Health Net® Health Net® LIFE INSURANCE COMPANY

MEMBER ENROLLMENT AND CHANGE FORM

EMPLOYER NAME

COVERAGE EFFECTIVE DATE | EMPLOYER GROUP NUMBER *(Medical)*

IMPORTANT – Please print all sections in black ink. For the application to be valid you must submit all applicable pages.

1 SELECTED COVERAGE

1a: CHECK THE DESIRED PLAN AS OFFERED BY YOUR EMPLOYER:

MEDICAL PLAN (write the plan number next to the product, if known)

- ☐ HMO: _____
- ☐ HMO Bronze Network: _____
- ☐ HMO Silver Network: _____
- ☐ HMO Variable Copay: _____
- ☐ HMO y Más: _____
- ☐ Elect Open Access℠ (EOA): _____
- ☐ EOA Silver Network: _____
- ☐ Elect (POS): _____
- ☐ EPO: _____
- ☐ FLEX NET (Indemnity): _____
- ☐ PPO: _____
- ☐ PPO HSA: _____
- ☐ Out-Of-State PPO (OOS PPO): _____
- ☐ Out-Of-State PPO HSA: _____
- ☐ Salud con Health Net®: _____
- ☐ SELECT (POS): _____
- ☐ SELECT 3-tier POS: _____
- ☐ Other: _____

Complete sections 1b /1c only if Health Net will be your dental and/or vision provider.

1b: DENTAL PLAN (choose one)
(write the plan number next to the product)

- ☐ HMO: _____
- ☐ PPO: _____
- ☐ Indemnity: _____

1c: VISION PLAN
(write the plan number next to the product)

- ☐ PPO: _____

REASON FOR APPLICATION:

- ☐ New hire
- ☐ Open Enrollment
- ☐ Loss of prior coverage date: _____
- ☐ COBRA effective date: _____
- Qualifying event: _____
- Qualifying event date: _____
- ☐ Add dependent
- Qualifying event: _____
- Qualifying event date: _____

REASON FOR CHANGE:

- ☐ Plan change
- ☐ Change address/name
- ☐ Delete dependent(s) (list names in Section 3)
- ☐ Other: _____

2 EMPLOYEE PERSONAL INFORMATION

Last name:	**First name:**	**MI:**	☐ **Male** ☐ **Female**
Residence address:	**City:**	**State:**	**ZIP:**
Mailing address (if different from residence):	**City:**	**State:**	**ZIP:**

Date of Birth (Mo/Day/Yr):	**Social Security #/Matricula ID#:**	**Job title:**
Home telephone number: ( )	**Work telephone number:** ( )	**Email address:**

Date of hire: / /	**Job class:**	**Dept. #:**	**Employment status:** ☐ Salaried ☐ Hourly	**Marital status:** ☐ Single ☐ Married ☐ Domestic partner

Are you choosing to decline coverage? ☐ **Yes** ☐ **No**
If "Yes," skip to Section 4.

For HMO y Más or Salud con Health Net members: If available, I would prefer to receive communication and plan information in Spanish.
☐ Yes ☐ No

Coverage type:		**Medicare Claim/HICN #:**	**Participating Physician Group/PPG #:**	**Primary Care Physician/PCP #:**
☐ Medical ☐ Dental ☐ Vision	**Medicare** ☐ Part A ☐ Part B ☐ Part D		☐ N/A I'm enrolling in a PPO or Flex Net Plan	

Physician name (First, Last):	**Is this your current M.D.?** ☐ Yes ☐ No	**Dental HMO Provider ID #:** (complete only if electing Health Net Dental)

Do you have other health care coverage? ☐ **Yes** ☐ **No** If "Yes," complete the following:
Name of insurance carrier: _____ **Prior coverage start date:** _____

Are you enrolling dependents? ☐ **Yes** ☐ **No**
If "Yes," complete and submit all pages of the form. If "No," skip to Section 5 and submit pages 1 and 3.

Employee name ____

3 FAMILY INFORMATION Please list all eligible family members to be enrolled. (Attach additional sheets if necessary.)

☐ Spouse ☐ M ☐ Domestic partner ☐ F	Last name:	First name:		MI:
Residence address: ❏ Check here if same as employee	City:		State:	ZIP:
Date of birth (Mo/Day/Yr):	**Social Security #/Matricula ID #:**			
Coverage type: ☐ Medical ☐ Dental ☐ Vision **Medicare** ☐ Part A ☐ Part B ☐ Part D	**Medicare Claim/HICN #:**	**Participating Physician Group/PPG #:**	**Primary Care Physician/PCP #:**	
Physician name (First, Last):	**Is this your current M.D.?** ☐ Yes ☐ No	**Dental HMO Provider ID #:** (complete only if electing Health Net Dental)		
Do you have other health care coverage? ☐ **Yes** ☐ **No** If "Yes," complete the following: **Name of insurance carrier:** ____________ **Prior coverage start date:** ____________				
☐ Son ☐ Daughter	Last name:	First name:		MI:
Residence address: ❏ Check here if same as employee	City:		State:	ZIP:
Date of birth (Mo/Day/Yr):	**Social Security #/Matricula ID #:**			
Coverage type: ☐ Medical ☐ Dental ☐ Vision **Medicare** ☐ Part A ☐ Part B ☐ Part D	**Medicare Claim/HICN #:**	**Over-age Dependent Type:** ☐ Disabled ☐ Full-time student ☐ Over 50% support	**Participating Physician Group/PPG #:** **Primary Care Physician/PCP #:**	
Physician name (First, Last):	**Is this your current M.D.?** ☐ Yes ☐ No	**Dental HMO Provider ID #:** (complete only if electing Health Net Dental)		
Do you have other health care coverage? ☐ **Yes** ☐ **No** If "Yes," complete the following: **Name of insurance carrier:** ____________ **Prior coverage start date:** ____________				
☐ Son ☐ Daughter	Last name:	First name:		MI:
Residence address: ❏ Check here if same as employee	City:		State:	ZIP:
Date of birth (Mo/Day/Yr):	**Social Security #/Matricula ID #:**			
Coverage type: ☐ Medical ☐ Dental ☐ Vision **Medicare** ☐ Part A ☐ Part B ☐ Part D	**Medicare Claim/HICN #:**	**Over-age Dependent Type:** ☐ Disabled ☐ Full-time student ☐ Over 50% support	**Participating Physician Group/PPG #:** **Primary Care Physician/PCP #:**	
Physician name (First, Last):	**Is this your current M.D.?** ☐ Yes ☐ No	**Dental HMO Provider ID #:** (complete only if electing Health Net Dental)		
Do you have other health care coverage? ☐ **Yes** ☐ **No** If "Yes," complete the following: **Name of insurance carrier:** ____________ **Prior coverage start date:** ____________				
☐ Son ☐ Daughter	Last name:	First name:		MI:
Residence address: ❏ Check here if same as employee	City:		State:	ZIP:
Date of birth (Mo/Day/Yr):	**Social Security #/Matricula ID #:**			
Coverage type: ☐ Medical ☐ Dental ☐ Vision **Medicare** ☐ Part A ☐ Part B ☐ Part D	**Medicare Claim/HICN #:**	**Over-age Dependent Type:** ☐ Disabled ☐ Full-time student ☐ Over 50% support	**Participating Physician Group/PPG #:** **Primary Care Physician/PCP #:**	
Physician name (First, Last):	**Is this your current M.D.?** ☐ Yes ☐ No	**Dental HMO Provider ID #:** (complete only if electing Health Net Dental)		
Do you have other health care coverage? ☐ **Yes** ☐ **No** If "Yes," complete the following: **Name of insurance carrier:** ____________ **Prior coverage start date:** ____________				

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

☐ **Declining medical coverage for:**
Name: _____
☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent(s)

Reason: ☐ Other group coverage through this employer ☐ Individual coverage
☐ Other group coverage by another group *(i.e., spouse's employer)* ☐ Other:_____

☐ **Declining dental coverage for:**
Name: _____
☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent(s)

Reason: ☐ Other group coverage through this employer ☐ Individual coverage
☐ Other group coverage by another group *(i.e., spouse's employer)* ☐ Other:_____

☐ **Declining vision coverage for:**
Name: _____
☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent(s)

Reason: ☐ Other group coverage through this employer ☐ Individual coverage
☐ Other group coverage by another group *(i.e., spouse's employer)* ☐ Other:_____

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.

Print employee name: _____

Employee signature: _____ **Date:** _____

(SIGN ONLY IF DECLINING COVERAGE. IF SIGNED IN ERROR, PLEASE CROSS OUT AND INITIAL.)

5 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 Health Net Entities, the DBP Entities and/or Fidelity Entities. Health Net Entities, the DBP 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 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 my 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.

Print employee name: _____

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 Insurance Company, and/or Fidelity Security Life Insurance Company Group Policy and Certificate of Insurance.

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 Trội) 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 ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար ձեր լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի 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 Կալիֆորնիայի 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

無料の言語サービス。日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号までお問い合わせください。雇用者団体への加入申込の方は、Health Net 民間コンタクト・センター、800-522-0088 までご連絡ください。個人・家族プラン (IFP) またはファーム・ビューローへの加入申込の方は、800-909-3447（ダイアル後 2 を選択）までお問い合わせください。メディケア・サプリメント保険への加入申込の方は、800-926-4178 までご連絡ください。更なるお問い合わせ事項がある場合、PPO プランにご加入の方は、カリフォルニア州保険庁、1-800-927-4357 までご連絡ください。HMOプランにご加入の方は、カリフォルニア州管理医療庁 (DMHC) の相談窓口、1-888-HMO-2219 までご連絡ください。

Japanese

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی برخوردار شده و بگوئید مدارک به زبان خودتان برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است تماس بگیرید. و یا متقاضیان گروههای کارفرمایان لطفاً با مرکز تجاری Health Net به شماره 800-522-0088 تماس بگیرند. متقاضیان «طرح افراد و خانواده ها» (IFP) یا «دفتر مزارع» لطفاً به شماره 800-909-3447 گزینه 2 تلفن کنند. متقاضیان «مکمل مدیکر» (Medicare Supplemental) لطفا به شماره 800-926-4178 تلفن کنند. برای دریافت کمک بیشتر، به اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تلفن کنید اگر در یک طرح PPO ثبت نام میکنید. اگر در یک طرح HMO ثبت نام میکنید، به خط کمکی DMHC به شماره 1-888-HMO-2219 تلفن کنید.

Farsi

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ। ਇੰਪਲਾਇਰ ਗਰੁੱਪ ਦੇ ਮੈਂਬਰ ਕਿਰਪਾ ਕਰਕੇ ਹੈਲਥ ਨੈਟ ਦੇ ਵਪਾਰਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ 800-522-0088 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਪਲਾਨ (IFP) ਜਾਂ ਫਾਰਮ ਬਿਊਰੋ ਦੇ ਅਰਜ਼ੀਦਾਤਾ ਕਿਰਪਾ ਕਰਕੇ 800-909-3447, ਔਪਸ਼ਨ 2 ਤੇ ਫੋਨ ਕਰੋ। ਮੈਡੀਕੇਅਰ ਸਪਲੀਮੈਂਟਲ ਦੇ ਅਰਜ਼ੀਦਾਤਾ ਕਿਰਪਾ ਕਰਕੇ 800-926-4178 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਜੇ ਤੁਸੀਂ ਕਿਸੇ PPO ਪਲਾਨ ਲਈ ਨਾਂ ਲਿਖਵਾ ਰਹੇ ਹੋ ਤਾਂ ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫੋਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਜੇ ਤੁਸੀਂ ਕਿਸੇ HMO ਪਲਾਨ ਲਈ ਨਾਂ ਲਿਖਵਾ ਰਹੇ ਹੋ ਤਾਂ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਮੈਨੇਜਡ ਹੈਲਥ ਕੇਅਰ (DMHC) ਦੀ ਹੈਲਪਲਾਈਨ 1-888-HMO-2219 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ।

Punjabi

ការបកប្រែភាសាដោយឥតអស់ថ្លៃ ។ អ្នកអាចទទួលអ្នកបកប្រែភាសា និងឲ្យគេអានឯកសារជូនអ្នកជាភាសាខ្មែរបាន ។ សំរាប់ជំនួយ សូមទូរស័ព្ទមកយើង តាមលេខដែលមានកត់នៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក ឬអ្នកដាក់ពាក្យសុំជាក្រុមនៃក្រុមហ៊ុនការងារ សូមទូរស័ព្ទទៅ មណ្ឌលទំនាក់ទំនងពាណិជ្ជកម្មរបស់ Health Net តាមលេខ 800-522-0088 ។ គំរោងបុគ្គលម្នាក់ៗ និងជាគ្រួសារ (IFP) ឬអ្នកដាក់ពាក្យសុំ Farm Bureau សូមទូរស័ព្ទទៅលេខ 800-909-3447 ចុចជំរើសទី 2 ។ អ្នកដាក់ពាក្យសុំ ជំនួយបន្ថែម Medicare សូមទូរស័ព្ទទៅលេខ 800-926-4178 ។ សំរាប់ជំនួយថែមទៀត សូមទូរស័ព្ទទៅ ក្រសួងធានារ៉ាប់រងកាលីហ្វ័រនីញ៉ា តាមលេខ 1-800-927-4357 បើសិនជាអ្នកកំពុងតែចុះឈ្មោះក្នុងគំរោង PPO ។ បើសិនជាអ្នកកំពុងតែចុះឈ្មោះក្នុងគំរោង HMO សូមទូរស័ព្ទទៅខ្សែជំនួយ DMHC តាមលេខ 1-888-HMO-2219 ។

Khmer

Cov Kev Pab Txhais Lus Uas Tsis Tau Them Nqi. Koj thov tau kom muaj ib tug neeg txhais lus thiab nyeem cov ntawv ua koj hom lus rau koj. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis cov neeg thov kev pab tom hauj lwm thov hu rau Health Net's Commercial Contact Center ntawm 800-522-0088. Cov neeg thov kev pab hauv pawg Tus Kheej thiab Tsev Neeg (Individual and Family Plan [IFP]) los sis Farm Bureau thov hu rau 800-909-3447, xaiv nqe 2. Cov neeg thov kev pab los ntawm Medicare Supplemental thov hu rau 800-926-4178. Yog xav tau kev pab ntxiv hu rau CA Qhov Chaw Saib Xyuas Txog Kev Tuav Pov Hwm (Dept. of Insurance) ntawm 1-800-927-4357 yog hais tias koj koom rau hauv ib qho kev pab los ntawm PPO. Yog hais tias koj koom rau hauv ib qho kev pab los ntawm HMO, hu rau DMHC Tus Xov Tooj Muab Kev Pab ntawm 1-888-HMO-2219.

Hmong

ບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າ. ທ່ານສາມາດໄດ້ຮັບບໍລິການແປພາສາແລະມີຜູ້ອ່ານເອກກະສານໃຫ້ທ່ານຟັງເປັນພາສາຂອງທ່ານເອງ. ເພື່ອຈະໄດ້ຮັບຄວາມຊ່ວຍເຫລືອ, ໃຫ້ໂທຫາພວກເຮົາຕາມໝາຍເລກທີ່ລະບຸໄວ້ໃນບັດປະກັນໄພຂອງທ່ານ ຫລືສະມາຊິກກຸ່ມລູກຈ້າງຜູ້ຂໍເອົາແຜນການປະກັນສຸກຂະພາບ ຂໍໃຫ້ໂທຫາສູນຮັບການຕິດຕໍ່ເລື່ອງແຜນການພານິດແຫ່ງ Health Net ຕາມ ໝາຍເລກ 800-522-0088. ຜູ້ຂໍເອົາແຜນການ Individual and Family Plan (IFP) ແລະຜູ້ຂໍເອົາແຜນການ Farm Bureau ຂໍໃຫ້ໂທຕາມໝາຍເລກ 800-909-3447 ແລ້ວເລືອກຂໍ້ທີ່ 2. ຜູ້ຂໍເອົາແຜນການເສີມເມດິແຄຣ໌ [Medicare Supplement] ຂໍໃຫ້ໂທຕາມໝາຍເລກ 800-926-4178. ຖ້າຫາກທ່ານກຳລັງຈະລົງທະບຽນແຜນການ PPO, ໃຫ້ໂທໄປຫາກົມປະກັນໄພ ແຫ່ງລັດຄາລິຟໍເນຍຕາມໝາຍເລກ 1-800-927-4357 ເພື່ອຈະໄດ້ຮັບຄວາມຊ່ວຍເຫລືອເພີ່ມຕື່ມ. ຖ້າຫາກທ່ານກຳລັງຈະລົງ ທະບຽນແຜນການ HMO, ໃຫ້ໂທຕາມສາຍດ່ວນ DMHC ຕາມໝາຍເລກ 1-888-HMO-2219.

Laotian

خدمات لغوية بدون تكلفة. يمكنك الاستعانة بمترجم وطلب قراءة الوثائق لك بلغتك. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك (ID) وبالنسبة لأعضاء المصالح التجارية رجاء الاتصال بمركز خدمات القطاع التجاري لمؤسسة Health Net على الرقم 800-522-0088. المتقدمين بطلبات الحصول على تأمين لشخص واحد أو لعائلة (IFP) أو Farm Bureau رجاء الاتصال بالرقم 800-909-3447، خيار 2. المتقدمين بطلب الحصول على مساعدات Medicare Supplemental رجاء الاتصال بالرقم 800-926-4178. للحصول على المزيد من المساعدة، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357 إذا كنت مشتركاً في برنامج PPO. وإذا كنت مشتركاً في برنامج HMO اتصل بالخط الساخن لـ DMHC على الرقم 1-888-HMO-2219.

Arabic

Please contact the Health Net Customer Contact Center at the toll-free numbers below should you need assistance in completing this form or if you have questions about your coverage:

English 1-800-522-0088
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

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, HMO Variable Copay, HMO y Más, Elect Open Access℠ (EOA), Elect (POS), EPO, Salud con Health Net EPO or SELECT (POS) Enrollees: select a Participating Physician Group (PPG) and a Primary Care Physician (PCP).

Dental HMO Enrollees: select a participating dentist.

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 physician group, primary care physician and dental provider will be selected for you.

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

Preexisting Conditions and Creditable Coverage

Your coverage under the PPO, PPO HSA, 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, PPO HSA, 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 occur 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

Medical 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 Dental Benefit Providers of California, Inc. and / or Unimerica 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.

Health Net of California, Inc. offers the following products: HMO, HMO Silver Network, HMO Bronze Network, HMO Variable Copay, HMO y Más, Salud con Health Net HMO, Elect Open Access (EOA), Elect (POS) and SELECT (POS).

Health Net Life Insurance Company offers the following products: PPO, PPO HSA, EPO, Flex Net and Salud con Health Net EPO and PPO.

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

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

Fidelity Security Life Insurance Company offers the following products serviced by EyeMed Vision Care, LLC: PPO Vision.

PLEASE VISIT US AT WWW.HEALTHNET.COM