

# ALLPOINTE Insurance Services

## Application Instructions For Health Net California

1. Print all pages of the application including instructions.
2. Complete all questions and sections of the application.
3. Complete the fax cover letter on the next page and fax to ALLPOINTE Insurance Services for review along with the completed application. If you do not have access to a fax machine, send the completed application to ALLPOINTE Insurance Services along with the required first month's payment.

### HELPFUL TIPS:

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- Indicate your requested effective date.
- Select your preferred billing method.
- Sign and date the application.

### IMPORTANT:

If you have requested that your monthly premium be deducted automatically from your checking account, you must attach a voided check to the area provided and also sign and date the authorization form.

Don't forget to **enclose a check for the required payment made payable to Health Net California** if you are not paying by credit card.

Mail completed application and check to:

**ALLPOINTE Insurance Services**

**Attn: New Enrollment**

**290 Missouri Street**

**San Francisco, CA 94107**

ALLPOINTE Insurance Services will review your application for completeness and accuracy before we submit it to Health Net California for processing. This may reduce the approval time because they cannot process unclear or incomplete applications until the missing information has been gathered.

Please contact us if you have any questions regarding the application or the application process. You may reach us at 1-888-992-2244 or e-mail us at [mybroker@allpointe-is.com](mailto:mybroker@allpointe-is.com).

# ALLPOINTE Insurance Services

## FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

**\*\*Please FAX this cover letter with the completed application to:**

**ALLPOINTE Insurance Services**

**FAX# 415-520-5554**

Dear ALLPOINTE Insurance Services,

Please accept my completed insurance application for submittal and contact me to confirm receipt of this application

Name \_\_\_\_\_

E-mail \_\_\_\_\_

Date \_\_\_\_\_

Time \_\_\_\_\_

Please contact me at this phone number \_\_\_\_\_ after you have reviewed my application for completeness and accuracy.

I will contact ALLPOINTE Insurance Services at 1-888-992-2244 to verify receipt of my application.

**\*\*I understand that ALLPOINTE Insurance Services will not review this application until the following weekday morning if I faxed this application after 5:00PM or on a weekend**

I understand that the original signed application must still be mailed to ALLPOINTE Insurance Services. I will mail the original signed application to :

**ALLPOINTE Insurance Services**

**Attn: New Enrollment**

**290 Missouri Street**

**San Francisco, CA 94107**

I will send the original application as soon as I have been contacted by ALLPOINTE Insurance Services with confirmation that my application has been received by fax and reviewed for completeness.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



Health Net

# Individual & Family Enrollment Application

## PART I. Tell us who you are enrolling and select the product:

Application must be typed or completed in **blue or black ink.**

Requested Effective Date

Grid for Requested Effective Date

**THE APPLICATION MUST BE COMPLETED BY THE APPLICANT.**

<p><b>A. Reason for Application</b></p> <p><b>FAMILY TYPE</b></p> <p><input type="checkbox"/> Self                      <input type="checkbox"/> Self &amp; Spouse  <input type="checkbox"/> Self &amp; Child            <input type="checkbox"/> Self &amp; Children  <input type="checkbox"/> Self, Spouse and Child(ren)</p> <p><input type="checkbox"/> Process as separate policies</p> <p><b>ENROLLMENT TYPE</b></p> <p><input type="checkbox"/> New Enrollment   <input type="checkbox"/> Change Plan*   <input type="checkbox"/> Add Dependent*</p> <p>*Member ID number (listed on your ID card): _____</p>	<p><b>C. Choice of coverage</b></p> <p><b>Health Net of California – Only 1<sup>st</sup> of the month effective</b></p> <p><input type="checkbox"/> EOA 15            <input type="checkbox"/> Dental &amp; Vision Plus  <input type="checkbox"/> HMO 15  <input type="checkbox"/> HMO 40</p> <p>Primary Dentist Number _____</p> <hr/> <p><b>Health Net Life Insurance Company</b></p> <p><u>Only 1<sup>st</sup> of the month effective date is available</u></p> <p><input type="checkbox"/> Life Insurance    <input type="checkbox"/> \$15,000   <input type="checkbox"/> \$30,000   <input type="checkbox"/> \$50,000</p> <p><u>1<sup>st</sup> and 15<sup>th</sup> of the month effective date is available.</u></p> <p><input type="checkbox"/> PPO Value 25    <input type="checkbox"/> PPO Value Basic 500  <input type="checkbox"/> PPO Value 30    <input type="checkbox"/> PPO Value Basic 1000  <input type="checkbox"/> PPO Value 400   <input type="checkbox"/> PPO Value Basic 2500  <input type="checkbox"/> PPO Value 750   <input type="checkbox"/> PPO Value Basic 4000</p> <p><input type="checkbox"/> Dental &amp; Vision Plus</p> <p><i>As a convenience to you, if you do not meet Health Net Life Insurance underwriting requirements for the coverage or rate you have applied for, you may be offered a different PPO option at a substantially higher rate. You are under no obligation to enroll.</i></p>
<p><b>B. Billing options (please choose for both medical and life)</b></p> <p><b>First Premium Payment (select one)</b></p> <p><input type="checkbox"/> Pay by Check (Please include completed check and send with application. Amount must match either monthly or quarterly premium corresponding to your billing choice.)</p> <p><input type="checkbox"/> Credit Card (Please complete the credit card section on application)</p> <p><b>Monthly Premium Payments (select one)</b></p> <p><input type="checkbox"/> Automated Bank Draft (Please complete the Simple Pay Option section)</p> <p><input type="checkbox"/> Monthly Bill (\$5.00 administrative fee applies; <b>not available with Term Life</b>)</p> <p><input type="checkbox"/> Credit Card (Please complete credit card section; <b>not available with Term Life</b>)</p> <p><input type="checkbox"/> Quarterly Bill (no administrative fee)</p>	

## PART II. Applicant Information (Note: For the most favorable rate, make the younger spouse the primary applicant.)

Primary Applicant's Last Name		First Name		MI	<input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address					
City		State	Zip	County applicant resides in	
Home Phone Number (     )		Work Phone Number (     )		Email address	
Primary Applicant's Birth Date (mo/day/year)			Primary Applicants Social Security Number		
Height	Weight	Primary Care Physician ID # (If applicable)		Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No	Physician Group ID #
Type of Business:			Occupation:	Salary Range (optional):	
<input type="checkbox"/> Self Employed/Consultant <input type="checkbox"/> Unemployed (between jobs) <input type="checkbox"/> Professional/Management <input type="checkbox"/> Student <input type="checkbox"/> Other: <input type="checkbox"/> Employed (Non-managerial) <input type="checkbox"/> Retired				<input type="checkbox"/> \$18,000 – 30,000 <input type="checkbox"/> \$60,001 – 75,000 <input type="checkbox"/> \$30,001 – 45,000 <input type="checkbox"/> \$75,001 – 90,001 <input type="checkbox"/> \$45,001 – 60,000 <input type="checkbox"/> \$90,001+	
The following information is voluntary. By indicating your ethnicity you are helping us to better serve your needs.				In the past 6 months, have you been a resident of California?	
<input type="checkbox"/> American/Alaskan Native <input type="checkbox"/> Filipino <input type="checkbox"/> Korean <input type="checkbox"/> Chinese <input type="checkbox"/> Black/African American (Non-Hispanic) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Vietnamese <input type="checkbox"/> Caucasian (Non-Hispanic/White) <input type="checkbox"/> Japanese <input type="checkbox"/> Other: _____				<input type="checkbox"/> Yes <input type="checkbox"/> No If no, where was your last residence? _____	
How did you hear about Health Net's Individual and Family coverage?					
<input type="checkbox"/> Radio	<input type="checkbox"/> Mail	<input type="checkbox"/> Billboard	<input type="checkbox"/> Newspaper	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Broker <input type="checkbox"/> Internet <input type="checkbox"/> Other

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**PART III. Family member(s) to be enrolled**

List yourself and all eligible family members to be enrolled. If a listed family member's last name is different from yours, please explain on a separate sheet of paper. To be processed under one Subscriber, all family members must reside at the same address.

\*HMO only: If you are applying for HMO coverage, you must select a Physician Group and Primary Care Physician. You may choose the same or different Physician Group and Primary Care Physician for each family member you are enrolling. If you do not select a Primary Care Physician, one will be selected for you within your regional area.

Relation	Last Name	First Name	MI	Social Security No.	Date of birth	Height	Weight	Primary Care Physician ID #*	Current Patient	Physician Group ID #*
<input type="checkbox"/> Husband <input type="checkbox"/> Wife	Spouse			- -	/ /				<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Child 1			- -	/ /				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	Units Carried	Name of School							
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Child 2			- -	/ /				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	Units Carried	Name of School							
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Child 3			- -	/ /				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	Units Carried	Name of School							
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Child 4			- -	/ /				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	Units Carried	Name of School							

For additional dependents please attach another sheet with the requested information.

**PART IV (a). Statement of health** (All questions must be answered. **Include information for yourself and each family member applying for coverage. Please answer all questions "Yes" or "No."** (IF "YES", PLEASE CIRCLE THE SPECIFIC CONDITIONS.)

1) A.	Is either the applicant or spouse, or female dependent, whether or not listed on the application, currently pregnant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
B.	If you are a male listed on this application, are you expecting a child with anyone, even if the mother is not listed on this application?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
C.	If you are a male listed on this application, has your spouse, even if not listed on this application, performed a home pregnancy test during the previous 90 days which has reacted positive?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
D.	During the previous 90 days, has any female applicant performed a home pregnancy test, which has reacted positive?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2)	Have you or any applying family member had an abnormal physical exam, laboratory results, EKG, X-rays, MRI, CT scan or been advised to have diagnostic tests, treatment(s), surgery or hospitalization(s)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3)	Have you or any applying family members been a patient in a hospital, clinic, surgicenter, sanatorium or other medical facility as an inpatient or outpatient?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4)	Are you or any applying family member eligible for Medicare benefits as a result of disability or chronic illness?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5)	Have you or any applying family member ever had any signs or symptoms, been consulted for, received advice, sought treatment, had treatment recommended, received treatment or been hospitalized for the following conditions? If "Yes", please list the specific condition and provide requested details in section IV (b).	Yes <input type="checkbox"/>	No <input type="checkbox"/>
A.	Chest pain, high or low blood pressure, heart disease, heart murmur, palpitations or irregular heart beat, peripheral vascular disease, blood clot, phlebitis, varicose veins, blood disorder, anemia, enlarged lymph nodes, or any other heart, cardiovascular, or circulatory disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
B.	Headaches, dizziness, paralysis, stroke, loss of consciousness, seizure disorder, sleep apnea, multiple sclerosis, cerebral palsy, or any other disorder of the brain or nervous system?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
C.	Disorder of the mouth, throat or esophagus, tonsillitis, ulcers, colitis, ulcerative colitis, spastic colitis, Crohn's disease, gall bladder disorder, chronic diarrhea, hernia, hemorrhoids, hepatitis, pancreatitis, intestinal or rectal problems, liver disease, cirrhosis, stomach disorder, or any other disorder of the digestive system?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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**PART IV (a). Statement of health (continued)**

D.	Allergies, sinusitis, bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), pneumonia, tuberculosis, coughing up blood, or any other lung or respiratory disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
E.	Asthma?  If "yes", have you been hospitalized or been to an emergency room in the past 24 months?  Have you received any adrenaline or epinephrine injections?	Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/>
F.	Disorder of the kidney or bladder, infections, blood in urine, pyelonephritis, or any other disorder of the urinary tract?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
G.	Arthritis, rheumatoid arthritis, bursitis, gout, disorder of the back, spine, bone or joint, herniated, ruptured, or bulging disc, muscle or tendon pain, carpal tunnel syndrome, muscular dystrophy, fixation device or any other disorder of the musculoskeletal system?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
H.	Jaw problems, temporal mandibular joint syndrome (TMJ), pain or difficulty breathing, chewing or swallowing?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I.	Diabetes, thyroid disorder, adrenal disorder, lupus, Raynaud's disease, chronic fatigue syndrome, Epstein-Barr virus, or any other disorder of the metabolic system?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
J.	Cancer, melanoma, tumor, cyst, growth, leukemia, Hodgkin's disease, or any other malignancy?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
K.	Psoriasis, keratosis, herpes, burns, birthmarks, warts, or any other disorder of the skin?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
L.	Disorder of the eyes or sight, glaucoma, cataracts, disorder of the ears or hearing, ear infection (otitis media), disorder of the nose or breathing, deviated nasal septum?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
M.	Nervous, mental, emotional or obsessive compulsive disorder, behavioral disorder, panic attacks, anxiety, depression, manic depression, schizophrenia, attention deficit disorder, ADHD, or eating disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
N.	Alcohol or substance abuse/dependency, counseling, member of a support group? Please indicate the number of alcoholic beverages (a beverage is 12 ounces of beer, 6 ounces of wine, 1 ounce of liquor) you consume per week?  Applicant _____ Spouse _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>

O.	Premature birth, developmental delay, congenital abnormalities, clubfoot, cleft lip or palate, or Down's syndrome?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
P.	Cosmetic or reconstructive surgery, including breast implants?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Q.	Male reproductive system: disorder of the prostate, infections, impotency, sexual dysfunction, infertility, sexually transmitted disease or any other disorder of the reproductive system?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
R.	Female reproductive system: disorder of the breast, fibroid tumors, infertility, menstruation disorders, abnormal Pap test, infections, sexually transmitted disease, abnormal bleeding, endometriosis or any other disorder of the uterus or reproductive system?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6)	Have you or any applying family member been diagnosed as having or been treated for AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS-Related Complex)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7)	Have you or any applying family member(s) consulted a provider for any condition or symptom(s) for which a diagnosis has not been established?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8)	During the past 12 months, have you or any applying family members smoked cigarettes, cigars, pipes, or used chewing tobacco?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9)	During the past three years, have you or any applying family members consulted a physician for any reason not already indicated on this form?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
10)	During the past 12 months, have you or any applying family members experienced symptoms for which a physician has not been consulted?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
11)	Is the applicant or any applying family member currently taking medication? If "Yes", please complete section IV (b).	Yes <input type="checkbox"/>	No <input type="checkbox"/>
12)	Has the applicant or any applying family member taken a prescription medication during the past 12 months for a period of more than two weeks? If "Yes", please complete Part IV (b).	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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**PART IV (a). Statement of health (continued)**

**Female applicants only (applicable to all females listed on the application)**

Applicant Name:	Applicant Name:
13) A. (i) Have you had a menstrual period in each of the last six months, including within the last 30 days?  If "No", please explain: _____  Yes <input type="checkbox"/> No <input type="checkbox"/>	13) A. (i) Have you had a menstrual period in each of the last six months, including within the last 30 days?  If "No", please explain: _____  Yes <input type="checkbox"/> No <input type="checkbox"/>
B. (i) Have you had a pelvic exam? Yes <input type="checkbox"/> No <input type="checkbox"/>  (ii) Date of last pelvic exam (Mo/Dy/Yr): / /  (iii) Were the results of the exam normal? If not, please explain: Yes <input type="checkbox"/> No <input type="checkbox"/>  _____	B. (i) Have you had a pelvic exam? Yes <input type="checkbox"/> No <input type="checkbox"/>  (ii) Date of last pelvic exam (Mo/Dy/Yr): / /  (iii) Were the results of the exam normal? If not, please explain: Yes <input type="checkbox"/> No <input type="checkbox"/>  _____

**PART IV (b). Statement of health - If you answered "Yes" to any questions in Section IV (a), please list condition(s) and explain in FULL DETAIL below. If additional space is necessary, please attach extra pages.**

Question Number	Family member name and name used on doctor's records	Diagnosis and treatment	Still under treatment? Yes/No	Dates of treatment, Hospitalization (Mo/Yr):		Name of hospital, full name and address of every physician, clinic or hospital (include ZIP Code)
				Began	Ended	

**DOCTOR'S VISITS - Please provide information regarding the last doctor visit/physical examination for ALL family members you wish to cover.**

Name of Individual	Date of Visit	Reason for and results of visit	Name, phone number and address of attending physician

				-					-				
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**Part IV (b) Statement of Health (continued)**

**MEDICATIONS - Please list all medications taken currently or within the last year by anyone listed on this application.**

Name of Individual	Condition	Name of Medication	Dosage and frequency (list last refill date)	Name, phone number and address of attending physician

**PART V. Other health coverage**

**A. During the previous 30 days, have you been covered by health insurance?** Yes  No

If "Yes," Current Carrier: \_\_\_\_\_ Effective date: \_\_\_\_\_ Expected termination date: \_\_\_\_\_

Individual & Family HMO                       Group HMO  
 Individual & Family PPO                       Group PPO  
 Disability, Short Term or Interim             Other: \_\_\_\_\_

**B. Have any applicants identified on this application been declined, postponed, waiver applied or charged an extra premium for life, disability or health insurance or had such insurance rescinded?** Yes  No

**C. Has anyone on this application been a Health Net or Foundation Health Member in the last five years?** Yes  No

If "Yes," former Health Net or Foundation Health Member name: \_\_\_\_\_  
 Group Number (listed on your ID card): \_\_\_\_\_  
 Member ID Number (listed on your ID card): \_\_\_\_\_

**D. HIPAA Coverage – If you answer "Yes" to every condition listed below, you are eligible for Guaranteed Issue coverage under the Health Insurance Portability and Accountability Act (HIPAA). Please call Health Net at 1-800-909-3447 for information regarding what coverage is available and rates of coverage under HIPAA.**

a. I have had a total of at least 18 months of health care coverage (including COBRA or Cal-COBRA, if applicable) without more than a 63-day break (excluding any employer imposed waiting periods) in coverage. Yes  No

b. My most recent coverage was through a group health plan (COBRA and Cal-COBRA are considered group coverage). Yes  No

c. I am not currently eligible for coverage under any group health plan, Medicare or Medicaid. Yes  No

d. My most recent coverage was not terminated because of nonpayment or fraud. Yes  No

e. I accepted COBRA or Cal-COBRA and exhausted all of its benefits, or was not eligible for COBRA or Cal-COBRA. Yes  No

If "Yes," please list the date that COBRA or Cal-COBRA was exhausted: \_\_\_\_\_ If not, please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PART VI. Individual Term Life Insurance – Underwritten by Health Net Life Insurance Company - Applicant Only**

**Applicant Only**  
 This insurance is not intended to replace any Life Insurance Policy currently in force. Life Insurance requires an additional premium. (Must be at least 19 years old to enroll). **The percentage indicated must equal 100%.**

Beneficiary (Full Name)	Relationship	%
Beneficiary (Full Name)	Relationship	%
Beneficiary (Full Name)	Relationship	%
SIGNATURE of APPLICANT	DATE	

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**PART VII. Individual & Family Plans Exception to Standard Enrollment – Statement of Accountability**

This is to be used when the Applicant cannot complete the application because of the reason(s) indicated below. The applicant must complete the appropriate section that applies to their enrollment. This form must be submitted with the Individual & Family Enrollment Application when applicable.

I, \_\_\_\_\_ personally read and completed the Individual & Family Enrollment Application for the Applicant named above because:

- Applicant does not read English     Applicant does not speak English     Applicant does not write English
- Other (explain) \_\_\_\_\_

I translated the contents of the Individual & Family Enrollment Application and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by:

I also translated and fully explained Part IX of the Individual & Family Enrollment Application, "Conditions of Enrollment."

**Signatures and date (required in ink)**

<b>SIGNATURE of TRANSLATOR</b>	<b>Today's Date</b>
<b>SIGNATURE of APPLICANT</b>	<b>Today's Date</b>

**Important:** The validity of this information is subject to the same conditions of the application as those signed on \_\_\_\_/\_\_\_\_/\_\_\_\_ and will become part of the agreement between Health Net and the above-listed applicant.

**PART VIII. Writing agent information -- Without complete agent name and address, correspondence will not be sent.**

Health Net Broker ID: _____ <b>V049</b>	
<b>Bradley Vaccaro</b>	<b>1-888-992-2244</b>
Name: <b>290 Missouri Street, San Francisco, CA 94107</b>	Phone number: <b>415-520-5554</b>
Address: _____	Fax Number: <b>mybroker@allpointe-is.com</b>
_____	Email address: _____
_____	_____ / _____ / _____
<b>Writing Agents Signature/Number (if different from Broker ID)</b>	<b>Date Signed (required)</b>
Writing Agent Certification Are you aware of any information not disclosed in this application that might have a bearing on the risk?  Yes <input type="checkbox"/> No <input type="checkbox"/>  If "Yes," please explain: _____ _____	Did you personally see the applicant (and spouse, if applying) at the time this application was executed?  Yes <input type="checkbox"/> No <input type="checkbox"/>

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**PART IX. Conditions of enrollment**

GENERAL CONDITIONS: Health Net reserves the right to reject any application for enrollment. Health Net may selectively accept the Applicant and not any applying dependent(s). There is no coverage unless this Application is accepted by Health Net's Underwriting Department and a Notice of Acceptance is issued to the Applicant even though you paid money to Health Net for the first month's premium. Cashing your check does not mean your application is approved. If rejected, your money will be returned to you. No other department, officer, agent or employee of Health Net is authorized to grant enrollment. An insurance agent cannot grant approval, change terms or waive requirements. Health Net may require that you take a medical examination and you will be responsible for payment of any related fees in such event. This application and all medical information or examination reports shall become a part of the Plan Contract or Insurance Policy. Any intentional or unintentional nondisclosure or misstatement of fact in application materials is cause for disenrollment and rescission of the Plan Contract or Insurance Policy and Health Net may recoup any amounts paid for Covered Services obtained as a result of such nondisclosure or misstatement of fact. In addition, if a Subscriber makes a false statement or omission as to the Subscriber's or Family Member's health status or history on application materials, Health Net shall have no liability for the provision of coverage under the Plan Contract or Insurance Policy.

AUTHORIZATION TO RECEIVE AND RELEASE INFORMATION: I, on my behalf and on behalf of any applying family members, do hereby authorize Health Net and its authorized employees, its agents, independent contractors and Participating or Preferred Providers to release to, or obtain from, any provider, organization or government agency, any information and records, including patient records of Members and any information concerning treatment for alcohol abuse, substance abuse, mental or emotional disorders, AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS-Related Complex), that Health Net is obligated to provide pursuant to legal process, federal, state or local law, or requires to administer the Plan Contract or Insurance Policy. Health Net requires access to this information to, as necessary: 1) make a determination on enrollment; 2) if enrolled, administer claims for benefits under the Plan Contract or Insurance Policy; or 3) provide such information pursuant to legal process, federal, state or local law. This authorization shall remain valid for thirty (30) months from the date application is signed as to Health Net's determination on enrollment, and for the term of coverage under the Plan Contract or Insurance Policy for the purpose of collecting information in connection with a claim for benefits under the Plan Contract or Insurance Policy. A photocopy or facsimile of this Application and Authorization is considered as valid as the original. You are entitled to submit a photocopy or facsimile of the Application and Authorization. Health Net recommends that you maintain a copy of this Application and Authorization for your records.

IF SOLE APPLICANT IS A MINOR: If the sole Applicant under this application is under 18 years of age, the Applicant's parent or legal guardian must sign as such.

In such event, the parent or legal guardian does hereby agree to be legally responsible for the accuracy of information in this Application and for payments of premiums. If such responsible party is not the natural parent of the Applicant, copies of the court papers authorizing guardianship must be submitted with this Application.

**IF APPLICANT CANNOT READ ENGLISH:** If an Applicant does not read English, the translator and Applicant must sign and submit the Statement of Accountability for translating this entire Application (on page 4, PART VII of this application).

**PART X. Important provisions**

**ACKNOWLEDGMENT AND AGREEMENT:** I understand and agree that by enrolling with or accepting services from Health Net, I and any enrolled dependents are obligated to understand and abide by all terms, conditions and provisions of the Plan Contract or Insurance Policy. I have read and understand the terms on this Application and my signature below indicates my acceptance of these terms and that the information entered in this Application is complete, true and correct.

I acknowledge that health care providers may disclose health information about me or my dependents, including information regarding substance abuse or mental/emotional conditions, to Health Net. The plans use and 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.

**BINDING ARBITRATION:** I understand and agree that any and all disputes or disagreements between me (including any of my enrolled family members or heirs or personal representatives) and Health Net regarding the construction, interpretation, performance or breach of the Health Net Plan Contract or Insurance Policy, or regarding other matters relating to or arising out of my Health Net membership, whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or employees, are also involved, 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, 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. 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. A more detailed arbitration provision is included in the Plan Contract or Insurance Policy.

**HIV TESTING PROHIBITED:** California law prohibits an HIV test from being required or used by health care service plans or insurance plans as a condition of obtaining coverage.

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.

**Part XI. Return Completed Application to**  
**Health Net Individual and Family Enrollment**  
**Post Office Box 1150**  
**Rancho Cordova, California 95741 - 1150**

**Signatures (required in ink)**

Family Contact's if different than Primary Applicant Name	Date Signed
APPLICANT or CASE CONTACT'S SIGNATURE	Date Signed
SPOUSE'S SIGNATURE	Date Signed
SIGNATURE OF APPLICANT'S DEPENDENT (age 18 or older)	Date Signed
SIGNATURE OF APPLICANT'S DEPENDENT (age 18 or older)	Date Signed

**Make personal check payable to "Health Net"**

All references to "Health Net" herein include the affiliates and subsidiaries of Health Net which underwrite or administer the coverage to which this Enrollment Application applies.



Primary's Social Security Number

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## Health Net's Pay Option - Monthly Automatic Payment for Individual & Family Plans

**SIMPLE PAYMENT OPTION (Automatic Bank Draft)**

Monthly premium charge can be withdrawn directly from your personal checking account. The premium will be withdrawn from your bank account about ten days in advance of the due date. **If you select this payment option you must send a personal check for the first month's premium.**

Account Holder's Social Security Number	Transit Routing Number	Account Number
Bank Name	State	

As a convenience, I request and authorize Health Net to pay and charge to the above account checks drawn on that account by and payable to the order of "Health Net" provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the Premium withdrawn from my account can be for the future bill period plus any past due balances and my first month's withdraw maybe for multiple periods if I did not submit a binder check or due to the timing of the set up. I agree that Health Net's rights in respect to each such check shall be the same as if it were a check written to Health Net and signed personally by me. This authority is to remain in effect until revoked by me in writing and until Health Net actually receives such notice, I agree that Health Net shall be fully protected in honoring any such check. (Note: A 30-day notice is required to discontinue this service due to the time required to initiate this change with your bank.)

I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, I will be charged a \$25 service charge for each occurrence. I understand Health Net shall be under no liability whatsoever even though such dishonor may result in the forfeiture of health coverage.

SIGNATURE of ACCOUNT HOLDER	Date
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**CREDIT CARD**       First Month's premium       Monthly Premium

Monthly premium charge can be charged directly to your credit card account. The premium will be charged to your credit card account approximately ten days in advance of the due date.

First Name (as appears on card)	Middle Name (as appears on card)	Last Name (as appears on card)	Card Type <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard
Account Number	Expiration Date (mm/yyyy)	*Signature Panel Code	Cardholder's email address
Billing Address	City	State	Zip

\*Signature Panel Code can be found on the back of your credit card. This 3-digit code is usually the last three digits located in the signature panel.

As a convenience, I request and authorize Health Net or Health Net Life Insurance Company ("Health Net") to charge my credit card account identified above for the payment of my initial premium and/or my monthly premium. This authority is to remain in effect until revoked by me in writing and until Health Net actually receives such notice, I agree that Health Net shall be fully protected in honoring any such charge. (Note: A 30-day notice is required to discontinue this service due to the time required to initiate this change with your credit card company.)

SIGNATURE of CREDIT CARD ACCOUNT HOLDER	Date
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