Health Net®
LIFE INSURANCE COMPANY

HEALTH NET LIFE INSURANCE COMPANY

1. You do not need more than one Medicare Supplement plan.
2. If you elect this plan, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medi-Cal and may not need a Medicare Supplement Plan.
4. If after electing this plan you become eligible for Medi-Cal, the benefits and the amount you pay under your Medicare Supplement plan can be suspended, if requested, during your entitlement to benefits under Medi-Cal for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal. If you are no longer entitled to Medi-Cal, your suspended Medicare Supplement plan or if that is no longer available, a substantially equivalent plan, will be reinstituted if requested within 90 days of losing Medi-Cal eligibility. If the Medicare Supplement plan provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your plan was suspended, the reinstituted plan will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
5. If you are eligible for, and have enrolled in, a Medicare Supplement plan by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and the amount you pay under your Medicare Supplement plan can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement plan under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare Supplement plan or if that is no longer available, a substantially equivalent plan, will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement plan provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your plan was suspended, the reinstituted plan will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
6. Counseling services are available in this state to provide advice concerning your election of Medicare Supplement insurance and concerning medical assistance through the Medi-Cal program, including benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB). If you want to discuss electing Medicare Supplement insurance with a trained insurance counselor, call the California Department of Insurance toll-free telephone number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

A rate guide is available that compares the plans sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Insurance consumer toll-free telephone number (1-800-927-HELP), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free number (1-800-434-0222), or by accessing the Department of Insurance Internet web site (www.insurance.ca.gov).

CA86231 (11/11) Health Net Life Insurance Company is a subsidiary of Health Net, Inc.

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HEALTH NET LIFE INSURANCE COMPANY ENROLLMENT FORM FOR A GROUP MEDICARE SUPPLEMENT PLAN

Effective Date: ___/___/_____
Plan/Group ID: _____
Reason for application:
☐ Open Enrollment
☐ Loss of prior coverage date: ___/___/_____
Qualifying event: ___/___/_____
Qualifying event date: ___/___/____
Reason for change:
☐ Plan change
☐ Change address/name
☐ Other: _____

Employer, Union or Trust Name _____

Please follow these enrollment form instructions:
1. Complete your enrollment form, provide any supporting information requested, sign and date it where indicated.
2. Submit your enrollment form to your employer group administrator.

Conditions of Membership in Health Net Life Insurance Company (Health Net Life) Medicare Supplement:
1. This enrollment form, together with the Health Net Life Certificate of Insurance and any endorsements, appendices, and attachments thereto, will collectively constitute the entire agreement for coverage.
2. I acknowledge receipt of the Outline of Coverage and "Guide to Health Insurance for People with Medicare." I have read the Outline of Coverage and the terms, conditions and authorizations set forth herein. I certify that I meet the eligibility requirements set forth in the Outline of Coverage. I alone am responsible for the accuracy and completeness of this enrollment form and have answered all questions to the best of my knowledge and belief. I understand that I will not be eligible for coverage if any information is false or incomplete, and that coverage may be revoked based on such finding.

Signature: _____	Date: ___/___/_____ (MM/DD/YYYY)
Print Name: _____	

Your Personal Information:

First Name:	Middle Initial:	Last Name:	
Primary Residence Street Address (PO Box is not allowed):			
City:	State:	County:	ZIP:
Mailing Address (if different from your Primary Residence Address):			
City:	State:	County:	ZIP:
Home Telephone: ( ) -	E-mail Address:	Gender: ☐ Male ☐ Female	
Date of Birth: ___/___/_____ (MM/DD/YYYY)	Preferred Language: ☐ English ☐ Other _____		
Which Health Net Life Medicare Supplement Plan are you applying for?			
Are you the primary retiree Yes ____ No ____ If yes, retirement date: ___/___/_____ (MM/DD/YYYY) If no, name of primary retiree: _____			
Your Requested Start Date: The 1st of Month _____ of Year _____			
Medicare Claim/HIC#	Social Security #		
You are entitled to: Medicare Part A (Hospital) Effective: ___/___/_____ (MM/DD/YYYY) Medicare Part B (Medical) Effective: ___/___/_____ (MM/DD/YYYY)			

Current Health Plan Information

PLEASE ANSWER ALL OF THE QUESTIONS BELOW BY MARKING "YES" OR "NO" WITH AN "X"

To the best of your knowledge:

1. ☐ YES ☐ NO a. Did you turn 65 years of age in the last six months?
   ☐ YES ☐ NO b. Did you enroll in Medicare Part B (Medical) in the last 6 months?
   If YES, what was the effective date? _____/_____/_____ (MM/DD/YYYY)

2. ☐ YES ☐ NO Are you covered for medical assistance through California's Medi-Cal program?
   NOTE TO APPLICANT: If you are eligible for Medi-Cal benefits with a "share of cost" and have not met your share of cost, please answer "NO" to this question

If you have answered "YES" to the above question, answer the following two questions:

   ☐ YES ☐ NO a. Will Medi-Cal pay your premiums for this Medicare Supplement plan?
   ☐ YES ☐ NO b. Do you receive benefits from Medi-Cal OTHER THAN payment towards your Medicare Part B premium?

3. ☐ YES ☐ NO a. If you have had coverage from any Medicare plan other than Medicare within the past 63 days (for example, a Medicare Advantage plan or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under the plan, leave the END DATE blank.
   START DATE _____/_____/_____ (MM/DD/YYYY) END DATE _____/_____/_____ (MM/DD/YYYY)
   ☐ YES ☐ NO b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this Health Net Life Plan?
   ☐ YES ☐ NO If yes, have you received and completed the Notice to Applicant Regarding Replacement of Medicare Supplement Coverage or Medicare Advantage form?
   ☐ YES ☐ NO c. Is this your first time in this type of Medicare plan?
   ☐ YES ☐ NO d. Did you drop a Medicare Supplement plan to enroll in the Medicare Plan?

4. ☐ YES ☐ NO a. Do you have another Medicare Supplement plan in force?
   b. If so, with what company and what plan do you have?
   _____
   ☐ YES ☐ NO c. If so, do you intend to replace your current Medicare Supplement plan with this plan?
   ☐ YES ☐ NO If yes, have you received and completed the Notice to Applicant Regarding Replacement of Medicare Supplement Coverage or Medicare Advantage form?

5. ☐ YES ☐ NO a. Have you had coverage under any other health insurance coverage within the past 63 days (For example, an employer, union, or individual plan)?
   b. If so with what companies and what kind of plan?
   _____
   c. What are your dates of coverage under the other plan? (if you are still covered under the other plan, leave "END DATE" blank.)
   START DATE _____/_____/_____ (MM/DD/YYYY) END DATE _____/_____/_____ (MM/DD/YYYY)

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

Signature Section

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION

I authorize the United States Department of Health and Human Services, the Centers for Medicare & Medicaid services, any health care provider, hospital or medical facility to furnish to any agent, designee, employee or representative of Health Net Life any and all records pertaining to claims payment or rejections, medical history, services rendered, or treatment given to myself for purposes of review, investigation or evaluation of a claim. I also authorize Health Net Life and its employees, participating providers, agents and representatives to disclose to any health care provider, health care service plan, insurer or self-insurer any such medical information obtained if such disclosure is necessary to allow the processing of a claim or if requested pursuant to legal process. This authorization shall become effective immediately and shall remain in effect for the term of coverage under the plan.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this enrollment form means that I have read and understand the contents of this enrollment form. If signed by an individual (as described previously), the signature certifies that:

1. The person is authorized under State law to complete this enrollment form on behalf of the named applicant and,
2. Documentation of the authority is available upon request by Health Net Life Insurance Company or other authorized regulatory agency.

Note: Health Net Life requests that a copy of the authorization form, Durable Power of Attorney for Health Care or similar document, be included with this enrollment form.

BINDING ARBITRATION

I, the applicant, understand and agree that any and all disputes or disagreements between me (including any of my heirs or personal representatives) and Health Net Life regarding the construction, interpretation, performance or breach of the Health Net Life Group Medicare Supplement Certificate of Insurance, but not as to professional negligence (medical malpractice), 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 Life, 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. A more detailed arbitration provision is included in the Certificate of Insurance. My signature below indicates that I understand the terms of this Binding Arbitration Clause and agree to submit disputes to binding arbitration.

Signature: _____	Date: ____/____/_____ (MM/DD/YYYY)
Print Name: _____	

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

First Name:	Middle Initial:	Last Name:
Home Address:		
City:	State:	ZIP:
Relationship to Applicant:	Phone Number: ( ) -	