

# INDIVIDUAL & FAMILY PLANS HIPAA PPO GUARANTEED ISSUE ENROLLMENT APPLICATION

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

**THE APPLICATION MUST BE COMPLETED BY THE APPLICANT APPLYING FOR COVERAGE AND CAN BE COMPLETED BY THE APPLICANT FOR MINOR DEPENDENTS OR BY AN INTERPRETER FOR APPLICANTS WHO DO NOT READ/WRITE ENGLISH. NEITHER BROKER NOR ANY OTHER PERSON THAN THOSE MENTIONED ABOVE MAY SIGN THIS APPLICATION AND AGREEMENT ON BEHALF OF THE APPLICANT.**

IMPORTANT: Can you read this form? If not, we can have somebody help you read it. You may also be able to get this form written in your language. For free help, please call right away at 1-800-909-3447, option 2.

IMPORTANTE: ¿Puede leer este formulario? De no ser así, podemos hacer que alguien le ayude a leerlo. También puede obtener este formulario escrito en su idioma. Para obtener ayuda sin costo, llame inmediatamente al 1-800-909-3447, opción 2.

重要資訊：您是否能閱讀此文件？如果您無法閱讀，我們將請專人協助您。我們也能以您使用的語言翻譯此份文件。請立即致電 1-800-909-3447，再按 2，洽詢免費服務。

If you need assistance in completing this Application, a broker may assist you. A broker who helped you read and complete this Application must sign the Application (see Part V).

## PART I – TELL US WHO YOU ARE ENROLLING AND SELECT THE PRODUCT

<b>A. Reason for Application</b> <b><i>Family type</i></b> <input type="checkbox"/> Self <input type="checkbox"/> Self and spouse/domestic partner <input type="checkbox"/> Self and child <input type="checkbox"/> Self and children <input type="checkbox"/> Self, spouse/domestic partner and child(ren) <input type="checkbox"/> <b>Please check box for domestic partner enrollment</b>  <b><i>Enrollment type</i></b> <input type="checkbox"/> New enrollment <input type="checkbox"/> Add dependent	<b>B. Billing options</b> <b><i>First premium payment (select one)</i></b> <input type="checkbox"/> Automated bank draft (Please complete the Simple Pay Option section on page 6.) <input type="checkbox"/> Pay by check (Please include completed check and send with application. Amount must match monthly premium.) <input type="checkbox"/> Credit card (Please complete the credit card section on page 6.)  <b><i>Monthly premium payments (select one)</i></b> <input type="checkbox"/> Automated bank draft (Please complete the Simple Pay Option section on page 6.) <input type="checkbox"/> Monthly bill <input type="checkbox"/> Credit card (Please complete the credit card section on page 6.)	<b>C. Choice of coverage</b> <b>Health Net Life Insurance Company –</b> 1st and 15th of the month effective dates are available. <input type="checkbox"/> <b>HIPAA PPO SimpleChoice HSA</b> <input type="checkbox"/> <b>HIPAA PPO SimpleValue 50</b>
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## PART II – APPLICANT INFORMATION

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 Applicant's Social Security Number:	
In the past 6 months, have you been a resident of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," where was your last residence? _____			

**PART III – FAMILY MEMBER(S) TO BE ENROLLED**

List all eligible family members to be enrolled other than yourself. If a listed family member's last name is different from yours, please explain on a separate sheet of paper. For additional dependents, please attach another sheet with the requested information.

Check here if supplemental page is attached.

For domestic partner coverage, all requirements for eligibility, as required by the applicable laws of the State of California, must be met and a joint Declaration of Domestic Partnership must be filed with the California Secretary of State. **To be processed under one Policyholder, all family members must reside at the same address.**

Relation	Last Name, First Name, MI	Social Security #	Date of Birth	Primary Care Physician ID #	Current Patient	Physician Group ID #
<input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Domestic partner		- -	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Relation Child 1	Last Name, First Name, MI	Social Security #	Date of Birth	Primary Care Physician ID #	Current Patient	Physician Group ID #
<input type="checkbox"/> Son <input type="checkbox"/> Daughter		- -	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Relation Child 2	Last Name, First Name, MI	Social Security #	Date of Birth	Primary Care Physician ID #	Current Patient	Physician Group ID #
<input type="checkbox"/> Son <input type="checkbox"/> Daughter		- -	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Relation Child 3	Last Name, First Name, MI	Social Security #	Date of Birth	Primary Care Physician ID #	Current Patient	Physician Group ID #
<input type="checkbox"/> Son <input type="checkbox"/> Daughter		- -	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	

**PART IV – HIPAA GUARANTEED ISSUE COVERAGE**

If you do not qualify for the Individual HMO or PPO plans, you may be considered for coverage under the HIPAA Guaranteed Issue plans. The HIPAA Guaranteed Issue plans do not require underwriting (medical history review and determination of coverage) and the rates are higher compared to the other Individual Plans. If you qualify for coverage under the HIPAA Guaranteed Issue plans, please request the complete benefit details and rates for those plans. To be eligible for HIPAA Guaranteed Issue coverage, you must meet every condition below.

1. Have you 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? Please note that you must apply for HIPAA coverage within the 63-day break after your group health care coverage (including COBRA or Cal-COBRA, if applicable) ended.  Yes  No
2. Was your most recent coverage through a group health plan (COBRA and Cal-COBRA are considered group coverage)?  Yes  No
3. Currently are you eligible for coverage under a group health plan, Medicare or Medicaid?  Yes  No  
*(If "Yes," you are not eligible for HIPAA coverage.)*
4. Was your most recent coverage terminated because of nonpayment or fraud?  Yes  No
5. Were you eligible under COBRA or Cal-COBRA? Yes, start date: \_\_\_\_\_ end date: \_\_\_\_\_  Yes  No  
 If "Yes," did you accept and use up all benefits that were available?  Yes  No  
 If "No," please explain: \_\_\_\_\_

U058

**PART V. APPLICANT'S AGENT/BROKER INFORMATION**

Complete agent/broker name and address is necessary for correspondence to be sent to the agent/broker.

**Health Net Broker ID:** U058

Name (print): John Conner

Phone number: 916-682-1117

Fax number: 916-258-0296

Address: 10425 Saddle Creek Dr Sacramento CA 95829

Email address: john@johnconner.com

**Applicant's Broker signature/number (required)**

**Date signed (required)**

**Broker Certification**

I, \_\_\_\_\_ (Name of Broker),

(NOTE: You must select the appropriate box. You may only select one box.)

(\_\_\_\_\_) did not assist the Applicant(s) in any way in completing or submitting this Application. All information was completed by the Applicant(s) with no assistance or advice of any kind from me. I understand that, if any portion of this statement by me is false, I may be subject to civil penalties, including but not limited to a fine of up to \$10,000.

**OR**

(\_\_\_\_\_) assisted the Applicant(s) in submitting this Application. All information in the health questionnaire(s) was completed by the Applicant(s). I advised the Applicant(s) that he or she should answer all questions completely and truthfully and that no information requested on the Application should be withheld. I explained that withholding information could result in rescission or cancellation of coverage in the future. The Applicant(s) indicated to me that he or she understood these instructions and warnings. To the best of my knowledge, the information on the Application is complete and accurate. I understand that, if any portion of this statement by me is false, I may be subject to civil penalties, including but not limited to a fine of up to \$10,000.

**Please answer all questions 1 through 4:**

- 1) **Who filled out and completed the Application form?** \_\_\_\_\_
- 2) Did you personally witness the Applicant(s) sign the Application?     Yes    No
- 3) Did you review the Application after the Applicant(s) signed it?     Yes    No
- 4) Are you aware of any information, including but not limited to medical history, not disclosed in this Application, that might have a bearing on the risk?     Yes    No

If "Yes," please explain: \_\_\_\_\_

**PART VI – INDIVIDUAL & FAMILY PLANS EXCEPTION TO STANDARD ENROLLMENT – STATEMENT OF ACCOUNTABILITY**

**Instructions for Part VI:** The following process is to be used when the Applicant cannot complete the Application because he or she cannot read, write and/or speak the language of the Application. Health Net requires that if you need assistance in completing this Application, you must employ the services of a Qualified Interpreter. Please contact Health Net at 1-800-909-3447, option 2, for information about qualified interpreter services and how to obtain them. This form must be submitted with the Individual & Family Plan HIPAA Guaranteed Issue Enrollment Application when applicable.

**Health Net Qualified Interpreter** – Please complete the following when assisted by a Health Net Qualified Interpreter.

I, \_\_\_\_\_, was assisted in the completion of this Application by a qualified interpreter authorized by Health Net because I:

- Do not read the language of this Application.    Do not speak the language of this Application.    Do not write the language of this Application.  
 Other (explain): \_\_\_\_\_

A Qualified Interpreter assisted me with the completion of:    The entire Application.  
 Other (explain): \_\_\_\_\_

A Qualified Interpreter read this Application to me in the following language: \_\_\_\_\_

**SIGNATURES AND DATE (REQUIRED IN INK)**

SIGNATURE OF APPLICANT:	Today's date:
Date Application was interpreted:	Time Application was interpreted:
Qualified Interpreter number:	

**PART VI – continued**

**Qualified Interpreter other than a Health Net Qualified Interpreter – Please complete the following when assisted by a Qualified Interpreter other than a Health Net Qualified Interpreter.**

If a Qualified Interpreter, other than a Qualified Interpreter provided by Health Net, assisted you in completing this Application, the interpreter must complete the following:

I, \_\_\_\_\_, understand that a Qualified Interpreter should: (a) have the vocabulary equivalent of a native speaker that has received an advanced education (college or university equivalent) in the non-English language; (b) be able to demonstrate cultural sensitivity in their communication, taking into consideration that every language encompasses a wide range of variation; (c) have native speaker language skills (native speaker language skills are developed by growing up or functioning in a language community); and (d) have corresponding reading and writing skills in the non-English language (the reading and writing skills would be demonstrated by advanced education in the native language).

As a Qualified Interpreter, I personally read and completed the Application for the Applicant named above because:

- Applicant does not read the language of this Application.
- Applicant does not speak the language of this Application.
- Applicant does not write the language of this Application.
- Other (explain): \_\_\_\_\_

Under the penalty of perjury, I declare that I read to the Applicant:

- The entire Application
- Other: \_\_\_\_\_

I read this Application to the Applicant in the following language: \_\_\_\_\_

Please provide the following information regarding the Qualified Interpreter who assisted the Applicant and who is not a Health Net Qualified Interpreter:

Last name:	First name:
Address of Qualified Interpreter:	City, State and ZIP:
Phone: (        )	Date:
Qualified Interpreter signature:	

**PART VII – CONDITIONS OF ENROLLMENT**

**GENERAL CONDITIONS: Health Net reserves the right to reject any Application for enrollment if the Applicant is not eligible for HIPAA guaranteed issue coverage. Health Net may selectively reject the Applicant or a dependent who is not eligible for HIPAA guaranteed issue coverage.** 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. The Applicant's agent or broker cannot grant approval, change terms or waive requirements of this Application. This Application shall become a part of the Insurance Policy.

**Any fraudulent or willful nondisclosure or misrepresentation of material facts** in Application materials is cause for disenrollment and rescission of the Insurance Policy, and Health Net may recoup from the Policyholder (or from you or from the Applicant) any amounts paid for covered services obtained as a result of such fraudulent or willful nondisclosure or misstatement of material fact. In addition, if a Policyholder makes a fraudulent or willful nondisclosure or misrepresentation of material facts on Application materials, Health Net shall have no liability for the provision of coverage under the Insurance Policy.

**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. Health Net uses 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 Insurance Policy, and that I may also obtain a copy of this Notice on the website at [www.healthnet.com](http://www.healthnet.com) or through the Health Net Customer Contact Center. Authorization for use and disclosure of protected health information shall be valid for a period of 24 months from the date of my signature below.

**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. By signing, he or she 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 THE LANGUAGE OF THIS APPLICATION:** If an Applicant does not read the language of this Application and an interpreter assisted with the completion of the Application, the Applicant must sign and submit the **Statement of Accountability** (see PART VI of this Application "Individual & Family Plans Exception to Standard Enrollment – Statement of Accountability").

**PART VIII – IMPORTANT PROVISIONS**

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.

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

Genetic Information Non-discrimination Act of 2008 (GINA) Compliance Statement: Please do not include any family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which you believe you may be at risk.

ACKNOWLEDGEMENT AND AGREEMENT: I, the Applicant, understand and agree that by enrolling with or accepting services from Health Net, I and any enrolled dependents shall comply with the terms, conditions and provisions of the Insurance Policy (to obtain a copy of the Insurance Policy, call Health Net at 1-800-909-3447, option 2). I, the Applicant, 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.

**BINDING ARBITRATION: I, the Applicant, 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 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 Insurance Policy. My signature below indicates that I understand the terms of this Binding Arbitration Clause and agree to submit disputes to binding arbitration.**

APPLICANT OR PARENT OR LEGAL GUARDIAN'S SIGNATURE IF APPLICANT IS UNDER 18 YEARS OLD:	Date signed:
SPOUSE/DOMESTIC PARTNER'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:

The Application and this Arbitration Clause must be signed by the Applicant(s). The Applicant(s) must personally sign his or her name in ink and agree to comply with the Arbitration Clause and the terms, conditions and provisions of the Application and the Insurance Policy in order for this Application to be processed. For this Application to be considered, neither Broker nor any other person may sign this Application and Arbitration Clause.

**Make personal check payable to "Health Net."  
 Return completed Application to: Health Net Individual and Family Enrollment  
 PO Box 1150, Rancho Cordova, CA 95741-1150**

You may submit a photocopy or facsimile of the Application and Authorizations. Health Net recommends that you retain a copy of this Application and Authorizations for your records.

**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.** "Insurance Policy" refers to Health Net Life Insurance Company Explanation of Your Insurance Plan, Health Net PPO Policy.



**HEALTH NET'S PAY OPTION – MONTHLY AUTOMATIC PAYMENT FOR INDIVIDUAL & FAMILY PLANS AND CALIFORNIA FARM BUREAU MEMBER'S HEALTH INSURANCE PROGRAM**

<b>SIMPLE PAYMENT OPTION (Automatic Bank Draft)</b> <input type="checkbox"/> First month's payment <input type="checkbox"/> Monthly premium payment Monthly premium charge can be withdrawn directly from your personal checking or savings account. The premium will be withdrawn from your bank account about ten days in advance of the due date. Please select your account type: <input type="checkbox"/> Checking <input type="checkbox"/> Savings	
Transit routing number (9 digits):	Account number:
Bank name:	State:
<p>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 "<b>Health Net</b>" provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the premium withdrawn from my account will be for the future bill period plus any past due balances and my first month's withdraw may be for multiple periods if I did not submit a 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. <i>(Note: A 30-day notice is required to discontinue this service due to the time required to initiate this change with your bank.)</i></p> <p>Automatic bank draft (ABD) transmissions are withdrawn from your bank approximately the 20th of every month, for the following month's premium. It can take upwards of 6 weeks to process an ABD request. Therefore, your premium should be submitted with your request for ABD.</p> <p>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.</p>	
SIGNATURE of ACCOUNT HOLDER (Required to process):	Date:

<b>CREDIT CARD</b> <input type="checkbox"/> First month's payment <input type="checkbox"/> Monthly premium payment 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. Your card will be charged for the first month's premium on the day your Application is approved by underwriting.			
First name (as on card):	Middle (as on card):	Last name (as on card):	Card type: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard
Account number (16 digits):		Expiration date (MM/YYYY):	
Billing address:	City:	State:	ZIP <sup>1</sup> :
<p>As a convenience, I request and authorize 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. I understand that the premium charged to my account will be for the future bill period plus any past due balances and that my first month's withdraw/charge may be for multiple periods depending upon date of approval and the bill period. 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. <i>(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.)</i> I further agree that if my credit card is declined for payment, whether with or without cause and whether intentionally or inadvertently, I will be charged a \$25 service charge for each occurrence. Credit card account will be charged approximately the 20th of every month, for the following month's premium.</p>			
SIGNATURE of CREDIT CARD ACCOUNT HOLDER (Required to process):			Date:

<sup>1</sup>The ZIP code must match the cardholder's address, otherwise the credit card cannot be processed.