



# SMALL BUSINESS GROUP ENROLLMENT AND CHANGE FORM

Medical and Life / AD&D plans are provided by Health Net of California, Inc. and / or Health Net Life Insurance Company (together, the “Health Net Entities”). Dental plans are provided by SafeGuard Health Plans, Inc. and / or its affiliate, SafeHealth Life Insurance Company, (together “SafeGuard Entities”). Vision plans are provided by Fidelity Security Life Insurance Company and serviced by Eyemed Vision Care LLC (together the “Fidelity Entities”).

Neither the SafeGuard Entities nor The Fidelity Entities are affiliated with the Health Net Entities. Obligations under dental and vision plans are not obligations of, and are not guaranteed by, the Health Net Entities.

## 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.
- 2) Carefully review and select the plan option(s) that are best for you and your covered family members. (Note: If your employer offers “Silver Network,” please mark the box for the plan number you have chosen).
- 3) If you choose to enroll in the HMO, HMO Silver Network, HMO Salud con Health Net, HMO Variable Copay, SELECT (POS), ELECT (POS), ELECT Open Access (EOA) or Dental HMO (DHMO), you must select your dental provider, physician group and primary care physician. Be sure to fill in the names and numbers as they appear in the HMO Health Net Directory of Providers, or call the Customer Contact Center from 8:00 a.m.- 6:00 p.m., Monday through Friday for assistance.

Small Business Group (English) 1-800-361-3366

Small Business Group (Spanish) 1-800-331-1777

Health Net Life 1-800-865-6288

Health Net Dental 1-800-880-8113

Health Net Vision 1-866-392-6058

- 4) If you choose to select PPO or Flex Net, you are not required to select a primary care physician or physician group to enroll.

Post Office Box 9103  
Van Nuys, California 91409-9103  
[www.healthnet.com](http://www.healthnet.com)

# HEALTH NET ENROLLMENT AND CHANGE FORM FOR SMALL BUSINESS GROUP

EMPLOYER NAME

EFFECTIVE DATE

EMPLOYER GROUP NUMBER (MEDICAL)

(SECTIONS 1, 2, 3, 4 AND 8 ARE REQUIRED.)

IMPORTANT: PLEASE PRINT ALL SECTIONS IN BLACK INK.

## 1) PERSONAL INFORMATION

LAST NAME		FIRST NAME		M.I.	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
STREET ADDRESS		CITY		STATE	ZIP
TELEPHONE NO. ( ) -	EMPLOYER NAME		JOB TITLE		
DATE OF HIRE / /	CLASS	DEPT. NO.	EMAIL ADDRESS	EMPLOYMENT STATUS <input type="checkbox"/> SALARIED <input type="checkbox"/> HOURLY	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DOMESTIC PARTNER

FOR SALUD CON HEALTH NET MEMBERS: IF AVAILABLE, I WOULD PREFER TO RECEIVE COMMUNICATION OR PLAN INFORMATION IN SPANISH.  YES  NO

## 3) EMPLOYEE & FAMILY INFORMATION Please list yourself and all eligible family members to be enrolled. (Attach additional sheets if necessary.)

	LAST NAME, FIRST NAME, M.I.	RESIDENCE ADDRESS, CITY, STATE, ZIP	DATE OF BIRTH MO DAY YR	SOCIAL SECURITY #/ MATRICULAR ID #
<input type="checkbox"/> SELF				
<input type="checkbox"/> SPOUSE <input type="checkbox"/> DOMESTIC PARTNER				
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER				
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER				

## 4) DO YOU OR YOUR DEPENDENTS HAVE OTHER HEALTH CARE COVERAGE? IF YES, PLEASE COMPLETE THIS SECTION INCLUDING MEDICARE.

Please fill out the following information to receive proper credit for PREVIOUS COVERAGE, if immediately prior to becoming eligible for this plan, you or your dependents were covered under any public or private health care coverage (including MediCal or individual coverage). According to federal law, your employer or FORMER CARRIER must provide you with a certificate that shows evidence of your prior coverage. We reserve the right to request a copy of this certificate.

	NAME	NAME AND ADDRESS OF OTHER INSURANCE CARRIER	PRIOR COVERAGE START DATE MO DAY YR
<input type="checkbox"/> SELF			
<input type="checkbox"/> SPOUSE <input type="checkbox"/> DOMESTIC PARTNER			
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER			
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER			

## 5) YOUR EMPLOYER COMPLETES THIS SECTION (IF APPLYING FOR GROUP LIFE AD&D.)

Effective Date	Annual Salary	Occupation	Life Class	Life / AD&D Amount
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## 6) GROUP TERM LIFE INSURANCE If Applicable (Attach separate sheet for additional or contingent beneficiaries.)

Life coverage  Yes  No If yes, I am applying for  Basic Life/AD&D \$ \_\_\_\_\_  Dependent Life \$ \_\_\_\_\_

Life Beneficiary (Full Name)	Relationship	%
Life Beneficiary (Full Name)	Relationship	%

## 7) DECLINATION OF COVERAGE (Complete this section if any coverage is to be declined by you or your eligible dependents.)

<input type="checkbox"/> Declining Medical coverage for:	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent(s) <input type="checkbox"/> Domestic Partner	Reason: <input type="checkbox"/> Other group coverage <input type="checkbox"/> Individual Coverage <input type="checkbox"/> Other _____ <input type="checkbox"/> Other group coverage by another group (i.e. spouse's employer)
<input type="checkbox"/> Declining Dental coverage for:	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent(s) <input type="checkbox"/> Domestic Partner	Reason: <input type="checkbox"/> Other group coverage <input type="checkbox"/> Individual Coverage <input type="checkbox"/> Other _____ <input type="checkbox"/> Other group coverage by another group (i.e. spouse's employer)
<input type="checkbox"/> Declining Vision coverage for:	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent(s) <input type="checkbox"/> Domestic Partner	Reason: <input type="checkbox"/> Other group coverage <input type="checkbox"/> Individual Coverage <input type="checkbox"/> Other _____ <input type="checkbox"/> 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 acknowledge 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.**

Employee Signature _____	Date _____
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(ONLY IF DECLINING COVERAGE; If signed in error, please cross out and initial.)



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**2) SELECTED COVERAGE**

**CHECK THE DESIRED PLAN AS OFFERED BY YOUR EMPLOYER:**

**EOA**

- EOA 10     EOA 20
- EOA 25     EOA 30

**HMO**

- HMO 15     HMO 20
- HMO 35     HMO 40
- HMO VCP 25 (So. CA only)
- HMO VCP 35 (So. CA only)
- HMO Xtra Value 20
- HMO Xtra Value 40

**HMO SILVER NETWORK**

- HMO 20
- HMO 40
- HMO Xtra Value 20
- HMO Xtra Value 40

**POS**

- POS 10
- POS 20
- POS 30

**FLEX NET**

(Out of service area only)

**PPO**

- Indemnity
- PPO 10
- PPO 15
- PPO 20
- PPO 30
- PPO 40
- PPO Catastrophic Saver
- PPO 2000
- PPO 3000

**SALUD CON HEALTH NET**

- Salud HMO  
(Available in Los Angeles and Orange counties)
- Salud HMO y más  
(Available in Los Angeles and Orange counties)
- Salud PPO  
(Available in Los Angeles, Orange and Ventura counties)
- Salud Mexico  
(Available in San Diego and Imperial counties)
- Salud EPO  
(Available in Los Angeles, Orange and Ventura counties)

**DENTAL**

- DHMO**
- Advantage 150 Plan \_\_\_\_\_
- Advantage 225 Plan \_\_\_\_\_
- DPPO**
- HB PLAN \_\_\_\_\_
- HC PLAN \_\_\_\_\_
- HD PLAN \_\_\_\_\_

**VISION**

- PPO**
- Preferred 1025-2
- Preferred 1025-3
- Value-10-2

**REASON FOR CHANGE:**

- Plan change
- Change address/name
- Delete dependent (list names below)
- Other \_\_\_\_\_

**REASON FOR APPLICATION:**

- New hire
- Open Enrollment
- Loss of prior coverage date
- COBRA<sup>1</sup> effective date \_\_\_\_\_
- Add dependent
- Qualifying event \_\_\_\_\_
- Qualifying event date \_\_\_\_\_

<sup>1</sup> EMPLOYERS WHO NORMALLY EMPLOYED 20 OR MORE EMPLOYEES DURING THE PREVIOUS CALENDAR YEAR ARE SUBJECT TO FEDERAL COBRA. EMPLOYERS WHO EMPLOYED 2-19 EMPLOYEES ON AT LEAST 50% OF ITS WORKING DAYS THE PREVIOUS CALENDAR YEAR ARE SUBJECT TO CAL-COBRA. PLEASE CONSULT YOUR LEGAL COUNSEL IF YOU NEED HELP DETERMINING WHICH LAW APPLIES TO YOU.

Section 3 continued.

COVERAGE TYPE	MEDICARE	MEDICARE CLAIM/HICN #	OVERAGE DEPENDENT TYPE	PARTICIPATING PHYSICIAN GROUP/PPG #	HEALTH NET PRIMARY CARE PHYSICIAN/PCP #	PHYSICIAN NAME (FIRST, LAST)	IS THIS YOUR CURRENT M.D.?	DENTAL HMO PROVIDER ID #
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> PART A <input type="checkbox"/> PART B		NOT APPLICABLE				<input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> PART A <input type="checkbox"/> PART B		NOT APPLICABLE				<input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> PART A <input type="checkbox"/> PART B		<input type="checkbox"/> Disabled <input type="checkbox"/> Full-time Student <input type="checkbox"/> Over 50% support				<input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> PART A <input type="checkbox"/> PART B		<input type="checkbox"/> Disabled <input type="checkbox"/> Full-time Student <input type="checkbox"/> Over 50% support				<input type="checkbox"/> YES <input type="checkbox"/> NO	

Section 4 continued.

PRIOR COVERAGE END DATE	REASON FOR ENDING COVERAGE	GROUP #/ POLICY ID #	IS THIS YOUR OR YOUR DEPENDENT'S PRIMARY COVERAGE?	DOES IT COVER?	MEDICARE	MEDICARE CLAIM/HICN #	OVERAGE DEPENDENT TYPE
MO DAY YR			<input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICAL: <input type="checkbox"/> YES <input type="checkbox"/> NO DENTAL: <input type="checkbox"/> YES <input type="checkbox"/> NO VISION: <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> PART A <input type="checkbox"/> PART B		NOT APPLICABLE
MO DAY YR			<input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICAL: <input type="checkbox"/> YES <input type="checkbox"/> NO DENTAL: <input type="checkbox"/> YES <input type="checkbox"/> NO VISION: <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> PART A <input type="checkbox"/> PART B		NOT APPLICABLE
MO DAY YR			<input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICAL: <input type="checkbox"/> YES <input type="checkbox"/> NO DENTAL: <input type="checkbox"/> YES <input type="checkbox"/> NO VISION: <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> PART A <input type="checkbox"/> PART B		<input type="checkbox"/> DISABLED <input type="checkbox"/> FULL-TIME STUDENT <input type="checkbox"/> OVER 50% SUPPORT
MO DAY YR			<input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICAL: <input type="checkbox"/> YES <input type="checkbox"/> NO DENTAL: <input type="checkbox"/> YES <input type="checkbox"/> NO VISION: <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> PART A <input type="checkbox"/> PART B		<input type="checkbox"/> DISABLED <input type="checkbox"/> FULL-TIME STUDENT <input type="checkbox"/> OVER 50% SUPPORT

**8) ACCEPTANCE OF COVERAGE** (signature required.)

**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, the SafeGuard Entities and/or Fidelity Entities. Health Net Entities, the SafeGuard Entities and/or Fidelity 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, 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 web site at www.healthnet.com or through the Health Net Customer Contact Center.

**NOTICE:** For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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

**ACKNOWLEDGEMENT AND AGREEMENT:** I understand and agree that by enrolling with or accepting services from the Health Net Entities, the SafeGuard Entities and/or the Fidelity 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, and I accept these terms.

**ARBITRATION AGREEMENT:** I understand and agree that any and all disputes or disagreements between Group (or enrolled members) and the Health Net Entities, the SafeGuard Entities and/or the Fidelity Entities regarding the construction, interpretation, performance or breach of the Health Net Entities, the SafeGuard Entities and/or the Fidelity Entities Group Policies, or regarding other matters relating to or arising out of the Health Net Entities, the SafeGuard Entities and/or the Fidelity Entities

**Group Policies, whether stated in tort, contract or otherwise, 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 the Health Net Entities, the SafeGuard Entities and/or the Fidelity Entities are giving up their constitutional rights to the extent permitted by law to have their dispute decided in a court of law before a jury. I also understand that disputes with the Health Net Entities, the SafeGuard Entities and/or the Fidelity Entities 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. A more detailed arbitration provision is included in the Health Net Entities, the SafeGuard Entities and/or the Fidelity Entities Group Policies.**

Effective July 1, 2002, members who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. § 1001 et seq., a federal law regulating benefit plans, are not required to submit disputes about certain "adverse benefit determinations" made by Health Net Entities, the SafeGuard Entities and/or the Fidelity Entities to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by Health Net Entities, the SafeGuard Entities and/or the Fidelity Entities to deny, reduce, terminate or not pay for all or a part of a benefit. However, I and Health Net Entities, the SafeGuard Entities and/or the Fidelity Entities may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

X _____ EMPLOYEE SIGNATURE	_____ DATE
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Please contact the Health Net Customer Contact Center at the toll free numbers below should you need assistance in completing this form or if you have questions about your coverage:

English	1-800-361-3366
Cantonese	1-877-891-9050
Korean	1-877-339-8596
Mandarin	1-877-891-9053
Spanish	1-800-331-1777
Tagalog	1-877-891-9051
Vietnamese	1-877-339-8621

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

Dental	1-800-880-8113
Vision	1-866-392-6058

If you have questions about your physician or physician group, call your physician group directly or contact Health Net Provider Services at 1-800-641-7761.

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

### **HMO, HMO Silver Network, HMO Variable Copay, Salud con Health Net HMO, SELECT, ELECT, ELECT Open Access, EPO Dental HMO Enrollees:**

*Participating Physician Group (PPG), Primary Care Physician (PCP) and Dental Provider Selection.*

Please note, if you do not select a participating physician group, Primary Care Physician, or Dental Provider for yourself and each of your eligible dependents, a physician group, Primary Care Physician, and Dental Provider will be selected for you.

#### *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 medical 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 physician group as soon as possible to inform them about your condition.

### **PPO, FLEX NET Enrollees:**

*Emergency and Urgently Needed Care*

- **If your situation is life threatening or an emergency:** Call **911** or go to the nearest hospital. Please call the appropriate number within 48 hours of being admitted, or as soon as possible.

### **PRE-CERTIFICATION**

You the member are responsible for obtaining certification for certain services. Please check your plan certificate for a list of services requiring pre-certification.

### **For pre-certification, please call 1-800-977-7282**

#### *Preexisting Conditions and Creditable Coverage*

Your coverage under the PPO, EPO and Flex Net benefit plans may be subject to pre-existing condition limitations for a maximum period of six months from the effective date of your enrollment. In accordance with state and federal law, Health Net Life Insurance Company will credit any prior coverage that you document at the time you apply to enroll in PPO, EPO or FLEX NET, provided the prior coverage qualifies as "creditable coverage" as defined under federal and state law. Creditable coverage will be applied to offset (in part or whole) the pre-existing condition limitation, which may apply to your coverage under this policy. If you're unable to provide documentation of bona fide creditable coverage at enrollment time, Health Net Life Insurance Company may provide assistance in obtaining the necessary documentation upon request. Note: Prior coverage, which is interrupted by a period of 63 days (or 180 days if your previous employer terminated the coverage) or more, does not qualify as creditable coverage.

#### **Disabling Conditions**

If you or your family member were disabled as of the date of termination of coverage with a prior health insurer and the loss of coverage was due to the termination of the employer's insurance policy, you may be entitled to an extension of health benefits according to California Insurance Code section 10128. Under this law, the prior insurer retains responsibility until whichever of the following occur first: (a) the member is no longer totally disabled; (b) the maximum benefits of the prior insurer's coverage are paid; or (c) a period of 12 consecutive months has passed since the date coverage ended with prior insurer.

#### **Products/Entities:**

Health Net of California, Inc. offers the following products: ELECT Open Access, HMO, Salud con Health Net EPO & PPO and SELECT POS.

Health Net Life Insurance Company offers the following products: EPO, Flex Net, PPO, Life and AD&D insurance.

SafeGuard Health Plans, Inc. offers the following products: Dental HMO (DHMO) and DHMO Ortho Rider.

SafeHealth Life Insurance Company offers the following products: PPO Dental, Indemnity Dental, Indemnity Ortho Rider.

Fidelity Security Life Insurance Company offers the following products serviced by EyeMed Vision Care, LLC: PPO Vision.

#### **Declination of Coverage**

If you decline coverage for yourself or an eligible dependent because of coverage under other health insurance and you lose that coverage, or, if you acquire a new dependent due to marriage, birth, adoption, or placement for adoption, you and your dependent may be eligible for special enrollment rights. You must request special enrollment within 30 days of the loss of coverage or acquisition of a new dependent.