتك. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك (ID). المتقدمين بطلبات الحصول على تأمين لشخص واحد أو لعائلة (IFP) رجاء الاتصال بالرقم 800-909-3447، خيار 2. للحصول على المزيد من المساعدة، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357 إذا كنت مشتركاً في برنامج PPO. وإذا كنت مشتركاً في برنامج HMO اتصل بالخط الساخن لـ DMHC على الرقم 1-888-HMO-2219.
Arabic

6018983 (7/09)

LANGUAGE PREFERENCE FORM
FORMULARIO DE PREFERENCIA DE IDIOMA
慣用語言資料表

TALK TO US – WE SPEAK YOUR LANGUAGE

Is English your second language? Is it easier to read and speak in a language other than English?

If yes, please complete this form and return it with your Enrollment Application. If you are accepted for enrollment, our records will be updated with this information. This information will help:

- Allow those whose preferred language is one of the two most prevalent non-English languages in Health Net's enrollment to receive certain plan documents in your preferred language.
- Provide you with interpreter assistance for health services in your preferred language.

Health Net is required to collect written and spoken language information in order to comply with California Department of Managed Health Care and California Department of Insurance language assistance regulations, however, you are not required to provide this information. Health Net will protect your information, including race, ethnicity, and your language choices.

HABLE CON NOSOTROS, HABLAMOS SU IDIOMA

¿Es el inglés su segundo idioma? ¿Le resulta más fácil leer y hablar en un idioma distinto del inglés?

Si la respuesta es sí, llene este formulario y devuélvalo junto con su Formulario de Inscripción. Si su solicitud de inscripción es aceptada, actualizaremos nuestros registros con esta información, la que nos servirá para:

- Permitir que aquellas personas cuyo idioma preferido es uno de los dos idiomas extranjeros más comunes entre todos los que se inscriben en Health Net, reciban ciertos documentos del plan en su idioma preferido.
- Brindarle la asistencia de un intérprete para servicios de salud en su idioma preferido.

A Health Net se le exige recopilar información sobre el idioma escrito y hablado para cumplir con los reglamentos sobre asistencia del idioma del Departamento de Cuidado Médico de California y el Departamento de Seguros de California, sin embargo, no es obligación que usted proporcione esta información. Health Net protegerá su información, incluidos su raza, origen étnico y sus alternativas de idioma.

請與我們交談 — 我們會說您的語言

英語是您的第二語言嗎？ 您是否覺得用英語以外的另一種語言來閱讀和溝通比較容易？

如果是的話，請您填寫這份表格，並連同您的投保申請書一併繳回。 如果您的投保申請獲准，我們會把本表的資料更新到紀錄中。 這些資料能幫助：

- 慣用語言為康寧保健投保時最通用的兩種非英文語言者，得以收到其慣用語言版本的部分計畫文件。
- 在您取得保健服務時以您慣用的語言提供您口譯員協助。

按加州醫療保健計畫管理局和加州保險局的語言協助法令規定，康寧保健必須收集書寫和口語使用語言的資訊，但是您無須提供這些資訊。 康寧保健會保護您所提供的資訊，包括種族、族裔和您的語言選擇。

Name/ Nombre/ 姓名：_____

Social Security Number/ Número del Seguro Social/ 社會安全號碼：_____

Written Language/ Idioma Escrito/ 書寫語言：_____

Spoken Language/ Idioma Hablado/ 口說語言： _____

Race (optional)/ Raza (opcional)/ 種族 (非必填)：_____

Ethnicity (optional)/ Origen Étnico (opcional)/ 族裔 (非必填)：_____