Health Net®

Small Business Application

for Group Enrollment and Change (Oregon)

Medical and Life/AD&D plans are provided by Health Net Health Plan of Oregon, Inc. (Health Net). Dental PPO insurance plans are underwritten by Health Net Health Plan of Oregon, Inc. and administered by Dental Benefit Providers, Inc. (DBP). Vision plans are underwritten by Health Net Health Plan of Oregon, Inc. and administered by EyeMed Vision Care, LLC (EyeMed).

Neither DBP nor EyeMed are affiliated with Health Net Health Plan of Oregon, Inc. Obligations under dental and vision plans are neither obligations of, nor guaranteed by, Health Net.

Welcome to Health Net

Simple steps for completing the form:

1. Review the materials enclosed in your enrollment packet. Be sure that you understand the coverage options that are available to you by your employer.

2a. **If you are *declining* coverage** for yourself and/or your dependents, section 7 is required. Do not fill out any other sections.

2b. **If you are *accepting* coverage** for yourself and/or your dependents, sections 1, 2, 3, 5, and 8 are required.

The Affordable Care Act (ACA) requires Health Net to provide to the IRS confirmation of health care coverage for yourself, as the subscriber, and your covered dependents. The IRS uses this information to confirm each member has minimum essential coverage and is not subject to the ACA's individual shared responsibility payment provision. Please ensure that the Social Security number (SSN) is accurate for yourself and each dependent you are enrolling. For more information about the individual shared responsibility payment provision, go to www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision.

3. If you choose to enroll in the EPO or CommunityCare Network plans, you must select your primary care physician (PCP). Be sure to fill in the names and numbers as they appear in Health Net's online ProviderSearch tool.

Note: If you do not select a PCP, one will be selected for you.

4. If you choose to enroll in a PPO insurance plan, you are not required to select a PCP to enroll.

5. Make a copy of the completed application for your records. **If a correction is needed, cross out and initial each correction. Please do not use a white-out product.**

For administrative use only:	
Existing Business/Group Please send all completed paperwork to your designated account manager or broker.	**New Business/Group** Please send all completed paperwork to your designated account executive or broker.

Health Net®

To be completed by employer	
Employer name:	
Requested effective date:	Employer group number *(medical)*:
Employee eligibility date *(new hire only)*: ☐ Same as hired date ☐ Other: _____	

Important: Please print all sections in black ink. You are entitled to see a *Summary of Benefits and Coverage* (SBC) before you choose a plan. Please contact your employer if you do not have the SBC for the plan you have selected.

1. Health plan information

CommunityCare 1T[1]		
Platinum	☐ CC1T15-500-2-2000DX	
Gold	☐ CC1T25-1000-2-4000DX	☐ CC1T15-2000-2-4500DX
Silver	☐ CC1T30-3000-2-6000ES	☐ CC1T35-4500-2-6350ES

CommunityCare 3T		
Platinum	☐ CC3T15-500-2-2000DX	
Gold	☐ CC3T25-1000-2-4000DX	☐ CC3T15-2000-2-4500DX
Silver	☐ CC3T30-3000-2-6000ES	☐ CC3T35-4500-2-6350ES

PPO		
Platinum	☐ P10-250-2-3000LX	☐ P10-500-1-3000LX
Gold	☐ P20-1000-2-5000DX	☐ P20-2000-2-5000DX
Silver	☐ P20-3000-3-6350ES	☐ P30-4500-2-6000ES
Bronze	☐ P75-5000-5-7150ES	

High Deductible PPO			
Silver	☐ HD2600-2-5500	**Bronze**	☐ HD6550-0-6550

Health Net of Oregon (HNOR) Standard PPO

☐ Health Net Oregon Standard Gold Plan
☐ Health Net Oregon Standard Silver Plan
☐ Health Net Oregon Standard Bronze Plan

Other plan

_____

Adult Dental	Adult Vision	Complementary Care
☐ Plus D50-1855-1500	☐ Elite 1010-1	☐ CAM 15-1000
☐ Value D50-185-1500V	☐ Preferred 1025-2	☐ CAM 15-1500
☐ Preferred Plus DP50-1855-1500	☐ Preferred 1025-3	☐ CAM 15-1000 Plus
☐ Essentials D50-16-500		

Notice for ACA-compliant plans: The health care reform law requires pediatric dental services to be covered as one of the 10 required Essential Health Benefits. Pediatric dental benefits must be available either as part of your Health Net plan or with another qualified plan offered by your employer.

2. Reason for application

☐ Plan change
☐ Change address/name
☐ Delete dependent *(list names below)*
☐ Other: _____

☐ New hire ☐ Rehire ☐ Open Enrollment
Special Enrollment Period
Qualifying event date: ____/____/_____
Add dependent:
☐ Marriage
☐ Newborn/Adoption/Legal guardianship/Court order/Assumption of parent-child relationship
☐ Loss of prior coverage ☐ Other (specify): _____

☐ **State Continuation**
☐ **COBRA**
Effective date: ____/____/_____
Qualifying event: _____
Qualifying event date: ____/____/_____

3. Employee personal information

Last name:	First name:	MI:	☐ Male ☐ Female
Residence address:	City:	State:	ZIP:

Date of birth *(mm/dd/yyyy)*:	Social Security # (required for all applicants):	Marital status: ☐ Single ☐ Married ☐ Domestic partner
Telephone #: ( )	Work phone #: ( )	Email address:
Date of hire: / /	Dept. #:	Job title: ☐ Salary ☐ Hourly ☐ Retired

Entering eligible class? ☐ Part-time to full-time ☐ Temporary to permanent ☐ Hourly to salaried

If available, I would prefer to receive communication and plan information in Spanish: ☐ Yes ☐ No

Primary care physician:

PCP Enrollment ID # *(10-digit PCP number)*:	Is this your current PCP? ☐ Yes ☐ No

Employee name: ____ Last 4 digits of Social Security #: __ __ __ __

4. Family information, please list all eligible family members to be enrolled.

(Attach additional sheets if necessary.)

Spouse/Domestic partner ☐ M ☐ F	Last name:	First name:		MI:
Residence address: ☐ Check here if same as subscriber		City:	State:	ZIP:
Date of birth *(mm/dd/yyyy):*		Social Security # (required for all applicants):		
Primary care physician:		PCP Enrollment ID # *(10-digit PCP number):*		
Is this your current PCP? ☐ Yes ☐ No				

☐ Son ☐ Daughter	Last name:	First name:		MI:
Residence address: ☐ Check here if same as subscriber		City:	State:	ZIP:
Date of birth *(mm/dd/yyyy):*		Social Security # (required for all applicants):		
Primary care physician:		PCP Enrollment ID # *(10-digit PCP number):*		
Is this your current PCP? ☐ Yes ☐ No				

☐ Son ☐ Daughter	Last name:	First name:		MI:
Residence address: ☐ Check here if same as subscriber		City:	State:	ZIP:
Date of birth *(mm/dd/yyyy):*		Social Security # (required for all applicants):		
Primary care physician:		PCP Enrollment ID # *(10-digit PCP number):*		
Is this your current PCP? ☐ Yes ☐ No				

☐ Son ☐ Daughter	Last name:	First name:		MI:
Residence address: ☐ Check here if same as subscriber		City:	State:	ZIP:
Date of birth *(mm/dd/yyyy):*		Social Security # (required for all applicants):		
Primary care physician:		PCP Enrollment ID # *(10-digit PCP number):*		
Is this your current PCP? ☐ Yes ☐ No				

Employee name: ____ Last 4 digits of Social Security #: __ __ __ __

5. Do you or your dependents have other health care coverage?

☐ No ☐ Yes If "Yes," please complete this section including Medicare.

☐ Self	Name:		Name of other insurance carrier:		Prior coverage start date *(mm/dd/yy):*	
Prior coverage end date *(mm/dd/yy):*	Reason for ending coverage:		Group #/Policy ID #:	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:

☐ Spouse ☐ Domestic partner	Name:		Name of other insurance carrier:		Prior coverage start date *(mm/dd/yy):*	
Prior coverage end date *(mm/dd/yy):*	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? ☐ Yes ☐ No	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:

☐ Son ☐ Daughter	Name:		Name of other insurance carrier:		Prior coverage start date *(mm/dd/yy):*	
Prior coverage end date *(mm/dd/yy):*	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? ☐ Yes ☐ No	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:

☐ Son ☐ Daughter	Name:		Name of other insurance carrier:		Prior coverage start date *(mm/dd/yy):*	
Prior coverage end date *(mm/dd/yy):*	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? ☐ Yes ☐ No	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:

☐ Son ☐ Daughter	Name:		Name of other insurance carrier:		Prior coverage start date *(mm/dd/yy):*	
Prior coverage end date *(mm/dd/yy):*	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? ☐ Yes ☐ No	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:

6. Group term life insurance, if applicable. *(Attach separate sheet for additional or contingent beneficiaries.)*

Life/AD&D coverage: ☐ Yes ☐ No

Life beneficiary (full name):	Relationship:	%
Life beneficiary (full name):	Relationship:	%
Life beneficiary (full name):	Relationship:	%
Life beneficiary (full name):	Relationship:	%

[1]Available to employer groups located in Multnomah, Clackamas, Washington, Clatsop, Columbia, and Tillamook counties. Available to employees in Multnomah, Clackamas, Washington, Clatsop, Columbia, and Tillamook counties, and Clark County, WA.

"Group Contract/Policy" refers to the Health Net Health Plan of Oregon, Inc., DBP and/or EyeMed *Group Service Agreement* and *Evidence of Coverage*.

Employee name: _____ Last 4 digits of Social Security #: __ __ __ __

7. Declination of coverage *(Complete this section if any coverage is being declined by you or your eligible dependents.)*

Employee personal information

Last name:	First name:	MI:	Social Security #:

Declining medical coverage for:
☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent(s)
Name(s): _____

Reason: ☐ Other group coverage through this employer ☐ Individual coverage
☐ Other group coverage by another group *(i.e., spouse's employer)*
☐ Other: _____

Declining dental coverage for:
☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent(s)
Name(s): _____

Reason: ☐ Other group coverage through this employer ☐ Individual coverage
☐ Other group coverage by another group *(i.e., spouse's employer)*
☐ Other: _____

Declining vision coverage for:
☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent(s)
Name(s): _____

Reason: ☐ Other group coverage through this employer ☐ Individual coverage
☐ Other group coverage by another group *(i.e., spouse's employer)*
☐ Other: _____

IF YOU ARE DECLINING COVERAGE – STOP AND READ CAREFULLY

I have decided to decline coverage for myself and/or my dependent(s). I acknowledge that my dependents and I may have to wait to be enrolled until the next annual Open Enrollment Period or Special Enrollment Period due to a qualifying event. The available coverages have been explained to me by my employer, and I have been given the chance to apply for the available coverages. Additionally, by signing below, I certify, to the best of my knowledge or belief, that the reason I am declining coverage is accurate as indicated by the check marks above.

Employee signature: _____ **Date:** _____
(Sign only if declining coverage. If signed in error, please cross out and initial.)

8. Acceptance of coverage *(Signature required.)*

In applying for enrollment as indicated on this enrollment form, I declare that, to the best of my knowledge, all of the information on this form is true and complete, and all of the persons for whom I am requesting enrollment are eligible for coverage. I, the applicant (employee), on my behalf and on behalf of every covered Dependent listed on this form or added in the future, agree that, in the event any health care benefits provided to me or any covered Dependent by Health Net, DBP and/or EyeMed are the primary responsibility of Medicare or of any coverage for work-related injuries, illness or conditions, or of any third party on account of any injury, illness, condition, or damage, I will fully inform Health Net, DBP and/or EyeMed, and I will execute such assignments, liens or other documents which may be necessary to enable Health Net, DBP and/or EyeMed to recover the value of services provided. I further agree that in the event I, any Dependent or any of my family members collect benefits, damages or reimbursement from Medicare, or any other third party with respect to such injury, illness, condition, or damage, I will immediately reimburse Health Net, DBP and/or EyeMed to the full extent of services provided by Health Net, DBP and/or EyeMed in accordance with the group contract/policy.

I also agree to be bound by each and every provision of the group contract/policy (including all schedules and attachments which are a part of the group contract/policy) as now in effect and as may be amended in the future, and I agree that all my rights are as specifically set forth in the group contract/policy. I authorize my employer to deduct from my earnings any amount required to cover my share of the premiums or prepayment fees, if any, payable under the group contract. I acknowledge that I have selected a Primary Care Physician/Provider from the current Health Net participating provider network, (for EPO and CommunityCare plans); that this list identifies participating providers as of the date of publication; that changes in a provider's status, and additions to, or deletions from, this list may occur; and that Health Net and/or its representatives neither warrants nor guarantees the availability of any specific participating provider. I acknowledge that Health Net, DBP and/or EyeMed's benefits are only available if obtained in compliance with all provisions of the group contract/policy. I acknowledge that all participating providers are independent contractors and are not agents, servants, officers, employees, partners, or joint venturers of or with, and are not controlled by, Health Net, DBP and/or EyeMed; that the participating providers, including primary care physicians, are responsible for the delivery of, or arrangement for, all medical services to me and my Dependents; and Health Net, DBP and/or EyeMed is not and will not be responsible for the deliberate or negligent acts or omissions of any such participating provider or any nonparticipating provider.

Employee signature: _____ **Date:** _____
(Sign only if accepting coverage. If signed in error, please cross out and initial.)

Please contact the Health Net Customer Contact Center at the toll-free number below if you need assistance in completing this form or if you have questions about your coverage:

Medical	1-888-802-7001

If you have questions about your dental, vision or life coverage, please call:

Dental	1-877-410-0176
Vision	1-866-392-6058
Life	1-800-865-6288

You can use your copy of the Health Net enrollment form as your temporary ID card until you receive your permanent ID card.

Emergency and urgently needed care:

- If your situation is life-threatening or an emergency: Call 911 or go to the nearest hospital.
- If your situation is not so severe: If you cannot call your primary care physician or physician group, or you need medical care right away, go to the nearest hospital or urgent care center.
- If you are outside your physician group's service area: Go to the nearest hospital, medical center or call 911. In all cases, contact your primary care physician or participating physician group as soon as possible to inform them about your condition.
- Call the number on your ID card within 48 hours of being admitted, or as soon as possible.

Prior authorization:

You, the member, are responsible for obtaining prior authorization for certain services. Please check your plan certificate for a list of services requiring prior authorization.

For prior authorization, please call 1-800-977-7282.

Products/Entities:

Health Net Health Plan of Oregon, Inc. offers the following products: CommunityCare Network, EPO Network, PPO, Life and AD&D insurance.

Health Net Health Plan of Oregon, Inc. offers the following products serviced by Dental Benefit Providers, Inc.: Dental PPO (DPPO).

Health Net Health Plan of Oregon, Inc. offers the following products serviced by EyeMed Vision Care, LLC: PPO Vision.

Declination of coverage:

If you are declining enrollment for yourself or your Dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this plan if you or your Dependents lose eligibility for that other coverage (or if your employer stops contributing toward your or your Dependents' other coverage). However, you must request enrollment within 31 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. If you previously declined enrollment in this plan for yourself or your Dependents because of coverage under a Medicaid plan or CHIP plan, you can enroll within 60 days of loss of such coverage. If you become eligible for premium assistance under a Medicaid plan or CHIP plan, you or your Dependents can enroll in this plan within 60 days of becoming eligible for premium assistance.

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. Applicants call 1-877-609-8715 (TTY: 711).

Arabic
اللغة مجانية. يمكنك الحصول على مترجم فوري. ويمكنك الحصول على وثائق مقروءة لك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة الهوية. على مقدمي الطلبات الاتصال على الرقم 1-877-609-8715 (TTY: 711).

Chinese
免費語言服務。您可使用口譯員。您可請人將文件內容唸給您聽。如需協助，請致電您會員卡上所列的電話號碼與我們聯絡。申請人請致電 1-877-609-8715 (TTY: 711) 。

Cushite (Oromo)
Waa Lacag la'aan Adeegyada Luuqada. Waxaad heli kartaa turjubaan. Waxaad heli kartaa in waraaqaha laguu aqriyo. Wixii caawin ah, naga soo wac lambarka ku qoran kaarka Aqoonsigaaga. Wicitaanka codsadayaasha 1-877-609-8715 (TTY: 711).

French
Services linguistiques sans frais. Vous pouvez obtenir un interprète. Les documents peuvent vous être lus. Pour obtenir de l'aide, appelez-nous au numéro indiqué sur votre carte d'identité. Les demandeurs composent le 1-877-609-8715 (TTY : 711).

German
Kostenloser Sprachendienst. Dolmetscher sind verfügbar. Dokumente können Ihnen vorgelesen werden. Wenn Sie Hilfe benötigen, rufen Sie uns unter der Nummer auf Ihrer ID-Karte an. Antragsteller rufen unter 1-877-609-8715 (TTY: 711) an.

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ください。申込者の方は、1-877-609-8715 (TTY: 711) までお電話ください。

Korean
무료 언어 서비스. 통역 서비스를 받을 수 있습니다. 문서 낭독 서비스를 받으실 수 있습니다. 도움을 원하시면, 보험 ID에 수록된 번호로 전화해 주십시오. 신청자분은 1-877-609-8715 (TTY: 711) 번으로 전화해 주십시오.

Khmer
សេវាភាសាដោយឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ អ្នកអាចស្តាប់គេអានឯកសារឱ្យអ្នក។ សម្រាប់ជំនួយ សូមទាក់ទងយើងខ្ញុំតាមរយៈទូរស័ព្ទដែលមាននៅលើកាតសម្គាល់ខ្លួនរបស់អ្នក។ បេក្ខជន សូមទាក់ទងទៅលេខ 1-877-609-8715 (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 کسب اطلاعات، با ما به شماره ای که در کارت شناسایی شما قید شده تماس بگیرید. درخواست کنندگان با شماره 1-877-609-8715 (TTY: 711) تماس بگیرند.

Romanian
Servicii lingvistice gratuite. Puteţi obţine un interpret. Puteţi avea documente citite pentru dvs. Pentru asistenţă telefonaţi-ne la numărul indicat pe cardul de membru. Solicitanţii să telefoneze la 1-877-609-8715 (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. Если вы хотите стать участником плана, звоните по телефону 1-877-609-8715 (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 aparece en su tarjeta de identificación. Los solicitantes deben llamar al 1-877-609-8715 (TTY: 711).

Thai
ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังได้ สำหรับความช่วยเหลือ โทรหาเราตามหมายเลขที่ให้ไว้บนบัตรประจำตัวของคุณ ผู้สมัคร โทร 1-877-609-8715 (TTY: 711)

Ukrainian
Безплатні послуги перекладу. Ви можете скористуватися послугами перекладача. Вам можуть прочитати ваші документи. Щоб отримати допомогу, телефонуйте нам за номером, який вказаний на вашій ідентифікаційній картці (ID). Заявники можуть телефонувати за номером 1-877-609-8715 (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. Người nộp đơn gọi số 1-877-609-8715 (TTY: 711).

Health Net complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health Net does not exclude people or treat them differently because of race, color, national origin, 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 **1-888-802-7001 (TTY: 711)**.

If you believe that Health Net has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by calling the number above and telling them you need help filing a grievance; Health Net's Customer Contact Center is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available 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.