



Small Business Application

for 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 HMO plans are provided by Dental Benefit Providers of California, Inc., and dental PPO and indemnity insurance plans are underwritten by Unimerica Life Insurance Company (together, the “DBP Entities”). Vision plans are provided by Fidelity Security Life Insurance Company and serviced by EyeMed Vision Care, LLC (together, the “Fidelity Entities”).

Neither the DBP 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.
- 3) If you choose to enroll in the HMO, HMO Silver Network, HMO Bronze Network, HMO Salud con Health Net® Select (POS), Elect Open AccessSM (EOA), EOA Silver Network or Dental HMO (DHMO), you must select your provider, physician group, primary care physician and dental provider. 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

Small Business Group (Mandarin): 1-877-891-9053

Health Net Life: 1-800-865-6288

Health Net Dental: 1-866-249-2382

Health Net Vision: 1-866-392-6058

- 4) If you choose to enroll in a PPO, HSA-compatible, HRA-compatible or Flex Net insurance plan, you are not required to select a primary care physician or physician group to enroll.
- 5) Make a copy of the completed application for your records.

Existing Business/Group

PO Box 9103
Van Nuys, CA 91409-9103
www.healthnet.com

New Business/Group

Please send all completed
paperwork to your
designated Account Executive
or Broker.



Health Net®

(For enrollment, sections 1, 2 and 8 are required. For waivers, only section 7 is required.)

IMPORTANT: PLEASE PRINT ALL SECTIONS IN BLACK INK.

Employer name:	
Effective date:	Employer group number (medical):
Social Security number:	

1A Health plan information (Select one network option only) (Applicable to HMO and EOA plans only)

<input type="checkbox"/> Full Network (HMO and EOA)	<input type="checkbox"/> Silver Network ¹ (HMO and EOA)	<input type="checkbox"/> Bronze Network ² (HMO only)
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1B Select coverage

Dual Network plans ³	HMO	EOA	PPO	HSA	H ⁿ Options	Salud con Health Net®
Standard <input type="checkbox"/> HMO 20 <input type="checkbox"/> HMO 30 Value <input type="checkbox"/> HMO 30 <input type="checkbox"/> HMO 40	Standard <input type="checkbox"/> HMO 10 <input type="checkbox"/> HMO 15 <input type="checkbox"/> HMO 20 <input type="checkbox"/> HMO 25 <input type="checkbox"/> HMO 30 <input type="checkbox"/> HMO 35 <input type="checkbox"/> HMO 40 <input type="checkbox"/> HMO 50 Value <input type="checkbox"/> HMO 10 <input type="checkbox"/> HMO 20 <input type="checkbox"/> HMO 30 <input type="checkbox"/> HMO 40 <input type="checkbox"/> HMO 50 Advantage <input type="checkbox"/> HMO 25 <input type="checkbox"/> HMO 35 <input type="checkbox"/> HMO 45	Standard <input type="checkbox"/> EOA 10 <input type="checkbox"/> EOA 15 <input type="checkbox"/> EOA 20 <input type="checkbox"/> EOA 25 <input type="checkbox"/> EOA 30 <input type="checkbox"/> EOA 35 <input type="checkbox"/> EOA 40 <input type="checkbox"/> EOA 50 Value <input type="checkbox"/> EOA 10 <input type="checkbox"/> EOA 20 <input type="checkbox"/> EOA 30 <input type="checkbox"/> EOA 40 <input type="checkbox"/> EOA 50 Advantage <input type="checkbox"/> EOA 25 <input type="checkbox"/> EOA 35 <input type="checkbox"/> EOA 45	Standard <input type="checkbox"/> PPO 10 <input type="checkbox"/> PPO 15 <input type="checkbox"/> PPO 20 <input type="checkbox"/> PPO 25 <input type="checkbox"/> PPO 30 <input type="checkbox"/> PPO 35 <input type="checkbox"/> PPO 40 <input type="checkbox"/> PPO 45 Value <input type="checkbox"/> PPO 10 <input type="checkbox"/> PPO 15 <input type="checkbox"/> PPO 20 <input type="checkbox"/> PPO 25 <input type="checkbox"/> PPO 30 <input type="checkbox"/> PPO 35 <input type="checkbox"/> PPO 40 <input type="checkbox"/> PPO 45	Standard <input type="checkbox"/> HSA 4000 Value <input type="checkbox"/> HSA 1500 <input type="checkbox"/> HSA 2500 <input type="checkbox"/> HSA 3500 <input type="checkbox"/> HSA 4500 HRA <input type="checkbox"/> HRA 3000 <input type="checkbox"/> HRA 5000 POS <input type="checkbox"/> POS 10 <input type="checkbox"/> POS 20	<input type="checkbox"/> Options PPO 250 <input type="checkbox"/> Options PPO 500 <input type="checkbox"/> Options PPO 1500 <input type="checkbox"/> Options PPO 1750 <input type="checkbox"/> Options PPO 3000 ⁵ <input type="checkbox"/> Options PPO 4000 ⁵ <input type="checkbox"/> Options HMO 25 <input type="checkbox"/> Options HMO 35 <input type="checkbox"/> Options EOA 25 <input type="checkbox"/> Options EOA 35	Salud HMO y Más⁴ <input type="checkbox"/> Salud HMO y Más 15 <input type="checkbox"/> Salud HMO y Más 25 <input type="checkbox"/> Salud HMO y Más 35 <input type="checkbox"/> Salud PPO ⁶ <input type="checkbox"/> Salud EPO ⁶ <input type="checkbox"/> Salud Mexico ⁷ Flex Net <input type="checkbox"/> Indemnity (Out of service area only)

Dental (DHMO)	Dental (DPPO)	Vision (PPO)
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<input type="checkbox"/> HN Plus Plan: _____ Plans below are for renewing groups only: <input type="checkbox"/> HN Value Plan: _____	<input type="checkbox"/> Classic Plus Plan #: _____ <input type="checkbox"/> Classic Plan #: _____ <input type="checkbox"/> Essential Plan #: _____ <input type="checkbox"/> Essential Value Plan #: _____ <input type="checkbox"/> Basic 500: _____ Plans below are for renewing groups only: <input type="checkbox"/> Value Plan: _____ <input type="checkbox"/> Preferred Value Plan: _____ <input type="checkbox"/> Plus Plan: _____	<input type="checkbox"/> Preferred 1025-2 <input type="checkbox"/> Preferred 1025-3 <input type="checkbox"/> Value 10-2
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Reason for change: <input type="checkbox"/> Plan change <input type="checkbox"/> Change address/name <input type="checkbox"/> Delete dependent (list names below) <input type="checkbox"/> Other: _____	Reason for application: <input type="checkbox"/> New hire Date of hire: ____/____/____ <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Loss of prior coverage date: ____/____/____ <input type="checkbox"/> COBRA ⁸ effective date: ____/____/____ <input type="checkbox"/> Add dependent: Qualifying event: _____ <input type="checkbox"/> Qualifying event date: ____/____/____
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¹Available in all or parts of Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Francisco, Santa Clara, Stanislaus and Ventura counties.
²Available in select ZIP codes of Los Angeles, San Bernardino and San Diego counties.
³Groups may only select one tailored network offering alongside the full network Dual Plans. Silver and Bronze may not be offered together.
⁴Available in Orange County and select ZIP codes of Los Angeles, Riverside, San Diego and San Bernardino counties.
⁵HSA-compatible.
⁶Available in Los Angeles, Orange and Ventura counties.
⁷Available in select ZIP codes of San Diego and Imperial counties.
⁸Generally, employers who normally employed 20 or more employees during the previous calendar year are subject to federal COBRA. Any employer who employed 2-19 employees on at least 50% of its working days the previous calendar year is subject to Cal-COBRA. Please consult your legal counsel if you need help determining which law applies to you.

Social Security number:

2 Employee personal information

Last name:		First name:		MI:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Residence address:			City:	State:	ZIP:
Date of birth: (mo/day/yr)		Social Security #/Matricular ID #:		Job title:	
Telephone #: () ()		Work phone #: () ()		Email address:	
Date of hire: / /	Class:	Dept. #:	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	
Medicare: <input type="checkbox"/> Part A <input type="checkbox"/> Part B		Participating physician group/PPG #:		Health Net primary care physician/PCP #:	
Physician name (First, Last):			Is this your current MD? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental HMO provider ID #:	

3 Family information, please list all eligible family members to be enrolled.*(Attach additional sheets if necessary.)*

<input type="checkbox"/> Spouse	<input type="checkbox"/> M	Last name:		First name:		MI:
<input type="checkbox"/> Domestic partner	<input type="checkbox"/> F					
Residence address: <input type="checkbox"/> Check here if same as subscriber			City:	State:	ZIP:	
Date of birth: (mo/day/yr)			Social Security #/Matricular ID #:			
Medicare: <input type="checkbox"/> Part A <input type="checkbox"/> Part B		Over-age dependent type: Not applicable		Participating physician group/PPG #:		
Health Net primary care physician/PCP #:		Physician name (First, Last):		Is this your current MD? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental HMO provider ID #:	
<input type="checkbox"/> Son	Last name:		First name:		MI:	
<input type="checkbox"/> Daughter						
Residence address: <input type="checkbox"/> Check here if same as subscriber			City:	State:	ZIP:	
Date of birth: (mo/day/yr)			Social Security #/Matricular ID #:			
Medicare: <input type="checkbox"/> Part A <input type="checkbox"/> Part B		Over-age dependent type: <input type="checkbox"/> Disabled <input type="checkbox"/> Full-time student <input type="checkbox"/> Over 50% support <input type="checkbox"/> N/A			Participating physician group/PPG #:	
Health Net primary care physician/PCP #:		Physician name (First, Last):		Is this your current MD? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental HMO provider ID #:	
<input type="checkbox"/> Son	Last name:		First name:		MI:	
<input type="checkbox"/> Daughter						
Residence address: <input type="checkbox"/> Check here if same as subscriber			City:	State:	ZIP:	
Date of birth: (mo/day/yr)			Social Security #/Matricular ID #:			
Medicare: <input type="checkbox"/> Part A <input type="checkbox"/> Part B		Over-age dependent type: <input type="checkbox"/> Disabled <input type="checkbox"/> Full-time student <input type="checkbox"/> Over 50% support <input type="checkbox"/> N/A			Participating physician group/PPG #:	
Health Net primary care physician/PCP #:		Physician name (First, Last):		Is this your current MD? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental HMO provider ID #:	

4 Do you or your dependents have other health care coverage?

If "Yes," please complete this section including Medicare.

<input type="checkbox"/> Self	Name:	Name of other insurance carrier:			Prior coverage start date: (mo/day/yr)	
Prior coverage end date: (mo/day/yr)	Reason for ending coverage:	Group #/Policy ID #:	Does it cover? 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		Medicare: <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare claim/ HICN #:
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner	Name:	Name of other insurance carrier:			Prior coverage start date: (mo/day/yr)	
Prior coverage end date: (mo/day/yr)	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does it cover? 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	Medicare: <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare claim/ HICN #:
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Name:	Name of other insurance carrier:			Prior coverage start date: (mo/day/yr)	
Prior coverage end date: (mo/day/yr)	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does it cover? 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	Medicare: <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare claim/ HICN #:
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Name:	Name of other insurance carrier:			Prior coverage start date: (mo/day/yr)	
Prior coverage end date: (mo/day/yr)	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does it cover? 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	Medicare: <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare claim/ HICN #:
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Name:	Name of other insurance carrier:			Prior coverage start date: (mo/day/yr)	
Prior coverage end date: (mo/day/yr)	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does it cover? 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	Medicare: <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare claim/ HICN #:
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Name:	Name of other insurance carrier:			Prior coverage start date: (mo/day/yr)	
Prior coverage end date: (mo/day/yr)	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does it cover? 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	Medicare: <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare claim/ HICN #:

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: <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," I am applying for: <input type="checkbox"/> Life/AD&D: \$ _____ <input type="checkbox"/> Dependent Life: \$ _____		
Life beneficiary (full name):	Relationship:	%
Life beneficiary (full name):	Relationship:	%
Life beneficiary (full name):	Relationship:	%
Life beneficiary (full name):	Relationship:	%

Social Security number: _____

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: _____	Reason: <input type="checkbox"/> Other group coverage through this employer <input type="checkbox"/> Individual coverage <input type="checkbox"/> Other group coverage by another group (i.e., spouse's employer) <input type="checkbox"/> Other: _____
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner <input type="checkbox"/> Dependent(s)	
<input type="checkbox"/> Declining dental coverage for: _____	Reason: <input type="checkbox"/> Other group coverage through this employer <input type="checkbox"/> Individual coverage <input type="checkbox"/> Other group coverage by another group (i.e., spouse's employer) <input type="checkbox"/> Other: _____
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner <input type="checkbox"/> Dependent(s)	
<input type="checkbox"/> Declining vision coverage for: _____	Reason: <input type="checkbox"/> Other group coverage through this employer <input type="checkbox"/> Individual coverage <input type="checkbox"/> Other group coverage by another group (i.e., spouse's employer) <input type="checkbox"/> Other: _____
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner <input type="checkbox"/> Dependent(s)	

Stop and read carefully.

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: _____

(Sign only if declining coverage. If signed in error, please cross out and initial.)

8 Acceptance of coverage (Signature required.)

THE 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 the Health Net Entities, the DBP Entities and/or the Fidelity Entities. The Health Net Entities, the DBP Entities and/or the 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 the Health Net Entities. I may also obtain a copy of this Notice on the website 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 DBP 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.

BINDING ARBITRATION AGREEMENT: Subject to the terms of the Plan Contract or Insurance Policy (which may prohibit mandatory arbitration of certain disputes if the Plan Contract or Insurance Policy is subject to ERISA, 29 U.S.C. section 1001, et seq.), I, the employee, 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 the Health Net Entities, the DBP Entities and/or the Fidelity Entities, regarding the construction, interpretation, performance or breach of the Plan Contract or Insurance Policy, or regarding other matters relating to or arising out of the Health Net Entities, the DBP Entities and/or the Fidelity Entities 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 the Health Net Entities, the DBP Entities and/or the Fidelity Entities, are giving up their constitutional right to have their dispute decided in a court of law before a jury. I also understand that disputes that I may have with the Health Net Entities, the DBP Entities and/or the Fidelity Entities involving claims for medical malpractice are also subject to final and binding arbitration. A more detailed arbitration provision is included in the Plan Contract or Insurance Policy. My signature below indicates that I agree to submit any dispute to binding arbitration.

Employee signature: _____ Date: _____

“Plan Contract” refers to the Health Net of California, Inc. and/or Dental Benefit Providers of California, Inc. Group Service Agreement and Evidence of Coverage; “Insurance Policy” refers to Health Net Life Insurance Company, Unimerica Life Insurance Company, and/or Fidelity Security Life Insurance Company’s Group Policy and Certificate of Insurance.

Please contact the Health Net Customer Contact Center at the toll-free numbers below if 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	1-866-249-2382
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 Bronze Network, Salud con Health Net HMO, Select (POS), Elect Open Access (EOA), EOA Silver Network, 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 participating 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 participating 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

Pre-existing 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 occurs 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: Health Net Elect, HMO, Salud HMO y Más and Select POS.

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

Dental Benefit Providers of California, Inc. offers the following products: Dental HMO (DHMO).

Unimerica Life Insurance Company offers the following products: Dental PPO and Dental Indemnity.

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.

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card, or employer group applicants please call Health Net's Commercial Contact Center at 800-522-0088. Individual and Family Plan (IFP) or Farm Bureau applicants please call 800-909-3447, option 2. Medicare Supplemental applicants please call 800-926-4178. For more help call the CA Dept. of Insurance at 1-800-927-4357 if you are enrolling in a PPO plan. If you are enrolling in an HMO plan, call the DMHC Helpline at 1-888-HMO-2219.

English

Servicios de Idiomas Sin Costo. Usted puede solicitar un intérprete. Puede solicitar que una persona le lea los documentos y que algunos se le envíen en su idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación; los solicitantes de grupo de empleadores deben llamar al Centro de Comunicación Comercial de Health Net al 800-522-0088. Los solicitantes del Plan Individual y Familiar (IFP, por sus siglas en inglés) o de la Oficina Agrícola, deben llamar al 800-909-3447, opción 2. Los solicitantes de un Plan Suplementario a Medicare deben llamar al 800-926-4178. Para obtener ayuda adicional llame al Departamento de Seguros de California al 1-800-927-4357, si desea inscribirse en un plan PPO. Si usted se inscribe en un plan HMO, llame a la Línea de ayuda de DMHC, al 1-888-HMO-2219.

Spanish

免費語言服務。您可以取得口譯員服務。我們可以把文件朗讀給您聽，部分文件可以翻譯成您的語言並寄送給您。如需協助，請撥打您會員卡上所列的電話號碼，雇主團體申請人請致電 Health Net 的商業聯絡中心，電話 800-522-0088。個人和家庭計畫 (IFP) 或農業局申請人請撥打 800-909-3447，請按 2。Medicare 附加保險申請人請撥打 800-926-4178。若您投保 PPO 計畫，請致電 1-800-927-4357 與加州保險局聯絡，詢求額外協助。若您投保 HMO 計畫，請撥打加州醫療保健計畫管理局 (DMHC) 協助專線，電話 1-888-HMO-2219。

Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch và được người khác đọc giúp các tài liệu bằng ngôn ngữ của quý vị. Để được giúp đỡ, xin gọi chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị. Những người muốn xin bảo hiểm theo nhóm do hãng sở đài thọ xin gọi Trung Tâm Liên Lạc Thương Mại của Health Net tại số 800-522-0088. Những người muốn xin bảo hiểm của Chương Trình Bảo Hiểm Cá Nhân và Gia Đình (IFP) hoặc Farm Bureau, xin gọi số 800-909-3447, bấm số 2. Những người nộp đơn xin Medicare Supplemental (Medicare Phụ Trợ) vui lòng gọi số 800-926-4178. Để được giúp đỡ thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357 nếu quý vị muốn tham gia một chương trình PPO. Nếu quý vị đang tham gia một chương trình HMO, xin gọi Đường Dây Trợ Giúp của DMHC tại số 1-888-HMO-2219.

Vietnamese

무료 언어 지원 서비스. 무료 통역사 서비스 및 여러분에게 편한 언어로 서류 낭독 서비스를 받을 수 있습니다. 도움이 필요하신 분은 본인의 ID 카드상에 적힌 안내 번호로 전화해 주십시오. 고용주 그룹 가입 신청자님의 경우 Health Net의 상업 (Commercial) 고객 서비스 센터, 안내번호 800-522-0088 번으로 전화해 주십시오. 개인 및 가족 플랜 (IFP) 혹은 Farm Bureau 가입 신청자님은 안내번호 800-909-3447번, 옵션 2를 이용해 주십시오. Medicare 보조 보험 가입 신청자님은 안내번호 800-926-4178번으로 전화해 주십시오. PPO 플랜에 가입하신 경우, 더 많은 도움이 필요하신 분은 캘리포니아 보험 담당국 안내번호 1-800-927-4357번으로 문의하십시오. HMO 플랜에 가입하신 경우, DMHC(보건관리부) 헬프라인, 안내번호 1-888-HMO-2219번으로 문의하십시오.

Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa iyong wika ang mga dokumento. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card, o para sa employer group applicants, mangyaring tumawag sa Commercial Contact Center ng Health Net sa 800-522-0088. Para sa Individual and Family Plan (IFP) o Farm Bureau applicants, mangyaring tumawag sa 800-909-3447, opsyon 2. Para sa Medicare Supplemental na mga aplikante, mangyaring tumawag sa 800-926-4178. Para sa karagdagang tulong, tumawag sa CA Dept. of Insurance sa 1-800-927-4357 kung ikaw ay nag-eenroll sa isang PPO plan. Kung ikaw ay nag-eenroll sa isang HMO plan, tawagan ang DMHC Helpline sa 1-888-HMO-2219.

Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման և տպագրել կամ փաստաթղթերը ընթերցել տալ ևեզ համար ևեք լեզվով: Օգնության համար մեզ զանգահարեք ևեք ինքնության (ID) տուսի վրա նշված համարով, կամ եթե գործատիրոջ խմբի դիմորդ եք, խնդրում ենք 800-522-0088 համարով զանգահարել Health Net-ի Հաճախորդի Կապի Կենտրոն: Անհատական և Ընտանեկան Ծրագրի (Individual and Family Plan/IFP) դիմորդներից խնդրվում է զանգահարել 800-909-3447 համարով, ընտրանք 2: Լրացուցիչ Medicare-ի դիմորդներից խնդրվում է զանգահարել 800-926-4178 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆոռնիայի Ապահովագրության Բաժանմունք, եթե գրանցվում եք PPO ծրագրում: Եթե գրանցվում եք HMO ծրագրում, 1-888-HMO-2219 համարով զանգահարեք DMHC-ի Օգնության գծին:

Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и вам могут прочесть документы на вашем языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте. Участники плана группового страхования по месту работы могут обратиться в коммерческий контактный центр компании Health Net по телефону 800-522-0088. Участники планов индивидуального или семейного страхования (Individual and Family Plan, IFP), а также планов страхования Фермерского бюро: пожалуйста, звоните по номеру 800-909-3447, добавочный 2. Участников плана Medicare Supplemental просим звонить по номеру 800-926-4178. Если вы участвуете в плане системы предпочтительного выбора (Preferred Provider Organization, PPO), для получения дополнительной помощи звоните в Департамент страхования штата Калифорния по телефону 1-800-927-4357. Если вы состоите в плане организаций медицинского обслуживания (Health Maintenance Organizations, HMO), пожалуйста, звоните в горячую линию Департамента организованного медицинского обслуживания (DMHC) по телефону 1-888-HMO-2219.

Russian

