Employer Group

Medical Coordination of Benefits

# Enrollment Request Form

| Employer name: | |
|---|---|
| Coverage effective date | Employer group number (Medical): |

**Important – Please print all sections in black ink. For the application to be valid, you must submit all applicable pages.**

## 1. Select coverage

### 1a: Check the desired plan as offered by your employer: (Write the plan number next to the product.)

☐ HMO: ______________________________

☐ HMO: ExcelCare ______________________

☐ HMO: SmartCare ______________________

☐ PPO: ______________________________

☐ POS: Select _________________________

☐ Flex Net/Flex Med: ____________________

**Reason for application:**

☐ Retiree ☐ Open Enrollment ☐ Loss of prior coverage date: ____________________

☐ COBRA effective date: ________ Qualifying event: ________ Qualifying event date: ________

☐ Add dependent Qualifying event: __________ Qualifying event date: ______________

**Reason for change:**

☐ Plan change ☐ Change address/name ☐ Delete dependent(s) (List names in Section 3.)

☐ Other: ____________________________________________________________

### 1b: Please provide your Medicare insurance information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

OR

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

______________________________________

Medicare number:

___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Is entitled to: Effective date:

**HOSPITAL (Part A)** ____________________

**MEDICAL (Part B)** ____________________

You must have Medicare Part A and Part B to join a Medicare Coordination of Benefits plan.

## 2. Retiree personal information

| Last name: | First name: | MI: | Date of birth (MM/DD/YYYY): | |
|---|---|---|---|---|
| Residence address: | City: | | State: | ZIP: |
| Mailing address (if different from residence): | City: | | State: | ZIP: |

| Retiree name: |
|---|

## 2. Retiree personal information (continued)

| Home telephone #: ( ) | Social Security #: | Email address: |
|---|---|---|

| ☐ Male ☐ Female | Marital status: ☐ Single ☐ Married ☐ Domestic partner |
|---|---|

| Participating physician group/PPG #: | Primary care physician/PCP #: | ☐ N/A. I'm enrolling in a PPO or Flex Net/Flex Med plan. |
|---|---|---|

| Physician name (first, last): | Is this your current MD? ☐ Yes ☐ No |
|---|---|

**Other health coverage?** If "Yes," please complete this section if you **currently** have or **previously** had coverage with any public or private health plan (including Medi-Cal or Individual coverage) immediately prior to becoming eligible for this plan. According to federal laws, if you had prior coverage, your employer or former carrier must provide you with a certificate that shows evidence of your coverage. We reserve the right to request a copy of this certificate.

| Name of subscriber: | Prior coverage start date: __/__/____ (MM/DD/YYYY) |
|---|---|

| Name and address of other insurance carrier: |
|---|

| Prior coverage start date: __/__/____ (MM/DD/YYYY) | Reason for ending coverage: |
|---|---|

| Group #/Policy ID #: | Is this your primary coverage? ☐ Yes ☐ No | Does it cover medical? ☐ Yes ☐ No |
|---|---|---|

Are you enrolling dependents? ☐ Yes ☐ No
If "Yes," complete and submit all pages of the form. If "No," and you are declining coverage for yourself or a dependent, please complete the Declination of Coverage section at the bottom of page 4.

## 3. Family information (Please list all eligible family members to be enrolled. To add additional dependents, fill out the Health Net Dependent Information Form, and submit it along with this application.)

### DEPENDENT 1

| ☐ Spouse ☐ Domestic partner | ☐ Male ☐ Female | Last name: | First name: | MI: |
|---|---|---|---|---|

| Residence address (☐ Check here if same as employee.): | City: | State: | ZIP: |
|---|---|---|---|

| Date of birth (MM/DD/YYYY): | Social Security #/Matricula ID #: |
|---|---|

## 3. Family information (continued)

**DEPENDENT 1 (CONTINUED)**

| Coverage type: ☐ Medical ☐ Medicare Part A ☐ Medicare Part B ☐ Medicare Part D | Medicare number: | Participating physician group/PPG #:<br>Primary care physician/PCP # |
|---|---|---|
| Physician name (first, last): | Is this your current MD? ☐ Yes ☐ No | Dental HMO Provider ID # (Complete only if electing Health Net Dental.): |

Does your dependent have other health care coverage? ☐ Yes ☐ No If "Yes," complete the following:
Name of insurance carrier: ______________________ Prior coverage start date: __________________

**DEPENDENT 2**

| ☐ Son ☐ Daughter | Last name: | First name: | MI: |
|---|---|---|---|

| Residence address (☐ Check here if same as employee.): | City: | State: | ZIP: |
|---|---|---|---|

| Date of birth (MM/DD/YYYY): | Totally disabled? ☐ Yes ☐ No | Social Security #/Matricula ID #: |
|---|---|---|

| Coverage type: ☐ Medical ☐ Medicare Part A ☐ Medicare Part B ☐ Medicare Part D | Medicare number: | Participating physician group/PPG #:<br>Primary care physician/PCP # |
|---|---|---|
| Physician name (first, last): | Is this your current MD? ☐ Yes ☐ No | Dental HMO Provider ID # (Complete only if electing Health Net Dental.): |

Does your dependent have other health care coverage? ☐ Yes ☐ No If "Yes," complete the following:
Name of insurance carrier: ______________________ Prior coverage start date: __________________

## 4. Acceptance of coverage (Signature required.)

**The 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 entities. Health Net entities use and may disclose this information for purposes of treatment, payment and health plan operations, including but not limited to, utilization management, quality improvement, and disease or case management programs. Health Net's Notice of Privacy Practices is included in the *Evidence of Coverage or Certificate of Insurance* for coverage underwritten by Health Net entities. I may also obtain a copy of this notice on the website at healthnet.com or through the Health Net Customer Contact Center.

**California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.**

## 4. Acceptance of coverage (continued)

**Acknowledgement and agreement:** I understand and agree that by enrolling with or accepting services from the Health Net entities, I and any enrolled dependents are obligated to understand and abide by the terms, conditions and provisions of the plan contract or insurance policy. I have read and understand the terms of this application, and my signature below indicates that the information entered in this application is complete, true and correct to the best of my knowledge, and I accept these terms.

**BINDING ARBITRATION AGREEMENT: I, the Applicant, understand and agree that any and all disputes between me (including any of my enrolled family members or heirs or personal representatives) and Health Net, except disputes concerning adverse benefit determinations as defined in 45 CFR 147.136, must be submitted to individual, final and binding arbitration instead of a jury or court trial and that I am waiving all rights to class arbitration. This Agreement to arbitrate includes any disputes arising from or relating to the Evidence of Coverage or Certificate of Insurance or my Health Net membership or coverage, stated under any legal theory. This agreement to arbitrate any disputes applies even if other parties, such as health care providers or their agents or employees, are involved in the dispute. I understand that, by agreeing to submit all disputes to individual, final and binding arbitration, all parties including Health Net are giving up their constitutional right to have their dispute decided in a court of law by a jury. I also understand that disputes that I may have with Health Net involving claims for medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) are also subject to final and binding arbitration. I understand that a more detailed arbitration provision is included in the Evidence of Coverage or Certificate of Insurance. My signature below indicates that I understand and agree with the terms of this Binding Arbitration Agreement and agree to submit any disputes to binding arbitration instead of a court of law.**

Retiree signature: ______________________________

Print retiree name: ______________________________ Date: ______________

If you are the authorized representative, you must sign above and provide the following information:

Name: ______________________________ Relationship to enrollee: ______________

Address: ______________________________ Phone number: ( _____ ) _____ — _______

## Complete this section only if any coverage is to be declined by you.

| | |
|---|---|
| ☐ Declining medical coverage | Reason: ☐ Other group coverage ☐ Individual coverage<br>☐ Other: ______________________________<br>☐ Other group coverage by another group (i.e., spouse's employer) |

The available coverages have been explained to me by my employer. I have been given the chance to apply for the available coverages. I have decided not to enroll myself and/or my dependent(s). By declining coverage, I acknowlege that my dependents and I may have to wait to be enrolled until the next open enrollment period or qualifying event. Additionally, by signing below I certify that the reason I am declining coverage is accurate as indicated by the check marks above.

**Note:** If you decline coverage for yourself or an eligible dependent because of coverage under other health insurance, you may be eligible for special enrollment rights if you or your dependent lose eligibility for that coverage. You must request special enrollment within 30 days of the loss of coverage or acquisition of a new dependent.

Employee signature: ______________________________ Date: ______________

**(ONLY IF DECLINING COVERAGE: If signed in error, please cross out and initial.)**

Medical Coordination of Benefits HMO health plans are offered by Health Net of California, Inc. Medical Coordination of Benefits health insurance policies are underwritten by Health Net Life Insurance Company.

ATTENTION: If you need help in your language, call 1-800-275-4737 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-800-275-4737 (TTY: 711). These services are free.

انتباه: إذا كنت بحاجة إلى مساعدة بلغتك، فاتصل على 1-800-275-4737 (TTY: 711). تتوفر أيضًا مساعدات وخدمات للأشخاص ذوي الإعاقات مثل المستندات بطريقة برايل وبطباعة كبيرة. اتصل على 1-800-275-4737 (TTY: 711). هذه الخدمات مجانية.

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե ցանկանում եք օգնություն ստանալ ձեր լեզվով, զանգահարեք 1-800-275-4737 (TTY՝ 711): Հասանելի են նաև հաշմանդամություն ունեցող անձանց համար նախատեսված օժանդակ միջոցներ և ծառայություններ, օրինակ՝ բրայլյան գրատեսակով և խոշոր տառաչափով փաստաթղթեր: Զանգահարեք 1-800-275-4737 (TTY՝ 711): Այս ծառայություններն անվճար են:

注意：如果您需要以您的语言提供的帮助，请致电 1-800-275-4737（TTY：711）。此外，还为残疾人提供辅助和相关服务，如盲文文件和大字体文件。请致电 1-800-275-4737（TTY：711）。这些服务均免费提供。

注意：如果您需要以您母語提供的協助，請致電 1-800-275-4737 (TTY：711)。我們也為殘疾人士提供輔助和服務，例如點字和大字體印刷的文件。請致電 1-800-275-4737 (TTY：711)。這些服務均為免費。

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ, ਤਾਂ 1-800-275-4737 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਬਰੇਲ ਲਿਪੀ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ਾਂ ਵਰਗੀਆਂ ਅਸਮਰੱਥਾ ਵਾਲੇ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਉਪਲਬਧ ਹਨ। 1-800-275-4737 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਇਹ ਮੁਫ਼ਤ ਸੇਵਾਵਾਂ ਹਨ।

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है, तो 1-800-275-4737 (TTY: 711) पर कॉल करें. विकलांग लोगों के लिए ब्रेल और बड़े प्रिंट में दस्तावेज जैसी सहायताएं और सेवाएं भी उपलब्ध हैं. 1-800-275-4737 (TTY: 711) पर कॉल करें. ये सेवाएं निःशुल्क हैं.

THOV MUAB SIAB RAU: Yog tias koj xav tau kev pab ua koj hom lus, ces hu rau 1-800-275-4737 (TTY: 711). Tsis tas i ntawd, peb tseem muaj cov neeg pab thiab cov kev pab cuam rau cov neeg uas muaj cov kev xiam oob qhab, xws li cov ntaub ntawv ua ntawv su rau neeg dig muag thiab ntawv luam loj. Hu rau 1-800-275-4737 (TTY: 711). Cov kev pab cuam no pab dawb xwb.

注意：言語のヘルプが必要な場合は1-800-275-4737（TTY：711）までお電話ください。障害をお持ちの方には、点字や大判プリントなどの補助機能やサービスもご利用になれます。1-800-275-4737（TTY：711）にお電話ください。これらのサービスは無料です。

주의: 귀하의 구사 언어로 도움을 받으셔야 한다면 1-800-275-4737(TTY: 711)번으로 연락해 주십시오. 점자 및 큰 활자 인쇄 형식으로 된 문서 등 장애인을 위한 도움 및 서비스도 제공됩니다. 1-800-275-4737(TTY: 711)번으로 연락해 주십시오. 이러한 서비스는 무료입니다.

ຂໍ້ຄວນເອົາໃຈໃສ່: ຫາກທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານ, ໃຫ້ໂທຫາ 1-800-275-4737 (TTY: 711). ນອກຈາກນີ້ ຍັງມີຄວາມຊ່ວຍເຫຼືອສຳລັບຜູ້ພິການ ເຊັ່ນ: ເອກະສານເປັນອັກສອນນູນ ແລະ ຕົວພິມໃຫຍ່ອີກດ້ວຍ. ໃຫ້ໂທຫາ 1-800-275-4737 (TTY: 711). ບໍລິການເຫຼົ່ານີ້ຟຣີ.

LIOUH EIX: Oix se nongc zuqc meih nyei wac jouh mienh bong zouc, cingv mboqv 1-800-275-4737 (TTY: 711). Hac haih weic waic fangx mienh zoux sic taengx qaqv, hnangv mangh wenh souh nzangc caux domh nzangc yenx benx nyei souh nzangc. Mboqv 1-800-275-4737 (TTY: 711). Naiv deix bong taengx meih se mv siou zinh.

ចំណាំ៖ ប្រសិនបើអ្នកត្រូវការជំនួយជាភាសារបស់អ្នក សូមទូរសព្ទទៅលេខ 1-800-275-4737 (TTY: 711) ជំនួយនិងសេវាកម្មសម្រាប់ជនពិការ ដូចជាឯកសារជាអក្សរស្ទាបសម្រាប់ជនពិការភ្នែក និងពុម្ពអក្សរធំ ក៏មានផងដែរ។ សូមទូរសព្ទទៅលេខ 1-800-275-4737 (TTY: 711)។ សេវាទាំងនេះមិនគិតថ្លៃនោះទេ។

توجه: اگر به زبان خودتان نیاز به کمک دارید با شماره 1-800-275-4737 (TTY: 711) تماس بگیرید. پشتیبانی و خدمات برای افراد دارای معلولیت، مانند اسناد با خط بریل و چاپ درشت، نیز موجود است. با شماره 1-800-275-4737 (TTY: 711) تماس بگیرید. این خدمات رایگان است.

ВНИМАНИЕ: если вам требуется помощь на родном языке, позвоните по номеру 1-800-275-4737 (TTY: 711). Также доступны сопутствующая помощь и услуги для людей с ограниченными возможностями, такие как материалы, напечатанные крупным шрифтом и шрифтом Брайля. Позвоните по номеру 1-800-275-4737 (TTY: 711). Эти услуги предоставляются бесплатно.

ATENCIÓN: Si necesita ayuda en su idioma llame al 1-800-275-4737 (TTY: 711). También están disponibles ayudas y servicios para personas con discapacidades, como documentos en Braille y letra grande. Llame al 1-800-275-4737 (TTY: 711). Estos servicios son gratuitos.

ATENSYON: Kung kailangan ninyo ng tulong sa inyong wika, tumawag sa 1-800-275-4737 (TTY: 711). Available din ang mga tulong at serbisyo para sa mga taong may kapansanan, gaya ng mga dokumento sa braille at malaking print. Tumawag sa 1-800-275-4737 (TTY: 711). Libre ang mga serbisyong ito.

**โปรดทราบ**: **หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ โปรดโทร** 1-800-275-4737 (TTY: 711) **นอกจากนี้ ยังมีความช่วยเหลือและบริการสำหรับผู้พิการ เช่น เอกสารที่เป็นอักษรเบรลล์และเอกสารที่ใช้ตัวอักษรขนาดใหญ่ โปรดโทร** 1-800-275-4737 (TTY: 711) **บริการเหล่านี้ไม่มีค่าใช้จ่าย**

УВАГА! Якщо ви потребуєте підтримки своєю мовою, телефонуйте за номером 1-800-275-4737 (TTY: 711). Також доступні засоби та послуги для людей з обмеженими можливостями, як-от документи шрифтом Брайля та великим шрифтом. Телефонуйте за номером 1-800-275-4737 (TTY: 711). Ці послуги безкоштовні.

CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của quý vị, hãy gọi số 1-800-275-4737 (TTY: 711). Các hỗ trợ và dịch vụ dành cho người khuyết tật, chẳng hạn như tài liệu bằng chữ nổi và bản in cỡ chữ lớn cũng được cung cấp. Gọi số 1-800-275-4737 (TTY: 711). Các dịch vụ này miễn phí.