Health Net®
MEDICARE PROGRAMS

Health Net Seniority Plus (Employer HMO)
Enrollment Request Form

Main subscriber ID

Effective date
M M D D Y Y Y Y

Please contact Health Net Seniority Plus (Employer HMO) if you need information in another language or format.

To enroll in Health Net Seniority Plus (Employer HMO), please provide the following information

Employer or union name

Group #

Middle initial

☐ Mr. ☐ Mrs. ☐ Ms.

Last name

First name

Birth date
M M D D Y Y Y Y

Sex: ☐ M ☐ F

Home phone number

Alternate phone number

Permanent residence street address
(PO Box is not allowed)

City

County

State

ZIP code

Mailing address (only if different from your permanent residence address)

Street address

City

State

ZIP code

Please provide your Medicare insurance information

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card

– OR –

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

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

SAMPLE ONLY

Name: _____

Medicare Claim Number _____ Sex _____

__ __ __ – __ __ – __ __ __ __ __

Is Entitled To

Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

White – Health Net Yellow – Member

FRM008718EO00 (8/16)

Y0020_EG_2017_0006 Compliance Approved 08222016

Please read and answer these important questions:

1. Are you the retiree? ☐ Yes ☐ No

   If "Yes," retirement date

M M	D D	Y Y Y Y

   If "No," name of retiree

2. Are you covering a spouse or dependents under this employer or union plan? ☐ Yes ☐ No

   If "Yes," name of spouse:

   Name of dependents:

3. Do you or your spouse work? ☐ Yes ☐ No

4. Do you have End Stage Renal Disease (ESRD)? ☐ Yes ☐ No

   If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis; otherwise, we may need to contact you to obtain additional information.

5. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits, or State pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to Health Net Seniority Plus (Employer HMO)? ☐ Yes ☐ No

   If "Yes," please list your other coverage and your identification (ID) number(s) for this coverage:

   Name of other coverage

   ID # for this coverage

6. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

   If "Yes," please provide the following information:

   Name of institution

   Phone number of institution

   Address of institution (number and street)

7. Do you receive Medicaid benefits? ☐ Yes ☐ No

   If "Yes,"please provide your Medicaid number:

8. Have you had Medicare prescription drug coverage or other drug coverage that was at least as good as Original Medicare drug coverage since you became eligible to join a Medicare drug program?

   ☐ Yes ☐ No

White – Health Net Yellow – Member

Please choose a Primary Care Physician (PCP): _____

PCP Access Number: _____ **Is this your current PCP?** ☐ Yes ☐ No

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in another format:

☐ Spanish ☐ Chinese ☐ Large print

Please contact Health Net Seniority Plus (Employer HMO) at 1-800-275-4737 if you need information in another format or language than what is listed above. From October 1 through February 14, our office hours are 8:00 a.m. to 8:00 p.m., Pacific time, 7 days a week, excluding certain holidays. However, after February 14, your call will be handled by our automated phone system on weekends and certain holidays. TTY users should call 711.

Please read and sign below

By completing this enrollment application, I agree to the following:

Health Net Seniority Plus (Employer HMO) has a contract with Medicare to offer HMO plans. Enrollment in a Health Net Medicare Advantage plan depends on contract renewal. I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (Example: Annual Enrollment Period from October 15–December 7), or under certain special circumstances.

Health Net Seniority Plus (Employer HMO) serves a specific service area. If I move out of the area that Health Net Seniority Plus (Employer HMO) serves, I need to notify the plan so that I can disenroll and find a new plan in my new area. Once I am a member of Health Net Seniority Plus (Employer HMO), I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Health Net Seniority Plus (Employer HMO) when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for the limited coverage near the U.S. border. I understand that beginning on the date Health Net Seniority Plus (Employer HMO) coverage begins, I must get all of my health care from Health Net Seniority Plus (Employer HMO), except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Health Net Seniority Plus (Employer HMO) and other services contained in my Health Net Seniority Plus (Employer HMO) Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HEALTH NET WILL PAY FOR THE SERVICES.**

Please read and sign below

I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with Health Net Seniority Plus (Employer HMO), he/she may be paid based on my enrollment in Health Net Seniority Plus (Employer HMO).

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Health Net Seniority Plus (Employer HMO) will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment, and 2) documentation of this authority is available upon request from Medicare.

Signature

Today's date

M M D D Y Y Y Y

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

Name

Address

Phone number – –

Relationship to enrollee

White – Health Net Yellow – Member

Please read and sign below

BINDING ARBITRATION: All benefits offered under this Medicare health plan, including optional supplemental benefits, if any, are subject to the Medicare appeals procedures and are not subject to arbitration. Conversely, all other claims including, but not limited to, the following claims, regardless of how they are characterized, are subject to arbitration: Determinations on items or services purchased by my employer, over and above the Medicare approved benefit package, such as payments of premiums or beneficiary cost-sharing provided by my employer, any disputes between myself, my heirs, relatives, or other associated parties on the one hand and the health plan, any contracted health care benefit providers, administrators, or other associated parties on the other hand for alleged violation of any duty arising out of or related to membership in the health plan that is not subject to the Medicare appeals process, including any claim for medical or hospital malpractice (a claim that medical services were unauthorized or were improperly, negligently or incompetently rendered), for premises liability, or relating to the delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under State law and not by lawsuit or resort to court process. By signing below, I agree to give up our right to a jury trial and accept the use of binding arbitration for claims that are not subject to the Medicare appeals procedures. I understand that the full arbitration provision is in the health plan's coverage document, which is available for my review.

Signature

Today's date

M M D D Y Y Y Y

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

Name

Address

Phone number – –

Relationship to enrollee

OFFICE USE ONLY:

Name of staff member/agent/broker (if assisted in enrollment):

Rep ID #: Plan ID #:

Group #: Batch #:

Effective date of coverage: M M D D Y Y Y Y

☐ ICEP/IEP ☐ AEP SEP (type): ☐ Not eligible

White – Health Net Yellow – Member

Y0020_EG_2017_0006 Compliance Approved 08222016

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 1-800-275-4737 (TTY: 711), 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.

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.

Health Net has a contract with Medicare to offer HMO plans.

Enrollment in a Health Net Medicare Advantage plan depends on contract renewal.

This information is available for free in other languages. Please call our Member Services number at 1-800-275-4737, TTY: 711. From October 1 through February 14, our office hours are 8:00 a.m. to 8:00 p.m., Pacific time, 7 days a week, excluding certain holidays. However, after February 14, our office hours are 8:00 a.m. to 8:00 p.m., Monday through Friday. On weekends and certain holidays, your call will be handled by our automated phone system.

Esta información está disponible en forma gratuita en otros idiomas. Llame a nuestro Departamento de Servicios al Afiliado al 1-800-275-4737, TTY: 711. Desde el 1.º de octubre hasta el 14 de febrero, nuestro horario de atención es de 8:00 a. m. a 8:00 p. m., los 7 días a la semana, excepto ciertos días feriados. Sin embargo, luego del 14 de febrero, nuestro horario de atención es de 8:00 a. m. a 8:00 p. m., de lunes a viernes. Durante los fines de semana y ciertos días feriados, su llamada será atendida por nuestro sistema automático de teléfono.

本資訊備有其他語言版本，可免費提供。請致電 1-800-275-4737（聽障專線：711）與會員服務部聯絡。從 10 月 1 日起至 2 月 14 日止，我們的服務時間為每週 7 天上午 8 點至晚上 8 點，特定假日除外。但從 2 月 14 日之後，我們的服務時間為週一至週五上午 8 點至晚上 8 點。您在週末及特定假日期間的來電將由本公司的自動電話系統處理。

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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

Multi-Language Insert

Multi-language Interpreter Services

English:
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Spanish:
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Chinese:
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711)。

Tagalog:
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

French:
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (ATS :711).

Vietnamese:
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

German:
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Korean:
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711) 번으로 전화해 주십시오.

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Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (телетайп: 711).

Arabic:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (رقم هاتف الصم والبكم: 711).

Hindi:
ध्यान दें: यदि आप हदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।
1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711) पर कॉल करें।

Italian:
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Portuguese:
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

French Creole:
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Polish:
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Japanese:
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711)まで、お電話にてご連絡ください。

Farsi:
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
با تماس 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711) بگیرید.

Armenian:
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY (հեռատիպ)՝ 711):

Cambodian:
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711)។

Punjabi:
ਧਿਆਨ ਦਓ1 ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। ,ਜੇ ਤੁਸੀ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ : 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711)ਤੇ ਕਾਲ ' ਕਰੋ।

Thai:
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Laotian:
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ ທ່ານ. ໂທຣ 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Serbo-Croatian:
OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Ukranian:
УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (телетайп: 711).

Syriac:
ܪܫܝܡ ܪܫܒܝܠ ܕܫܒܠܚܬ ܕܫܒ ܥܡ ،ܪܬܝܫܫܪ ܪܥܝ ܕܫܒܚܝܡ ܪܒ ܕܫܡܒ ܥܡ :ܪܝܫܘܣ
ܚܝܥܪ ܟܬ ܚܒ. ܡܢ ܟܠ ܚܬܪ

1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711)

Hmong:
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Romanian:
ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Amharic:
ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (**መስማት ለተሳናቸው**: 711).

Navajo:
Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíilnih 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Cushite:
XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711.)