




HEALTH NET SENIORITY PLUS HMO EMPLOYER GROUP ENROLLMENT REQUEST FORM

To enroll in Health Net Seniority Plus, please provide the following information:

Employer or Union Name		Group #	
Last Name	First name	Middle initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Birth date (mm/dd/yyyy)		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Home phone # ()
Permanent residence Street address		Apt #	City
Mailing address (only if different from above)		Apt #	City
		State	Zip

<p>Please provide your Medicare insurance information</p> <p>Please take out your Medicare card to complete this section.</p> <ul style="list-style-type: none"> Please fill in these blanks so they match your red, white and blue Medicare card - OR - Attach a copy of your Medicare card or your letter from Social Security or Railroad Retirement Board. <p>You must have Medicare Part A and Part B to join a Medicare Advantage drug plan.</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center; background-color: #cccccc;">MEDICARE</td> <td style="text-align: center;"></td> <td style="text-align: center; background-color: #cccccc;">HEALTH INSURANCE</td> </tr> <tr> <td colspan="3" style="text-align: center; background-color: #cccccc;">SAMPLE ONLY</td> </tr> <tr> <td colspan="3">Name: _____</td> </tr> <tr> <td>Medicare Claim Number</td> <td colspan="2">Sex _____</td> </tr> <tr> <td>_____ - _____ - _____</td> <td colspan="2">_____</td> </tr> <tr> <td>Is Entitled To</td> <td colspan="2">Effective Date</td> </tr> <tr> <td>HOSPITAL (Part A)</td> <td colspan="2">_____</td> </tr> <tr> <td>MEDICAL (Part B)</td> <td colspan="2">_____</td> </tr> </table>	MEDICARE		HEALTH INSURANCE	SAMPLE ONLY			Name: _____			Medicare Claim Number	Sex _____		_____ - _____ - _____	_____		Is Entitled To	Effective Date		HOSPITAL (Part A)	_____		MEDICAL (Part B)	_____	
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Provider selection	Language Preference	Participating Physician Group (PPG)	Primary Care Physician (PCP) name
	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other	PPG ID# _____	PCP ID# _____ <input type="checkbox"/> Prior patient

Please read and answer these important questions.
NOTE: Medicare eligible spouse or dependent(s) must fill out separate forms.
Please contact your employer group administrator.

<p>1. Are you the retiree? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, retirement date (mm/dd/yy): _____ If no, name of retiree: _____</p>	<p>2. Are you covering a spouse or dependents under this employer or union plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of spouse: _____ Name of dependents: _____</p>
<p>3. Do you or your spouse work? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>4. Do you receive Medicaid benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide your Medicaid number: _____</p>	
<p>5. Do you have End Stage Renal Disease (ESRD)? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered "yes" to this question and you don't need regular dialysis anymore, or have had a successful kidney transplant, please attach a note or records from your doctor showing you don't need dialysis or have had a successful kidney transplant.</p>	
<p>6. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits, or state pharmaceutical assistance programs.</p> <p>Will you have other prescription drug coverage in addition to Health Net? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes," please list your other coverage and your identification (ID) number(s) for this coverage: Name of other coverage: _____ ID # for coverage: _____</p>	
<p>7. Are you a resident in a long-term care facility, such as a nursing home? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes," please provide the following information: Name of institution: _____ Address & Phone Number of institution: _____</p>	
<p>8. Have you had Medicare prescription drug coverage or other drug coverage that was at least as good as standard Medicare drug coverage since you became eligible to join a Medicare drug plan? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Please check the box below if you would prefer that we send you information in a language other than English or in another format: <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese</p> <p>Please contact Health Net SP Member Services at 1-800-977-7522 (TTY users should dial 711) if you need information in another format or language other than what is listed above. Our office hours are 8:00 a.m. - 8:00 p.m., 7 days a week.</p>	

Please read the reverse side and sign below.

Your signature:	Today's date:
If you are the authorized representative, you must sign above and provide the following information:	
Name:	Relationship to Enrollee:
Address:	Phone number:

By completing this enrollment application, I agree to the following:

Health Net Seniority Plus is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (Example: Annual Enrollment Period from November 15 – December 31), or under certain special circumstances.

Health Net Seniority Plus serves a specific service area. If I move out of the area that Health Net Seniority Plus serves, I need to notify the plan so that I can disenroll and find a new plan in my new area. Once I am a new member of Health Net Seniority Plus, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Health Net Seniority Plus when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for the limited coverage near the U.S. border.

I understand that beginning on the date Health Net Seniority Plus coverage begins, I must get all of my health care from Health Net Seniority Plus, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Health Net Seniority Plus and other services contained in my Health Net Seniority Plus Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HEALTH NET WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, Broker, or other individual employed by or contracted with Health Net Seniority Plus, he/she may be paid based on my enrollment in Health Net Seniority Plus.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options as well as medical assistance through the state Medicaid program and Medicare Savings Program.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I acknowledge that Health Net Seniority Plus will release my information to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Health Net Seniority Plus or by Medicare.

Office use only			
Name of staff member/agent/broker (if assisted in enrollment):			Rep ID:
Plan ID #:			
Group #:	ICEP/IEP:	OEP:	
Effective Date of Coverage:	AEP:	SEP (type):	
		Not eligible:	