



Health Net®

Individual & Family Enrollment Application

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

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

THE APPLICATION MUST BE COMPLETED BY THE APPLICANT.

Requested Effective Date

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A. Reason for Application	
FAMILY TYPE	
<input type="checkbox"/> Self	<input type="checkbox"/> Self & Spouse
<input type="checkbox"/> Self & Child	<input type="checkbox"/> Self & Children
<input type="checkbox"/> Self, Spouse and Child(ren)	
<input type="checkbox"/> Process as separate policies	
ENROLLMENT TYPE	
<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Change Plan*
<input type="checkbox"/> Add Dependent*	
*Member ID number (listed on your ID card)	
B. Billing options (please choose one for both medical and life)	
<input type="checkbox"/> Quarterly (no administrative charge)	
<input type="checkbox"/> Monthly (electronic funds transfer-no administrative charge) If chosen, attach a completed Simple Pay Option form	
<input type="checkbox"/> Monthly (billed - \$5 administrative fee) – Not available for Life	

C. Choice of coverage	
Health Net HMO – Only 1st of the month effective date is available	
<input type="checkbox"/> EOA 15	
<input type="checkbox"/> HMO 15	
<input type="checkbox"/> HMO 40	

<input type="checkbox"/> EOA 15 Plus	
<input type="checkbox"/> HMO 15 Plus	
<input type="checkbox"/> HMO 40 Plus	
Primary Dentist Number	_____
Health Net Life Insurance Company	
<u>Only 1st of the month effective date is available</u>	
<input type="checkbox"/> Life Insurance	<input type="checkbox"/> \$15,000 <input type="checkbox"/> \$30,000 <input type="checkbox"/> \$50,000
<u>1st and 15th of the month effective date is available.</u>	
<input type="checkbox"/> Optimum PPO 10	As a convenience to you, if you do not meet Health Net Life Insurance underwriting requirements for the coverage or rate you have applied for, you may be offered a different PPO option at a substantially higher rate. You are under no obligation to enroll.
<input type="checkbox"/> Executive PPO 20	
<input type="checkbox"/> Value PPO 20	
<input type="checkbox"/> Value PPO – No Deductible	
<input type="checkbox"/> Value PPO 2500	
<input type="checkbox"/> Value PPO 1000	
<input type="checkbox"/> Value PPO 500	

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

Primary Applicants Last Name		First Name		MI	<input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address					
City		State	Zip	County applicant resides in	
Home Phone Number ()		Work Phone Number ()		Email address	
Primary Applicant's Birth Date (mo/day/year)			Primary Applicants Social Security Number		
Height		Weight	Primary Care Physician ID # (If applicable)	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No	Physician Group ID #
Type of Business:		Occupation:	Salary Range (optional):		
<input type="checkbox"/> Self Employed/Consultant	<input type="checkbox"/> Student		<input type="checkbox"/> \$18,000 – 30,000	<input type="checkbox"/> \$60,001 – 75,000	
<input type="checkbox"/> Professional/Management	<input type="checkbox"/> Retired		<input type="checkbox"/> \$30,001 – 45,000	<input type="checkbox"/> \$75,001 – 90,001	
<input type="checkbox"/> Employed (Non-managerial)	<input type="checkbox"/> Other:		<input type="checkbox"/> \$45,001 – 60,000	<input type="checkbox"/> \$90,001+	
<input type="checkbox"/> Unemployed (between jobs)					
The following information is voluntary. By indicating your ethnicity you are helping us to better serve your needs.				In the past 6 months, have you been a resident of California?	
<input type="checkbox"/> American/Alaskan Native	<input type="checkbox"/> Filipino	<input type="checkbox"/> Korean	<input type="checkbox"/> Yes		
<input type="checkbox"/> Black/African American (Non-Hispanic)	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> No		
<input type="checkbox"/> Caucasian (Non-Hispanic/White)	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other:	If no, where was your last residence? _____		
<input type="checkbox"/> Chinese					
How did you hear about Health Net's Individual and Family coverage?					
<input type="checkbox"/> Radio	<input type="checkbox"/> Mail	<input type="checkbox"/> Billboard	<input type="checkbox"/> Newspaper	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Broker
					<input type="checkbox"/> Internet <input type="checkbox"/> Other

Primary's Social Security Number

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PART III. Family member(s) 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.

Relation	Last Name	First Name	MI	Social Security No.	Date of birth	Height	Weight	Primary Care Physician ID #*	Current Patient	Physician Group ID #*
<input type="checkbox"/> Husband <input type="checkbox"/> Wife	Spouse			— —	/ /				<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, or female dependent, whether or not listed on the application, currently pregnant?	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"/>
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?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	If "yes", have you been hospitalized or been to an emergency room in the past 24 months?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Have you received any adrenaline or epinephrine injections?	Yes <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, temporomandibular 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, 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"/>

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

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"/>	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"/>
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 _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	7)	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"/>
O.	Premature birth, developmental delay, congenital abnormalities, clubfoot, cleft lip or palate, or Down's syndrome?	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"/>
P.	Cosmetic or reconstructive surgery, including breast implants?	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"/>
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"/>	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"/>
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"/>	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"/>

Female applicants only (applicable to all females listed on the application)

Applicant Name:				Applicant Name:							
13)	A.	(i)	Do you menstruate?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	13)	A.	(i)	Do you menstruate?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
		(ii)	Date of first day of last menstrual period (Mo/Dy/Yr):	/	/			(ii)	Date of first day of last menstrual period (Mo/Dy/Yr):	/	/
		(iii)	Average number of days from first of menstrual period to first day of next period:	_____				(iii)	Average number of days from first of menstrual period to first day of next period:	_____	
	B.	(i)	Have you had a pelvic exam?	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):	/	/			(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"/>			(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 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 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 attending physician

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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 _____ Expected Termination Date _____
 Type of Coverage:
 Individual & Family HMO Group HMO
 Individual & Family PPO Group PPO
 Disability, Short Term or Interim Other: _____

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 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: _____
 Group Number (listed on your ID card): _____
 Member ID Number (listed on your ID card): _____

D. HIPAA Coverage – If you answer "Yes" to every condition listed below, you are eligible for Guaranteed Issue coverage under the Health Insurance Portability and Accountability Act (HIPAA). Please call Health Net at 1-800-909-3447 for information regarding what coverage is available and rates of coverage under HIPAA.
 a. I have 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
 b. My most recent coverage was through a group health plan (COBRA and Cal-COBRA are considered group coverage). Yes No
 c. I am not currently eligible for coverage under any group health plan, Medicare or Medicaid. Yes No
 d. My most recent coverage was not terminated because of nonpayment or fraud. Yes No
 e. I accepted COBRA or Cal-COBRA and exhausted all of its benefits, or was not eligible for COBRA or Cal-COBRA. Yes No
 If "Yes," please list the date that COBRA or Cal-COBRA was exhausted: _____ If not, 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	

Life Insurance was discussed with my Health Net Broker and I wish to decline. Initial _____

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) _____

I translated the contents of the Individual & Family Enrollment Application and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by: _____

I also translated and fully explained Part IX of the Individual & Family Enrollment Application, "Conditions of Enrollment."

Signatures and date (required in ink)

SIGNATURE of TRANSLATOR	Today's Date
SIGNATURE of APPLICANT	Today's Date

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.

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

Health Net Broker ID: <u>F-369</u>													
95-386-0414													
Federal Tax ID: <u>M.E. Andrews & Associates Insurance Agency, Inc.</u>	Office Assigned Number <u>877-433-7868</u>												
Name <u>8190 E. Kaiser Blvd., Ste. 100</u>	Phone number: <u>714-279-1990</u>												
Address <u>Anaheim, CA 92808</u>	Fax Number: <u>info@3dquotes.com</u>												
	Email address: / /												
Writing Agents Signature/Number (if different from Broker ID)	Date Signed (required)												
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td>Writing Agent Certification</td> <td>Yes</td> <td>No</td> </tr> <tr> <td>Are you aware of any information not disclosed in this application that might have a bearing on the risk? If "Yes," please explain:</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>	Writing Agent Certification	Yes	No	Are you aware of any information not disclosed in this application that might have a bearing on the risk? If "Yes," please explain:	<input type="checkbox"/>	<input type="checkbox"/>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td>Did you personally see the applicant (and spouse, if applying) at the time this application was executed?</td> <td>Yes</td> <td>No</td> </tr> <tr> <td></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input checked="" type="checkbox"/></td> </tr> </table>	Did you personally see the applicant (and spouse, if applying) at the time this application was executed?	Yes	No		<input type="checkbox"/>	<input checked="" type="checkbox"/>
Writing Agent Certification	Yes	No											
Are you aware of any information not disclosed in this application that might have a bearing on the risk? If "Yes," please explain:	<input type="checkbox"/>	<input type="checkbox"/>											
Did you personally see the applicant (and spouse, if applying) at the time this application was executed?	Yes	No											
	<input type="checkbox"/>	<input checked="" 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 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 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. **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 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.**

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 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 is obligated to provide pursuant to legal process, federal, state or local law, or 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 or facsimile of this Application and Authorization is considered as valid as the original. You are entitled to submit a photocopy or facsimile of the Application and Authorization. Health Net recommends that you maintain a copy of this Application and Authorization for your records.

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. 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.

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 4, PART VII of 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.

PART X. Important provisions

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.

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.

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.

Signatures (required in ink)

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

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.



Primary's Social Security Number

SSN input boxes: [][][] - [][] - [][][][]

Health Net's Simple Pay Option Monthly Automatic Payment for Individual & Family Plans

If you 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.

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:

Marsha Andrews
M.E. Andrews & Associates Insurance Agency., Inc.
8190 E. Kaiser Blvd., Ste. 100
Anaheim, CA 92808

Applicant's Social Security Number		Transit Routing Number	
[][][] - [][] - [][][][]			
Account Number			
Bank Name			
Bank Address			
City	State	ZIP	

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	Date

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