



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/Domestic Partner
<input type="checkbox"/> Self & Child	<input type="checkbox"/> Self & Children
<input type="checkbox"/> Self, Spouse/Domestic Partner and Child(ren)	
<input type="checkbox"/> Please check for Domestic Partner enrollment	
<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 for both medical and life)	
First Premium Payment (select one)	Monthly Premium Payments (select one)
<input type="checkbox"/> Pay by Check (Please include completed check and send with application. Amount must match monthly premium.)	<input type="checkbox"/> Automated Bank Draft (Please complete the Simple Pay Option section)
<input type="checkbox"/> Credit card (Please complete the credit card section on application)	<input type="checkbox"/> Monthly Bill (\$5.00 administrative fee applies; not available with Term Life)
	<input type="checkbox"/> Credit card (Please complete credit card section; not available with Term Life)

C. Choice of Coverage
PPO* – Health Net Life Insurance Company: Available for 1st and 15th of the month effective dates
SimpleValue <input type="checkbox"/> 30 <input type="checkbox"/> 40 <input type="checkbox"/> 50 with <input type="checkbox"/> Generic Rx or <input type="checkbox"/> Combo Rx
HSA (Compatible Plans) <input type="checkbox"/> SimpleChoice <input type="checkbox"/> SmartChoice
SimpleChoice <input type="checkbox"/> 15 <input type="checkbox"/> 25 <input type="checkbox"/> 35 <input type="checkbox"/> 40 <input type="checkbox"/> 50 <input type="checkbox"/> FirstChoice PPO <input type="checkbox"/> ValueChoice 1500
HMO – Health Net of California: Only available for the 1st of the month effective dates <input type="checkbox"/> HMO 15 <input type="checkbox"/> HMO 40
Add – Term Life Insurance Coverage (Part VI must be completed) <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$30,000 <input type="checkbox"/> \$50,000
Add – Dental and Vision Plus <input type="checkbox"/> Dental & Vision Plus Primary Dentist Number (HMO plans only): _____
<i>*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.</i>

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

Primary Applicant's 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 Applicant's Social Security Number □ □ □ □ □ □ □ □ □ □		
Height	Weight (lbs)	Primary Care Physician ID # (if applicable)		Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No	Physician Group ID#
Type of Business: <input type="checkbox"/> Self Employed/Consultant <input type="checkbox"/> Unemployed (between jobs) <input type="checkbox"/> Professional/Management <input type="checkbox"/> Student <input type="checkbox"/> Other: <input type="checkbox"/> Employed (Non-managerial) <input type="checkbox"/> Retired		Occupation:		Salary Range (optional): <input type="checkbox"/> \$18,000–30,000 <input type="checkbox"/> \$60,001–75,000 <input type="checkbox"/> \$30,001–45,000 <input type="checkbox"/> \$75,001–90,000 <input type="checkbox"/> \$45,001–60,000 <input type="checkbox"/> \$90,001+	
Would you be interested in other Health Net or affiliated entities, products and services May we contact you by email? The release of your information may result in a Health Net representative or Authorized Agent contacting you.			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	In the past 6 months, have you been a resident of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, where was your last residence? _____	
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: _____					

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PART III. Family member(s) to be enrolled

List all eligible family members to be enrolled other than yourself. If a listed family member's last name is different from yours, please explain on a separate sheet of paper. For Domestic Partner coverage all requirements for eligibility, as required by the applicable laws of the State of California, must be met and a joint Declaration of Domestic Partnership must be filed with the California Secretary of State. **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	M	Social Security No.	Date of Birth	Height	Weight (lbs)	Primary Care Physical ID#	Current Patient	Physician Group ID#
<input type="checkbox"/> Husband <input type="checkbox"/> Wife	Spouse/Domestic Partner			- -					<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/domestic partner, or female dependent, whether or not listed on the application, currently pregnant? 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? 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? 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"/>	4) Are you or any applying family member eligible for Medicare benefits as a result of disability or chronic illness? 5) Have you or any applying family member ever had any signs or symptoms of, consulted a medical practitioner, received advice from a medical practitioner, sought treatment from a medical practitioner, had treatment recommended by a medical practitioner, received treatment from a medical practitioner, or been hospitalized for any of the following conditions? 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? 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"/>
	Yes <input type="checkbox"/>	No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Yes <input type="checkbox"/>	No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Yes <input type="checkbox"/>	No <input type="checkbox"/>		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"/>			

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

<p>5) 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?</p> <p style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></p>			<p>O. Premature birth, developmental delay, congenital abnormalities, clubfoot, cleft lip or palate, or Down's syndrome?</p> <p style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></p>		
<p>D. Allergies, sinusitis, bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), pneumonia, tuberculosis, coughing up blood, or any other lung or respiratory disorder?</p> <p style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></p>			<p>P. Cosmetic or reconstructive surgery, including breast implants?</p> <p style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></p>		
<p>E. Asthma?</p> <p style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></p>			<p>Q. Male reproductive system: disorder of the prostate, infections, impotency, sexual dysfunction, infertility, sexually transmitted disease or any other disorder of the reproductive system?</p> <p style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></p>		
<p>If "Yes," have you been hospitalized or been to an emergency room in the past 24 months?</p> <p style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></p>			<p>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?</p> <p style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></p>		
<p>Have you received any adrenaline or epinephrine injections?</p> <p style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></p>			<p>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)?</p> <p style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></p>		
<p>F. Disorder of the kidney or bladder, infections, blood in urine, pyelonephritis, or any other disorder of the urinary tract?</p> <p style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></p>			<p>7) Have you or any applying family member(s) consulted a health care practitioner for any condition or symptom(s) for which a diagnosis has not been established?</p> <p style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></p>		
<p>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?</p> <p style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></p>			<p>8) During the past 12 months, have you or any applying family members smoked cigarettes, cigars, pipes, or used chewing tobacco?</p> <p style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></p>		
<p>H. Jaw problems, temporal mandibular joint syndrome (TMJ), pain or difficulty breathing, chewing or swallowing?</p> <p style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></p>			<p>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?</p> <p style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></p>		
<p>I. Diabetes, thyroid disorder, adrenal disorder, lupus, Raynaud's disease, chronic fatigue syndrome, Epstein-Barr virus, unintentional weight loss or any other disorder of the metabolic system?</p> <p style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></p>			<p>10) During the past 12 months, have you or any applying family members experienced symptoms for which a physician has not been consulted?</p> <p style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></p>		
<p>J. Cancer, melanoma, tumor, cyst, growth, leukemia, Hodgkin's disease, or any other malignancy?</p> <p style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></p>			<p>11) Is the applicant or any applying family member currently taking medication? If "Yes," please complete section IV (b).</p> <p style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></p>		
<p>K. Psoriasis, keratosis, herpes, burns, birthmarks, warts, or any other disorder of the skin?</p> <p style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></p>			<p>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).</p> <p style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></p>		
<p>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?</p> <p style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></p>					
<p>M. Nervous, mental, emotional or obsessive compulsive disorder, behavioral disorder, panic attacks, anxiety, depression, manic depression, schizophrenia, attention deficit disorder, ADHD, or eating disorder?</p> <p style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></p>					
<p>N. Alcohol or substance abuse/dependency, counseling, member of a support group?</p> <p style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></p>					
<p>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?</p> <p style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></p>					
<p>Applicant _____ Spouse/Domestic Partner _____</p>					

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

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

Applicant Name:

13) A. (i) Have you had a menstrual period in each of the last six months, including within the last 30 days? Yes No
 If "No," please explain:

B. (i) Have you had a pelvic exam? Yes No

(ii) Date of last pelvic exam (Mo/Dy/Yr):

(iii) Were the results of the exam normal? Yes No
 If "No," please explain:

Applicant Name:

13) A. (i) Have you had a menstrual period in each of the last six months, including within the last 30 days? Yes No
 If "No," please explain:

B. (i) Have you had a pelvic exam? Yes No

(ii) Date of last pelvic exam (Mo/Dy/Yr):

(iii) Were the results of the exam normal? Yes No
 If "No," please explain:

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, condition, treatment or recommendation	Still under treatment?	Dates of treatment, Hospitalization (Mo/Yr)		Full name, address & telephone number of every physician, clinic or hospital (Include ZIP code)
				Began	Ended	
			<input type="checkbox"/> Yes <input type="checkbox"/> No			
			<input type="checkbox"/> Yes <input type="checkbox"/> No			
			<input type="checkbox"/> Yes <input type="checkbox"/> No			
			<input type="checkbox"/> Yes <input type="checkbox"/> No			
			<input type="checkbox"/> Yes <input type="checkbox"/> No			
			<input type="checkbox"/> Yes <input type="checkbox"/> No			

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 visit	Result of Visit	Full name, address & telephone number of every physician, clinic or hospital (Include ZIP code)

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

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	Prescribing Physician	Most Recent Refill Date	Strength (No. of milligrams)	Dosage & Frequency (How many pills and how often take)	Number of refills per year

PART V. Prior health coverage:

A. During the previous 62 days, have you been covered by health insurance? Yes No

If "Yes," Current Carrier: _____ Effective date: _____ Expected termination date: _____

Individual & Family HMO Group HMO

Individual & Family PPO Group PPO

Disability, Short Term or Interim Other: _____

B. 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): _____

C. HIPAA Coverage

You may be considered for coverage under the HIPAA plans. The plan does not require medical underwriting and the rates are higher compared to the other Individual Plans. If you qualify please request the complete benefit details and rates. If you meet every condition below you are eligible for guaranteed issue in accordance with HIPAA.

1. Have you 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

2. Was your most recent coverage through a group health plan (COBRA and Cal-COBRA are considered group coverage)? Yes No

3. Currently are you eligible for coverage under a group health plan, Medicare or Medicaid? Yes No
(If yes, you are not eligible for HIPAA coverage.)

4. Was your most recent coverage terminated because of nonpayment or fraud? Yes No

5. Were you eligible under COBRA or Cal-COBRA? Yes No

Yes, start date: _____ End Date: _____

If Yes, did you accept and exhaust all benefits that were available? Yes No

If No, 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

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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) _____

Under the penalty of perjury I attest that, I translated the contents of the Individual & Family Enrollment Application and fully explained Part IX of the Individual & Family Enrollment Application, "Conditions of Enrollment." To the best of my knowledge I obtained and listed all the requested personal and medical history disclosed by:

_____ (Name of applicant)

Signatures and date (required in ink)

SIGNATURE OF APPLICANT		Today's Date	
SIGNATURE OF TRANSLATOR		Today's Date	
TRANSLATOR'S NAME (PRINT)		TRANSLATOR'S PHONE NUMBER	
TRANSLATOR'S ADDRESS			
TRANSLATOR'S CITY	STATE	ZIP	

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.

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

Health Net Broker ID: <u>0337</u>	Sub – Agent ID: <u>943262357</u> (Must be completed only if Sub-Agent Agreement is approved)
Name (Print) <u>David Rudick</u>	Phone number: <u>800-966-5167</u>
Address <u>2633 Lincoln Blvd., Suite 611</u>	Fax Number: <u>310-577-4721</u>
<u>Santa Monica, CA 90405</u>	Email address: _____
Writing Agents Signature/Number (Required) _____	Date Signed (required) _____

Writing Agent Certification	Yes	No	Did you personally see the applicant signing the application (includes spouse/domestic partner, if applying)?	Yes	No
Are you aware of any information not disclosed in this application that might have a bearing on the risk?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
If "Yes," please explain: _____					

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 or only a dependant(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.

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PART IX. Conditions of enrollment (continued)

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 from the Subscriber (or from You or from the Applicant) 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.

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. Health Net uses 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 Plan Contract and Insurance Policy, and I may also obtain a copy of this Notice on the website at www.healthnet.com or through Health Net Member Services.

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. By signing, he or she 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 6, PART VII of this Application).

PART X. Important Provisions

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 care services plans or insurance companies as a condition of obtaining coverage.

ACKNOWLEDGEMENT AND AGREEMENT: I, the applicant, 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 the terms, conditions and provisions of the Plan Contract or Insurance Policy. I, the applicant, 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: I, the applicant, 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 Health Net regarding the construction, interpretation, performance or breach of the Health Net Plan Contract or Insurance Policy, or regarding other matters relating to or arising out of my Health Net 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 Health Net, are giving up their constitutional right to the extent permitted by law to have their dispute decided in a court of law before a jury. I also understand that disputes that I may have with Health Net involving claims or medical 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 Plan Contract or Insurance Policy. My signature below indicates that I understand the terms of this Binding Arbitration Clause and agree to submit disputes to binding arbitration.

Agreeing to the Arbitration & signing your name below constitutes your signature. Health Net reserves the right to cancel, rescind, or terminate any policy where this arbitration clause was signed by anyone other than the applicant. Neither Broker nor any other person may sign this Arbitration Agreement.

Applicant's Signatures (the applicant must personally sign his/her name and agree to the Arbitration Clause in order for the application to be processed); **Required in ink.**

APPLICANT OR PARENT OR LEGAL GUARDIAN'S SIGNATURE IF APPLICANT IS UNDER 18 YEARS OLD	Date Signed:
SPOUSE/DOMESTIC PARTNER'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." Return Completed Application to:
Health Net Individual and Family Enrollment, Post Office Box 1150 Rancho Cordova, California 95741-9847

You may submit a photocopy or facsimile of the Application and Authorizations. Health Net recommends that you retain a copy of this Application and Authorizations for your records.

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. "Plan Contract" refers to the Health Net of California, Inc. Combined Contract and Evidence of Coverage; "Insurance Policy" refers to Health Net Life Insurance Company Explanation of Your Insurance Plan, Health Net PPO Policy.



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

SSN input boxes

SIMPLE PAYMENT OPTION (Automatic Bank Draft)

Monthly premium charge can be withdrawn directly from your personal checking account. The premium will be withdrawn from your bank account about ten days in advance of the due date. If you select this payment option you must send a personal check for the first month's premium.

Account Holder's Social Security Number, Transit/Routing Number, Account Number, Bank Name, State

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.

Automatic Bank Draft (ABD) transmissions are submitted to the bank approximately the 20th of every month, for the following month's premium. It can take upwards of 6 weeks to process an ABD request.

I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, I will be charged a \$25 service charge for each occurrence.

SIGNATURE of ACCOUNT HOLDER (Required to Process), Date

CREDIT CARD First month's payment Monthly premium payment

Monthly premium charge can be charged directly to your credit card account. The premium will be charged to your credit card account approximately ten days in advance of the due date.

First Name, Middle, Last Name, Card Type, Account Number, Expiration Date, Signature Panel Code, Cardholder's email address, Billing Address, City, State, ZIP

*Signature Panel Code can be found on the back of your credit card. This 3-4 digit code is usually the last three digits located in the signature panel.

As a convenience, I request and authorize Health Net or Health Net Life Insurance Company ("Health Net") to charge my credit card account identified above for the payment of my initial premium and/or my monthly premium.

The zip code must match the cardholder's address otherwise the credit card cannot be processed.

SIGNATURE of CREDIT CARD ACCOUNT HOLDER (Required to Process), Date