For company use only
Approved: _____
Date: _____

Evidence of Insurability Application for Group Life Insurance

Note: Please print in black ink. Any alteration to the printed copy will void this application.

Reason for application: ☐ Addition to existing group ☐ Change of benefits	Group number: _____ Application is made for: ☐ Basic Life amount: _____ ☐ Supplemental Life amount: _____ ☐ Dependent Life amount: _____ ☐ Other: _____			
Name of applicant:				
If dependent, relationship to employee:				
Home address:				
City:			State:	ZIP:
Home phone number: ( )	Date of birth (mm/dd/yyyy): / /	Sex:	Social Security number: – –	
Your occupation (in detail):				
Employer's name:		Date of hire: / /		
Employer's address:				
City:			State:	ZIP:
Height:	Weight:	Have you gained or lost more than 20 pounds in the last year? ☐ Yes ☐ No If "Yes," which one? ☐ Gained ☐ Lost _____ pounds (give details):		
Full name of your regular physician:				
Date last consulted: / /	Reason:			
Full address of your regular physician:				
City:			State:	ZIP:

(continued)

Life Premium Accounting and Eligibility
PO Box 9103, Van Nuys, CA 91409-9103
1-800-865-6288

FRM1685101EC01w (9/24)

Health questions (Answer all questions – Attach separate sheet if necessary.)

1. If employed, are you actively at work at least 30 hours a week?	☐ Yes ☐ No
2. During the last five years, have you been absent from work more than five consecutive working days because of illness or injury? If "Yes," give details below.	☐ Yes ☐ No
3. Are you now under regular medical observation or taking medical treatment? If "Yes," give details below.	☐ Yes ☐ No
4. Within the last five years, have you consulted a member of the medical profession for any disease or injury, or have you had or been advised to have any surgical operation or diagnostic tests? If "Yes," give details below.	☐ Yes ☐ No
5. To the best of your knowledge, have you had or been told you have acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC)?	☐ Yes ☐ No
6. Please check either "Yes" or "No" if you have ever had or been treated for, or counseled or advised by a member of the medical profession that you have or may have, any of the following. If "Yes," give details below.	☐ Yes ☐ No

	Yes	No		Yes	No		Yes	No
High blood pressure	☐	☐	Diabetes or albumin or sugar in urine	☐	☐	Cancer or tumors	☐	☐
Rheumatic fever	☐	☐	Disorder of the stomach or intestines or liver	☐	☐	Lung disorder	☐	☐
Heart murmur	☐	☐	Nervous disorder or epilepsy	☐	☐	Kidney disease	☐	☐
Paralysis	☐	☐	Heart disease, stroke or other circulatory disorders	☐	☐	Back disorder	☐	☐
Chest pain	☐	☐	Sexually transmitted diseases	☐	☐			

Condition	Date	Remaining effects	Physician's full name/address

I hereby state that the foregoing statements and answers made by me on behalf of myself are complete and true, to the best of my knowledge and belief, that they are correctly and fully recorded, and that no material circumstance or information has been withheld or omitted concerning myself. I agree that the answers and statements herein shall form a part of the contract. I understand that any misstatement or failure to report information may be used as the basis of a recision of insurance for myself. I understand that if medical records are necessary to determine my insurability, they will be provided by me at my expense. I also understand that insurance will not be in force until the application is approved in writing by Health Net Life Insurance Company. I AGREE that a photocopy of this AUTHORIZATION shall be as valid as the original and that this AUTHORIZATION will be valid from the date signed below for a period of twenty-four (24) full months, or less if required by applicable state law. Furthermore, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically-related facility, insurance company or other health care provider, or the Medical Information Bureau, that has any medical records or knowledge of me, to give to Health Net Life Insurance Company, its reinsurers or their legal representative, any such information, including, without limitation, information relating to mental health treatment, chemical dependency, and sexually transmitted diseases.

Signature of applicant: _____ Date: _____

(and parent if applicant is under age 18)

HN1035

Cut off – for applicant's reference

Notice of exchange of information

Thank you for enrolling for Group Life Insurance with Health Net Life Insurance Company. As a part of the normal procedure of processing the group policy, information concerning proposed insureds may be obtained relative to each person's insurability. Information regarding your insurability will be treated as confidential. Health Net Life Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a nonprofit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is MIB, Inc., 50 Braintree Hill Park, Ste. 400, Braintree, MA 02184-8734; telephone number: (781) 751-6000.

Health Net Life Insurance Company, or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Nondiscrimination Notice

In addition to the State of California nondiscrimination requirements (as described in benefit coverage documents), Health Net of California, Inc. complies with applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, gender affirming care, sexual orientation, age, disability, or sex.

Health Net:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at: 800-522-0088 (TTY: 711)

If you believe that Health Net has failed to provide these services or discriminated in another way based on one of the characteristics listed above, you can file a grievance by calling Health Net's Customer Contact Center at the number above and telling them you need help filing a grievance. Health Net's Customer Contact Center is available to help you file a grievance. You can also file a grievance by mail, fax or email at:

Health Net of California, Inc., Appeals & Grievances
PO Box 10348, Van Nuys, CA 91410-0348

Fax: 1-877-831-6019
Email: Member.Discrimination.Complaints@healthnet.com (Members)

If your health problem is urgent, if you already filed a complaint with Health Net of California, Inc. and are not satisfied with the decision or it has been more than 30 days since you filed a complaint with Health Net of California, Inc., you may submit an Independent Medical Review/Complaint Form with the Department of Managed Health Care (DMHC). You may submit a complaint form by calling the DMHC Help Desk at 1-888-466-2219 (TDD: 1-877-688-9891) or online at www.dmhc.ca.gov/FileaComplaint.

If you believe you have been discriminated against because of race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights (OCR), electronically through the OCR Complaint Portal, at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

English
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 or call 1-800-522-0088 (TTY: 711).

Arabic
خدمات اللغة مجانية. يمكنك الحصول على مترجم فوري. ويمكنك الحصول على وثائق مقروءة لك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة الهوية، أو اتصل على مركز الاتصال التجاري (TTY: 711) 1-800-522-0088

Armenian
Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեզ համար: Օգնության համար զանգահարեք մեզ ձեր ID քարտի վրա նշված հեռախոսահամարով կամ զանգահարեք 1-800-522-0088 (TTY: 711).

Chinese
免費語言服務。您可使用口譯員。您可請人使用您的語言將文件內容唸給您聽，並請我們將有您語言版本的部分文件寄給您。如需協助，請致電您會員卡上所列的電話號碼與我們聯絡，或致電 1-800-522-0088 (TTY: 711)。

Hindi
बिना लागत की भाषा सेवाएँ। आप एक दुभाषिया प्राप्त कर सकते हैं। आपको दस्तावेज पढ़ कर सुनाए जा सकते हैं। मदद के लिए, आपके आईडी कार्ड पर दिए गए सूचीबद्ध नंबर पर हमें कॉल करें, या 1-800-522-0088 (TTY: 711)।

Hmong
Kev Pab Txhais Lus Dawb. Koj xav tau neeg txhais lus los tau. Koj xav tau neeg nyeem cov ntaub ntawv kom yog koj hom lus los tau. Xav tau kev pab, hu peb tau rau tus xov tooj ntawm koj daim npav los yog hu 1-800-522-0088 (TTY: 711).

Japanese
無料の言語サービス。通訳をご利用いただけます。文書をお読みします。援助が必要な場合は、IDカードに記載されている番号までお電話いただくか、1-800-522-0088 、(TTY: 711)。

Khmer
សេវាភាសាដោយឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ អ្នកអាចស្តាប់គេអានឯកសារឱ្យអ្នក។ សម្រាប់ជំនួយ សូមទាក់ទងយើងខ្ញុំតាមរយៈលេខទូរសព្ទដែលមាននៅលើកាតសម្គាល់ខ្លួនរបស់អ្នក ឬ ទាក់ទងទៅមជ្ឈមណ្ឌលទំនាក់ទំនងពាណិជ្ជកម្មនៃក្រុមហ៊ុន 1-800-522-0088 (TTY: 711).។

Korean
무료 언어 서비스. 통역 서비스를 받을 수 있습니다. 귀하가 구사하는 언어로 문서의 낭독 서비스를 받으실 수 있습니다. 도움이 필요하시면 보험 ID 카드에 수록된 번호로 전화하시거나 1-800-522-0088 (TTY: 711).

Navajo
Saad Bee Áká E'eyeed T'áá Jíík'e. Ata' halne'ígíí hóló. T'áá hó hazaad k'ehjí naaltsoos hach'i' wóltah. Shíká a'doowoł nínízingo naaltsoos bee néího'dólzinígíí bikáa'gi béésh bee hane'í bikáá' áajį' hodíílnih éí doodaii' 1-800-522-0088 (TTY: 711).

Persian (Farsi)
خدمات زبان به طور رایگان. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید که اسناد برای شما قرائت شوند. برای دریافت راهنمایی، با ما به شماره ای که روی کارت شناسایی شما درج شده تماس بگیرید یا با مرکز تماس بازرگانی 1-800-522-0088 (TTY: 711).

Panjabi (Punjabi)
ਬਨਿਾਂ ਕਸਿੇ ਲਾਗਤ ਤੋ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ਿਆ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਚਿ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦੱਤਿ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ ਕਰਿਪਾ ਕਰਕੇ 1-800-522-0088 (TTY: 711).

Russian
Бесплатная помощь переводчиков. Вы можете получить помощь устного переводчика. Вам могут прочитать документы. За помощью обращайтесь к нам по телефону, приведенному на вашей идентификационной карточке участника плана. Кроме того, вы можете позвонить в 1-800-522-0088 (TTY: 711).

Spanish
Servicios de idiomas sin costo. Puede solicitar un intérprete. Puede obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o comuníquese con el 1-800-522-0088 (TTY: 711).

Tagalog
Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng isang interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo. Para sa tulong, tawagan kami sa nakalistang numero sa inyong ID card o tawagan ang 1-800-522-0088 (TTY: 711).

Thai
ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังได้ สำหรับความช่วยเหลือ โทรหาเราตามหมายเลขที่ให้ไว้บนบัตรประจำตัวของคุณ หรือ โทรหาศูนย์ติดต่อเชิงพาณิชย์ของ 1-800-522-0088 (TTY: 711)

Vietnamese
Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu cầu được đọc cho nghe tài liệu. Để nhận trợ giúp, hãy gọi cho chúng tôi theo số được liệt kê trên thẻ ID của quý vị hoặc gọi 1-800-522-0088 (TTY: 711).