SMALL BUSINESS EMPLOYEE ENROLLMENT FORM

Welcome to Health Net Small Business Plans.

Post Office Box 9103
Van Nuys, California 91409-9103
www.health.net

If you have any questions or need assistance completing this form, please contact Member Services:

Small Business Group	1-800-361-3366
Salud Con Health Net	1-800-331-1777

Health Net of California, Inc. offers the following products: ELECT Open Access, HMO, and SELECT POS.
Health Net Life Insurance Company offers the following products: EPO, Flex Net, PPO, Life and AD&D insurance.
SafeGuard Health Plans, Inc. offers the following products: Dental HMO (DHMO) and DHMO Ortho Rider.
SafeHealth Life Insurance Company offers the following products: PPO Dental, Indemnity Dental, Indemnity Ortho Rider.
Fidelity Security Life Insurance Company offers the following products serviced by EyeMed Vision Care, LLC: PPO Vision.

6007293 (1/04)

6005512 (6/03) :LGL

CHECK THE DESIRED PLAN AS OFFERED BY EMPLOYER:

MEDICAL PLAN	DENTAL PLAN	VISION PLAN
WRITE THE PLAN NUMBER NEXT TO THE PRODUCT	WRITE THE PLAN NUMBER NEXT TO THE PRODUCT	WRITE THE PLAN NUMBER NEXT TO THE PRODUCT
❑ HMO________	❑ PPO________	❑ PPO________
❑ Elect Open Access________	❑ HMO________	
❑ Select 3-Tier POS________	❑ Indemnity________	
❑ PPO________		
❑ Flex Net (Indemnity)________		
❑ Salud Con Health Net________		

❑ New Enrollment
❑ New Hire
❑ Rehire/Re-Enrollee
❑ Late Enrollment (Loss of coverage)
❑ Cobra Eff. Date__________
❑ Qualifying Event__________ Date of Event__________
❑ Change Coverage
❑ Add Dependent
❑ Change Dependent

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 plans are provided by SafeGuard Health Plans, Inc. and/or its affiliate, SafeHealth Life Insurance Company, (together the "SafeGuard Entities"). Vision plans are provided by Fidelity Security Life Insurance Company and serviced by Eyemed Vision Care LLC (together the "Fidelity Entities").

Neither the SafeGuard 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.

IMPORTANT: PLEASE PRINT ALL SECTIONS IN BLACK INK.

1 YOUR EMPLOYER COMPLETES THIS SECTION

Company Name	Medical Group Number	FT/Date of Hire	Effective Date

2 YOUR EMPLOYER COMPLETES THIS SECTION (IF APPLYING FOR GROUP LIFE AD&D)

Effective Date	Annual Salary	Occupation	Life Class	Life/AD&D Amount

3 YOU COMPLETE SECTIONS 3-9 Note: Even if you are declining coverage, you must complete Sections 3 and 9

Last Name	First Name	M.I.	Marital Status ❑ Single ❑ Married
Social Security Number	Employment Status ❑ Salaried ❑ Hourly	Job Title	
Residence Mailing Address (Number, Street, Apartment, City)		State	Zip
Home Telephone ( )	Work Telephone ( )	E-mail address	Have you or any of your dependents ever been a Health Net member? ❑ Yes ❑ No Have you or any of your dependents waived Health Net coverage in the past 12 months? ❑ Yes ❑ No

NOTE: Please complete the entire enrollment form. This form cannot be processed if information is incomplete. Dependents age 19 up to 23rd birthday require proof of full-time student status or permanent disability status within 31 days of enrollment.

4 EMPLOYEE/DEPENDENT ENROLLMENT INFORMATION

Please list eligible applicants to be enrolled below, HMO, ELECT Open Access and SELECT 3-Tier (POS) members must reside within the geographic service area established by Health Net to assure reasonable access to care. If you have more than three dependents, please attach an additional Enrollment Form.

If applying for HMO, ELECT Open Access and SELECT 3-Tier (POS) please choose a Physician group within 15-30 mile radius of residence or job site for each memberof your family by entering the names and numbers in the area below. For a listing of physicians you may visit our website at www.health.net, or review the Health Net Small Business Plans Provider Directory. You may choose a different Physician group and Primary Care Physician for each family member. If the group you've selected has an "X" after the number (e.g., IPA 135X), indicate a Primary Care Physician for yourself and each family member enrolling in that group. **Questions? Call Health Net Member Services at 1-800-361-3366** or for Salud con Health Net **1-800-331-1777.**

If applying for dental HMO coverage please choose a dental provider for each member of your family by entering the dental provider ID number in area below. You may locate a provider within the provided dental directory or call Health Net Dental member services at **1-800-880-8113.** If you are enrolling in the Dental HMO plan, you MUST indicate a dental provider ID. If a dental provider ID is not indicated, you and your Dependent(s) will be automatically assigned to a dental provider.

Please Note: Dependents are only eligible for coverage selected by the subscriber. You must indicate coverage type(s) for each dependent.

For HMO, ELECT, ELECT Open Access and SELECT POS and Dental HMO Plans Only

Name / Address Last – First – M.I. (If Different) Address – City – State – Zip	Telephone Numbers (If Different)	Relationship	Sex M / F	Date of Birth (Mo-Day-Yr)	Social Security Number or Matricula Consular ID#		Physician Group (PPG) number, Primary Care Physician (PCP) and Dental HMO Provider ID number	Existing Patient Y = YES N = NO
	Home Work	SELF				**Review the Health Net Provider Directory and choose a Participating Physician Group and Primary Care Physician for each family member.**	PPG ID Number PCP Name and ID Number Dental HMO Provider ID Number	
❑ MEDICAL ❑ DENTAL ❑ VISION								
	Home Work	SPOUSE					PPG ID Number PCP Name and ID Number Dental HMO Provider ID Number	
❑ MEDICAL ❑ DENTAL ❑ VISION								
	Home Work	DEPENDENT				Disabled ❑ Full-time Student ❑ Over 50% support ❑	PPG ID Number PCP Name and ID Number Dental HMO Provider ID Number	
❑ MEDICAL ❑ DENTAL ❑ VISION								
	Home Work	DEPENDENT				Disabled ❑ Full-time Student ❑ Over 50% support ❑	PPG ID Number PCP Name and ID Number Dental HMO Provider ID Number	
❑ MEDICAL ❑ DENTAL ❑ VISION								

5 GROUP TERM LIFE INSURANCE If Applicable *(Attach separate sheet for additional or contingent beneficiaries)*

Life coverage ❑ Yes ❑ No If yes, I am applying for ❑ Basic Life/AD&D $__________________ ❑ Dependent Life $____________________

Life Beneficiary (Full Name)	Relationship	%
Life Beneficiary (Full Name)	Relationship	%

6 DISABILITY INFORMATION

1. Do you believe that you or any family member for whom you are applying for coverage would be considered totally disabled according to the definitions of disability given on the back of this application?

❑ Yes ❑ No If yes, who?____

Disabling Condition(s)____ Date Disability Commenced______________

7 ACCEPTANCE OF COVERAGE (Signature required)

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 Entities, the SafeGuard Entities and/or Fidelity Entities. Health Net Entities, the SafeGuard Entities and/or 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 Health Net Entities. I may also obtain a copy of this Notice on the web site at www.health.net or through Health Net Member Services.

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 SafeGuard 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.

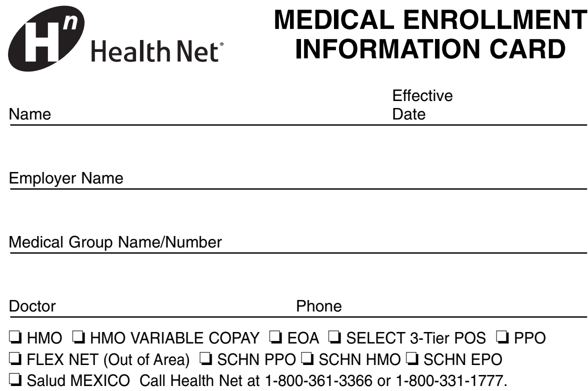
Arbitration Agreement: I understand and agree that any and all disputes or disagreements between Group (or enrolled members) and the Health Net Entities, the SafeGuard Entities and/or the Fidelity Entities regarding the construction, interpretation, performance or breach of the Health Net Entities, the SafeGuard Entities and/or the Fidelity Entities Group Policies, or regarding other matters relating to or arising out of the Health Net Entities, the Safeguard Entities and/or the Fidelity Entities Group Policies, whether stated in tort, contract or otherwise, 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 SafeGuard Entities and/or the Fidelity Entities are giving up their constitutional rights to the extent permitted by law to have their dispute decided in a court of law before a jury. I also understand that disputes with the Health Net Entities, the SafeGuard Entities and/or the Fidelity Entities involving claims for medical, services 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 Health Net Entities, the SafeGuard Entities and/or the Fidelity Entities Group Policies.

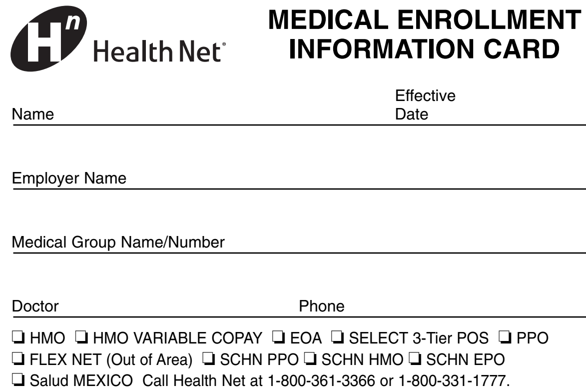
Effective July 1, 2002, members who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. § 1001 et seq., a federal law regulating benefit plans, are not required to submit disputes about certain "adverse benefit determinations" made by Health Net Entities, the SafeGuard Entities and/or the Fidelity Entities to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by Health Net Entities, the SafeGuard Entities and/or the Fidelity Entities to deny, reduce, terminate or not pay for all or a part of a benefit. However, I and Health Net Entities, the SafeGuard Entities and/or the Fidelity Entities may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

Employee signature:____ **Date:**______________________________

(see back side of form for more questions)

Welcome to Health Net. Please complete these temporary Enrollment Information Cards and keep until you receive your permanent ID card.





8 OTHER HEALTH INSURANCE

1. Is anyone listed in Section 4 on previous page eligible for Medicare? ❑ Yes ❑ No If yes, who?____

2. Are you or have you and/or any of your eligible family members been covered by other medical coverage within the last six months?

   ❑ Yes ❑ No If yes, complete the section below. Please list all current or prior medical coverage. **Failure to provide complete information may result in significant delay of claims processing.** (Attach additional sheets if necessary)

Covered Person's Name Last – First – M.I.	Policy Holder Name(s)	Insurance Company Name(s)	Type of Coverage	Policy No.	Effective Date	Termination Date
			❑ Health ❑ Other ______________			(If Applicable)
			❑ Health ❑ Other ______________			

Coverage under PPO, EPO or Flex Net may be subject to pre-existing condition limitations for certain enrollees. Please see the back of this form for additional information.

9 DECLINATION OF COVERAGE (Complete this section if any coverage is to be declined by you or your eligible dependents.)

Declining Medical coverage for: ❑ Self ❑ Spouse ❑ Dependent(s)

❑ I am covered under another group health benefit plan offered by ANOTHER employer (i.e., spouse's employer)

❑ I am covered under another group health benefit plan offered by MY employer

❑ Other: ____

I am declining for my spouse, name:____

I am declining for my child/children, name(s):____

Declining Vision Coverage for: ❑ Self ❑ Spouse ❑ Dependent(s)

Declining Dental Coverage for: ❑ Self ❑ Spouse ❑ Dependent(s)

The available coverage's have been explained to me by my employer. I have been given the chance to apply for the available coverage. 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**__________________

(ONLY IF DECLINING COVERAGE; If signed in error, please cross out and initial)

Preexisting Conditions and Creditable Coverage - Your coverage under this benefit plan may be subject to preexisting 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 Entities 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 credit-able coverage at enrollment time, Health Net Entities may provide assistance in obtaining the necessary documentation upon request. Note: Prior coverage which is interrupted by a period of 63 days (181 days if coverage through employment has ended.) or more does not qualify as creditable coverage.

Disabling Conditions

If you or a family member were disabled as of the date of termination of coverage with a prior health insurer, you may be entitled to an extension of health benefits according to California Insurance Code § 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 the prior insurer.

Total disability, as it relates to the law described above, means: Employee: when, as a result of bodily injury or disease, the employee is unable to engage in any employment or occupation for which he or she is or becomes qualified for by reason of education, training or experience and is not, in fact, engaged in any employment or occupation for wage or profit. Family member: when the family member is prevented from performing all regular and customary activities usual for a person of that age.

Please answer the questions as completely as possible to avoid delay in the processing of your application.

MEDICAL ENROLLMENT INFORMATION CARD

Additional Enrollees Covered

Name ______________________

Doctor ______________ Phone ______________

Name ______________________

Doctor ______________ Phone ______________

Name ______________________

Doctor ______________ Phone ______________

Coverage shall not begin until acceptance of your application by Health Net of California, Inc. or Health Net Life Insurance Company. Upon acceptance of your application, Health Net shall be bound by the terms of the Agreement and any Amendments thereto.

MEDICAL ENROLLMENT INFORMATION CARD

Additional Enrollees Covered

Name ______________________

Doctor ______________ Phone ______________

Name ______________________

Doctor ______________ Phone ______________

Name ______________________

Doctor ______________ Phone ______________

Coverage shall not begin until acceptance of your application by Health Net of California, Inc. or Health Net Life Insurance Company. Upon acceptance of your application, Health Net shall be bound by the terms of the Agreement and any Amendments thereto.

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