

Enrolling is Simple. Just Follow These 3 Easy Steps...

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department

at: (949) 394-7676 fax: (949) 203-8786

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly

Step 3

SEND THE COMPLETED APPLICATION TO:

Cal-Health-Plans
1300 Park Newport, Suite 415
Newport Beach, CA 92660

Please make your check payable to: Health Net

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

If you have questions please contact our office at: (949) 394-7676

Thank you for choosing...





Health Net

Individual & Family Enrollment Application

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

Requested Effective Date

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

Grid for Requested Effective Date

THE APPLICATION MUST BE COMPLETED BY THE APPLICANT.

A. Reason for Application
B. Billing options (please choose for both medical and life)

C. Choice of coverage
Health Net of California
Health Net Life Insurance Company

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

Primary Applicant's Last Name, First Name, MI, Home Address, City, State, Zip, County applicant resides in, Home Phone Number, Work Phone Number, Email address, Primary Applicant's Birth Date, Primary Applicants Social Security Number, Height, Weight (lbs), Primary Care Physician ID #, Current Patient, Physician Group ID #, Type of Business, Occupation, Salary Range, Would you be interested in other Health Net or affiliated entities products and services?, In the past 6 months, have you been a resident of the United States?, How did you hear about Health Net's Individual and Family coverage?

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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 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 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 (lbs)	Primary Care Physician ID #*	Current Patient	Physician Group ID #*
<input type="checkbox"/> Husband <input type="checkbox"/> Wife	Spouse/Domestic Partner			- -	/ /				<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/domestic partner, or female dependent, whether or not listed on the application, currently pregnant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	5) Have you or any applying family member ever had any signs or symptoms of, consulted a medical practitioner, received advice from a medical practitioner, sought treatment from a medical practitioner, had treatment recommended by a medical practitioner, received treatment from a medical practitioner, or been hospitalized for any of the following conditions? 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? 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? 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"/>
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"/>			

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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, unintentional weight loss 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/Domestic Partner _____	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 health care practitioner 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? Yes <input type="checkbox"/> No <input type="checkbox"/> If "No", please explain: _____	13) A. (i) Have you had a menstrual period in each of the last six months, including within the last 30 days? Yes <input type="checkbox"/> No <input type="checkbox"/> If "No", please explain: _____
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, condition, treatment, or recommendation	Still under treatment? Yes/No	Dates of treatment, Hospitalization (Mo/Yr):		Full name, address, & telephone number 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 visit	Result of Visit	Full name, address, & telephone number of every physician, clinic, or hospital (include ZIP code)

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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	Prescribing Physician	Most Recent Refill Date	Strength (No. of milligrams)	Dosage & Frequency (How many pills & how often take)	Number of refills per year

PART V. Prior health coverage

A. During the previous 62 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. 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): _____

C. HIPAA Coverage

You may be considered for coverage under the HIPAA plans. The plan does not require medical underwriting and the rates are higher compared to the other Individual Plans. If you qualify please request the complete benefit details and rates. If you meet every condition below you are eligible for guaranteed issue in accordance with HIPAA.

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? 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 No

If Yes, start date _____ End Date: _____

If Yes, did you accept and exhaust all benefits that were available? Yes No

If No, 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

Primary's Social Security Number

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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) _____

Under the penalty of perjury I attest that, I translated the contents of the Individual & Family Enrollment Application and fully explained Part IX of the Individual & Family Enrollment Application, "Conditions of Enrollment." To the best of my knowledge I obtained and listed all the requested personal and medical history disclosed by:

_____ (Name of applicant)

Signatures and date (required in ink)

SIGNATURE of APPLICANT		Today's Date
SIGNATURE of TRANSLATOR		Today's Date
TRANSLATOR'S NAME (PRINT)		TRANSLATOR'S PHONE NUMBER
TRANSLATOR'S ADDRESS		
TRANSLATOR'S CITY	STATE	ZIP

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: _____	Sub – Agent ID _____ (Must be completed only if Sub-Agent Agreement is approved)
Name (Print) _____	Phone number: _____
Address _____	Fax Number: _____
_____	Email address: _____ / /
Writing Agents Signature/Number (Required) _____	Date Signed (required) _____
Writing Agent Certification Are you aware of any information not disclosed in this application that might have a bearing on the risk? If "Yes," please explain: _____ _____	Yes No <input type="checkbox"/> <input type="checkbox"/> Did you personally see the applicant signing the application (includes spouse/domestic partner, if applying)? Yes No <input type="checkbox"/> <input type="checkbox"/>

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 or only a 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.

Primary's Social Security Number

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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 from the Subscriber (or from You or from the applicant) 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.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: I acknowledge and understand that health care providers may disclose health information about me or my dependents, including information regarding substance abuse, mental/emotional conditions, AIDS (Acquired Immune Deficiency Syndrome), or ARC (AIDS-Related Complex) 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 Plan Contract and Insurance Policy, and that I may also obtain a copy of this Notice on the website at www.healthnet.com or through Health Net Member Services.

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 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 6, PART VII of this Application).

PART X. 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. 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.

ACKNOWLEDGEMENT AND AGREEMENT: I, the applicant, 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 the terms, conditions and provisions of the Plan Contract or Insurance Policy. 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 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 or 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. My signature below indicates that I understand the terms of this Binding Arbitration Clause and agree to submit disputes to binding arbitration.

Agreeing to the Arbitration & signing your name below constitutes your signature. Health Net reserves the right to cancel, rescind, or terminate any policy where this arbitration clause was signed by anyone other than the applicant. Neither Broker nor any other person may sign this Arbitration Agreement.

Applicants' Signatures (the applicant must personally sign his/her name and agree to the Arbitration Clause in order for the application to be processed) **Required in ink**

Family Contact's if different than Primary Applicant Name	Date Signed
APPLICANT or CASE CONTACT'S SIGNATURE	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

Make personal check payable to "Health Net"

Return Completed Application to: Health Net Individual and Family Enrollment, Post Office Box 1150 Rancho Cordova, California 95741-9847

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. "Plan Contract" refers to the Health Net of California, Inc. Combined Contract and Evidence of Coverage; "Insurance Policy" refers to Health Net Life Insurance Company Explanation of Your Insurance Plan, Health Net PPO Policy.



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.)*

Automatic Bank Draft (ABD) transmissions are submitted to the 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, you premium should be submitted with your request for ABD, and/or manual payment should continued to be remitted to Health Net, until such time that you receive confirmation of ABD commencement in writing from Health Net.

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 \$15 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 (Required to Process)	Date
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CREDIT CARD First month's payment 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.

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 (complete)	Expiration Date (mm/yyyy)	*Signature Panel Code	Cardholder's email address
Billing Address	City	State	Zip¹

***Signature Panel Code can be found on the back of your credit card. This 3-4 digit code is usually the last three digits located in the signature panel. This information is required in order for the credit card to be processed**

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. 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. *(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 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 \$15 service charge for each occurrence. Credit card transmissions are submitted to the bank approximately the 20th of every month, for the following month's premium.

¹The zip code must match the cardholders address otherwise the credit card cannot be processed.

SIGNATURE of CREDIT CARD ACCOUNT HOLDER (Required to Process)	Date
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Authorization for Use or Disclosure of Information for Enrollment

This authorization for use or disclosure of personal health information is being requested by Health Net to comply with the terms of federal HIPAA Privacy Rules. A copy of this form is as valid as the original.

THIS AUTHORIZATION FORM MUST BE COMPLETED IN ORDER TO ENABLE HEALTH NET TO UNDERWRITE YOUR COVERAGE. THE ENROLLMENT PROCESS CANNOT BE COMPLETED WITHOUT YOUR EXPRESS AUTHORIZATION WHICH IS MORE FULLY DESCRIBED BELOW. THIS FORM MUST BE SIGNED BY THE APPLICANT AND EACH ADULT FAMILY MEMBER APPLYING FOR COVERAGE (including dependents age 18 and over).

Applicant and Family Members Requesting Enrollment:

Applicant Name	Social Security Number:
Spouse Name	Social Security Number:
Dependent (age 18 or older)	Social Security Number:
Dependent (age 18 or older)	Social Security Number:

I, _____, _____,
 (applicant print name) (spouse print name)
 _____, _____,
 (adult dependent print name) (adult dependent print name)

hereby authorize the use or disclosure of personal health information as described below. Additional adult dependents may be listed below.

As the applicant/parent, I, (print name) _____, authorize the use or disclosure of personal health information about my minor dependent(s), age 17 and under, as described below:

_____, _____, _____,
 (print dependent'(s) name)
 _____, _____, _____.

- Person(s) or group of persons authorized to disclose the information to Health Net include:
 - Any medical professional, hospital, or other healthcare facility, clinic, pharmacy, insurer or health benefit plan administrator, Medicare or Medicaid, or any other health care provider or health plan that has medical information about me or my dependent(s);
 - Health care providers or health plans indicated in my application for coverage or on my dependents' applications for coverage, or identified by me during a health history interview in regard to myself or my dependent(s), or identified by me or my dependent(s) to my agent, or any other healthcare provider or health plan referred to in my medical records or my dependent(s) medical records. Medical records include information concerning treatment for alcohol abuse, substance abuse, mental or emotional disorders (excluding psychotherapy notes), AIDs (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex).
- I authorize the following person(s) or group of persons to receive the information disclosed by one of the persons or organizations listed in paragraph 1 above, and to use that information and the information included on my application for coverage to underwrite and rate the health plan coverage for which I have applied:
 - Health Net and its affiliates including, but not limited to, its agents, underwriting operations, claims operations, legal representatives, its Medical Director or his/her designees, and its sales and

marketing operations. I understand that Health Net may condition my or my dependents' enrollment in the health plan on my signing this Authorization and initialing this paragraph 2.

Applicant ____ Spouse ____ Dependent ____ Dependent ____

3. Description of the information that may be used or disclosed includes:
All health information pertaining to me or my minor dependent(s), if applicable, related to the diagnosis, treatment or prognosis with respect to any physical, accident, illness, medical or mental condition, except psychotherapy notes, and any other related information, including but not limited to, the information provided on my application.
4. I understand that if this Authorization is for disclosures to someone other than Health Net, personal health information disclosed may be subject to re-disclosure by the recipient, in which case it would no longer be protected by federal Privacy Rules. However, Health Net is subject to federal Privacy Rules and any information Health Net receives is protected by these Rules.
5. I understand that my enrollment in Health Net's health plan may be conditioned on my signing this Authorization and initialing paragraph 2. I understand that I may refuse to initial paragraph 2 of this Authorization, and that such refusal could affect my enrollment in the health plan or eligibility for benefits under the health plan.
6. If the person completing this Authorization is the personal representative of the applicant or dependent, describe your authority to act on this person's behalf.

7. As described in the "Notice of Privacy Practices", I understand that I may revoke this Authorization in writing at any time, except to the extent that action has been taken by Health Net and its subsidiaries and affiliates in reliance on this Authorization. I may send a written and dated revocation to Health Net to: Health Net Privacy Office, 21650 Oxnard Street, Ste. 2125, Woodland Hills, CA 91367. Health Net's "Notice of Privacy Practices" is available on the Health Net website at www.healthnet.com or will be provided to me in writing upon request.
8. I understand that either I am, or my personal representative is, entitled to receive a copy of my signed Authorization and by my signature below, I acknowledge that I have been provided with a copy.
9. This authorization will remain valid for thirty (30) months from the date the authorization form is signed as to Health Net's determination on enrollment.

Signatures (required in ink)

APPLICANT'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
PERSONAL REPRESENTATIVE'S NAME, IF APPLICABLE (Print)	
PERSONAL REPRESENTATIVE'S SIGNATURE	Date Signed