



HEALTH NET® Individual Enrollment Application

Requested Effective Date

/ 01 /

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

A. Complete the following

FAMILYTYPE

- Self
- Self & Spouse
- Self & Child Process as separate policies
- Self & Children
- Self, Spouse and Child(ren)

ENROLLMENTTYPE

- New Enrollment Change Plan** Add Dependent**

**Member ID number (listed on your ID card):

B. Billing options (please choose one)

- Quarterly (no administrative charge)
- Monthly (electronic funds transfer--no administrative charge)
If chosen, attach a completed Simple Pay Option form
- Monthly (billed--\$5 administrative fee)

C. Choice of coverage

Health Net, California's Health Plan

- HMO 15
- HMO 40

- HMO 15 Plus
(includes dental and vision coverage)

Primary Dentist Number

Health Net Life Insurance Company

- Value PPO 20
- Value PPO - No Deductible
- Value PPO 2500
- Value PPO 500
- Value PPO 1000

PART II. Primary applicant information

(Note: For the most favorable rate, make the younger spouse the primary applicant.)

Last Name _____ First Name _____ MI _____

Home Address _____

City _____ State _____ ZIP _____

County Resides In _____ Social Security Number _____ - _____ - _____

Birth Date _____ / _____ / _____ Home Phone Number _____ - _____ - _____

Work Phone Number _____ - _____ - _____ Fax Number _____ - _____ - _____

E-mail Address _____

Occupation _____

PART III. Applicant/family member to be enrolled

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

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

SELF (Primary)

Male Female Height _____ ft. _____ in. Weight _____ lbs. Primary Care Physician ID Number* _____ Existing Patient Physician Group ID Number* _____

17533



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

Primary's Social Security Number

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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 member been a patient in a hospital, clinic, surgicenter, sanatorium or other medical facility as an inpatient or outpatient?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4)	Are you or any applying family member eligible for Medicare benefits as a result of disability or chronic illness?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5)	Have you or any applying family member ever had any signs or symptoms, been consulted for, received advice, sought treatment, had treatment recommended, received treatment or been hospitalized for the following conditions? If "Yes", please list the specific condition and provide requested details in section IV (b).		
A.	Chest pain, high or low blood pressure, heart disease, heart murmur, palpitations or irregular heart beat, peripheral vascular disease, blood clot, phlebitis, varicose veins, blood disorder, anemia, enlarged lymph nodes, or any other heart, cardiovascular, or circulatory disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
B.	Headaches, dizziness, paralysis, stroke, loss of consciousness, seizure disorder, sleep apnea, multiple sclerosis, cerebral palsy, or any other disorder of the brain or nervous system?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
C.	Disorder of the mouth, throat or esophagus, tonsillitis, ulcers, colitis, ulcerative colitis, spastic colitis, Crohn's disease, gall bladder disorder, chronic diarrhea, hernia, hemorrhoids, hepatitis, pancreatitis, intestinal or rectal problems, liver disease, cirrhosis, stomach disorder, or any other disorder of the digestive system?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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? (i) If "yes", have you been hospitalized or been to an emergency room in the past 24 months? (ii) 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, or any other disorder of the musculoskeletal system?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

H.	Jaw problems, temporalmandibular 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, AIDS, 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, otitis, disorder of the nose or breathing, deviated nasal septum?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
M.	Nervous, mental, or emotional 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.	Alcoholism, alcohol, drug or substance abuse?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
O.	Premature birth, developmental delay, congenital abnormalities, club foot, 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 consulted a provider for any condition or symptom(s) for which a diagnosis has not been established?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7)	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"/>
8)	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"/>
9)	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"/>



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

Primary's Social Security Number

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10) Is the applicant or any applying family member currently taking medication? If "Yes", please complete section IV (b).
 Yes No

11) Has the applicant of 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 No

Female applicant's only (applicable to all females listed on the application)

<p>Applicant Name: _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>12) A. (i) Do you menstruate? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(ii) Date of first day of last menstrual period (Mo/Dy/Yr:) ____/____/____</p> <p>(iii) Average number of days from first of menstrual period to first day of next period _____</p> <p>B. (i) Have you had a pelvic exam? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>(ii) Date of last pelvic exam (Mo/Dy/Yr:) ____/____/____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>(iii) Were the results of the exam normal? If "No", please explain _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Applicant Name: _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>12) A. (i) Do you menstruate? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(ii) Date of first day of last menstrual period (Mo/Dy/Yr:) ____/____/____</p> <p>(iii) Average number of days from first of menstrual period to first day of next period _____</p> <p>B. (i) Have you had a pelvic exam? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>(ii) Date of last pelvic exam (Mo/Dy/Yr:) ____/____/____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>(iii) Were the results of the exam normal? If "No", please explain _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p>
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PART IV (b). Statement of health -- If you answered "Yes" to any questions in Section IV (a), please list condition(s) and explain in FULL DETAIL below. If additional space is necessary, please attach extra pages.

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

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

Name of individual	Date of visit	Reason for and results of visit	Name, phone number and address of a attending physician

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

Name of individual	Condition	Name of medication	Dosage and frequency (list last refill date)	Name, phone number and address of a attending physician



Primary's Social Security Number

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PART V. Other health coverage

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

If "Yes",

Current Carrier

□□□□□□□□□□□□□□□□□□□□□□

Effective Date

□□ / □□ / □□□□

Termination Date

□□ / □□ / □□□□

Type of coverage:

- Individual & Family HMO Group HMO
- Individual & Family PPO Group PPO
- Disability, Short Term, or Interim
- Other _____

Benefit Level (deductible, coinsurance, etc):

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

If "Yes", provide name of applicant, company name and a brief explanation: _____

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

If "Yes", former Health Net or Foundation Health Member name: _____

Member ID Number (listed on your ID card):

□□□□□□□□□□□□□□□□

Group Number (listed on your ID card): _____

How did you hear about Health Net's Individual and Family plan?

- Radio Billboard Newspaper YellowPages Broker Internet Other _____

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

Health Net Writing Agent Number

□□□□□□□□

Federal Tax ID: _____

Office Assigned Number: _____

Name and Address: _____

Phone Number: _____

Fax Number: _____

E-mail Address: _____

Writing Agent's Signature _____

□□ / □□ / □□□□

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? Yes No

If "Yes", please explain: _____

Did you personally see the applicant (and spouse, if applying) at the time this application was executed? Yes No



Primary's Social Security Number

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VII. Conditions of enrollment

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

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

IF SOLE APPLICANT IS MINOR: If the sole Applicant under this application is under 18 years of age, the Applicant's parent or legal guardian must sign as such. In such event, the parent or legal guardian does hereby agree to be legally responsible for the accuracy of information in this Application and for payments of premiums. If such responsible party is not the natural parent of the Applicant, copies of the court papers authorizing guardianship must be submitted with this Application.

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

VIII. Important provisions

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

MANDATORY BINDING ARBITRATION: As more fully set out in the Plan Contract and Insurance Policy, I agree that binding arbitration is the final process for the resolution of any dispute arising out of or relating to the Plan Contract or Insurance Policy, whether involving a claim in tort, contract or otherwise (not including claims of medical malpractice), involving myself and/or any family member and Health Net (including any of its agents or employees). By enrolling with or accepting services from Health Net, Members waive their constitutional right (or any such right) to a trial before a jury or judge. Any dispute alleging the medical malpractice, negligence and/or wrongful act of a health care provider, shall not include Health Net and shall include only the provider subject to the allegation.

Family Contact's Last Name, if different than Primary Applicant

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First Name

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APPLICANT or CASE CONTACT'S SIGNATURE (in ink)

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Date Signed (required)

SPOUSE'S SIGNATURE (in ink)

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Date Signed (required)

SIGNATURE OF APPLICANT'S DEPENDENT (age 18 or older)

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Date Signed (required)

Make personal check payable to "Health Net"

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





Monthly Automatic Payment for Individual & Family Plans

If you so choose, you can have your monthly premium charged directly to your personal checking account. The premium will be withdrawn from your bank account about ten days in advance of the due date. If you wish to use this option, complete the instructions below.

Instructions

- 1. Fill out and sign this form. Please use black ink.
2. Attach a blank check from your personal checking account and write "void" on it. We will use it as a record of your checking account number. Do not submit your deposit slip.
3. We will communicate with your bank to direct them to honor this authorization.
4. Send a personal check for the first month's premium.
5. If you are returning this authorization separately from your Individual & Family enrollment application, please mail to: Health Net, Individual & Family Enrollment, Post Office Box 2066, Rancho Cordova, California 95741-2066

Applicant's Social Security Number

Form for Social Security Number: three boxes, dash, two boxes, dash, five boxes

Transit Routing Number

Form for Transit Routing Number: nine boxes

Account Number

Form for Account Number: sixteen boxes

Bank Name

Form for Bank Name: sixteen boxes

Bank Address

Form for Bank Address: thirty-two boxes

City

Form for City: sixteen boxes

State

Form for State: two boxes

ZIP

Form for ZIP: five boxes

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 agree that Health Net's rights in respect to each such check shall be the same as if it were a check written to Health Net and signed personally by me. This authority is to remain in effect until revoked by me in writing and until Health Net actually receives such notice, I agree that Health Net shall be fully protected in honoring any such check. (Note: A 30-day notice is required to discontinue this service due to the time required to initiate this change with your bank.)

I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, Health Net shall be under no liability whatsoever even though such dishonor may result in the forfeiture of health coverage.

Signature of account holder

Form for Date: two boxes, slash, two boxes, slash, four boxes

Date

Be sure to include a voided check for the account from which you wish your premiums to be deducted.

I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor may result in the forfeiture of health coverage.





If necessary, please use this form in addition with the Individual Enrollment Application. List your additional dependents below:

Primary Applicant's Social Security Number

____ - ____ - _____

Primary Applicant's Last Name

First Name

MI

Child's Last Name

Child's First Name

MI

Male

Height

Weight

Primary Care Physician (PCP #)*

Existing Patient

Female

ft.

in.

lbs.

Child's Date of Birth

____ / ____ / _____

Full Time Student

Yes No

Units Carried

Primary Medical Group (PMG #)*

Social Security Number

____ - ____ - _____

Name of School

Child's Last Name

Child's First Name

MI

Male

Height

Weight

Primary Care Physician (PCP #)*

Existing Patient

Female

ft.

in.

lbs.

Child's Date of Birth

____ / ____ / _____

Full Time Student

Yes No

Units Carried

Primary Medical Group (PMG #)*

Social Security Number

____ - ____ - _____

Name of School

Child's Last Name

Child's First Name

MI

Male

Height

Weight

Primary Care Physician (PCP #)*

Existing Patient

Female

ft.

in.

lbs.

Child's Date of Birth

____ / ____ / _____

Full Time Student

Yes No

Units Carried

Primary Medical Group (PMG #)*

Social Security Number

____ - ____ - _____

Name of School

Child's Last Name

Child's First Name

MI

Male

Height

Weight

Primary Care Physician (PCP #)*

Existing Patient

Female

ft.

in.

lbs.

Child's Date of Birth

____ / ____ / _____

Full Time Student

Yes No

Units Carried

Primary Medical Group (PMG #)*

Social Security Number

____ - ____ - _____

Name of School

