



# 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.**

Requested Effective Date

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**THE APPLICATION MUST BE COMPLETED BY THE APPLICANT.**

<p><b>A. Reason for Application</b></p> <p><b>FAMILY TYPE</b></p> <p><input type="checkbox"/> Self                      <input type="checkbox"/> Self &amp; Spouse  <input type="checkbox"/> Self &amp; Child            <input type="checkbox"/> Self &amp; Children  <input type="checkbox"/> Self, Spouse and Child(ren)</p> <p><input type="checkbox"/> Process as separate policies</p> <p><b>ENROLLMENT TYPE</b></p> <p><input type="checkbox"/> New Enrollment   <input type="checkbox"/> Change Plan*   <input type="checkbox"/> Add Dependent*</p> <p>*Member ID number (listed on your ID card: _____)</p> <p><b>B. Billing options (please choose for both medical and life)</b></p> <p><b>First Premium Payment</b>                      <b>Monthly Premium Payments (select one)</b></p> <p><input checked="" type="checkbox"/> Pay by Check (Please include completed check and mail-in with application. Amount must match either monthly or quarterly premium corresponding to your billing choice.)</p> <p><input type="checkbox"/> Automated Bank Draft (Please complete the Simple Pay Option section)</p> <p><input type="checkbox"/> Monthly Bill (\$5.00 administrative fee applies; <b>option not available for Life</b>)</p> <p><input type="checkbox"/> Quarterly Bill (no administrative fee)</p>	<p><b>C. Choice of coverage</b></p> <p><b>Health Net of California – Only 1<sup>st</sup> of the month effective</b></p> <p><input type="checkbox"/> EOA [15]            <input type="checkbox"/> Dental &amp; Vision [Plus]  <input type="checkbox"/> HMO [15]  <input type="checkbox"/> HMO [40]</p> <p>Primary Dentist Number _____</p> <p><b>Health Net Life Insurance Company</b></p> <p><u>Only 1<sup>st</sup> of the month effective date is available</u></p> <p><input type="checkbox"/> Life Insurance    <input type="checkbox"/> \$15,000   <input type="checkbox"/> \$30,000   <input type="checkbox"/> \$50,000</p> <p><u>1<sup>st</sup> and 15<sup>th</sup> of the month effective date is available.</u></p> <p><input type="checkbox"/> PPO [Value 25]    <input type="checkbox"/> PPO [Value Basic 500]  <input type="checkbox"/> PPO [Value 30]    <input type="checkbox"/> PPO [Value Basic 1000]  <input type="checkbox"/> PPO [Value 400]   <input type="checkbox"/> PPO [Value Basic 2500]  <input type="checkbox"/> PPO [Value 750]   <input type="checkbox"/> PPO [Value Basic 4000]</p> <p><input type="checkbox"/> Dental &amp; Vision [Plus]</p> <p><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></p>
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**PART II. Applicant Information (Note: For the most favorable rate, make the younger spouse 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 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: <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 – 90,001 <input type="checkbox"/> \$45,001 – 60,000 <input type="checkbox"/> \$90,001+
The following information is voluntary. By indicating your ethnicity you are helping us to better serve your needs. <input type="checkbox"/> American/Alaskan Native <input type="checkbox"/> Filipino <input type="checkbox"/> Korean <input type="checkbox"/> Chinese <input type="checkbox"/> Black/African American (Non-Hispanic) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Vietnamese <input type="checkbox"/> Caucasian (Non-Hispanic/White) <input type="checkbox"/> Japanese <input type="checkbox"/> Other:				In the past 6 months, have you been a resident of California? <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 checked="" type="checkbox"/> Broker <input type="checkbox"/> Internet <input type="checkbox"/> Other

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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).	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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"/>

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

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"/>
	<b>If "yes", have you been hospitalized or been to an emergency room in the past 24 months?</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	<b>Have you received any adrenaline or epinephrine injections?</b>	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, temporalmandibular 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, Raynauld'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"/>
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"/>
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"/>

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

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

**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"/>
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**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

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**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	Dosage and frequency (list last refill date)	Name, phone number and address of attending physician

**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: \_\_\_\_\_

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

**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%.**

<b>Beneficiary (Full Name)</b>	<b>Relationship</b>	<b>%</b>
<b>Beneficiary (Full Name)</b>	<b>Relationship</b>	<b>%</b>
<b>Beneficiary (Full Name)</b>	<b>Relationship</b>	<b>%</b>
<b>SIGNATURE of APPLICANT</b>	<b>DATE</b>	

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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) \_\_\_\_\_

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.

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

Health Net Broker ID: <u>S922</u>			
Name <b>Moisey Rodshteyn</b> <hr/> Address <b>7510 Sunset Blvd. PMB 218</b> <hr/> <b>Los Angeles, CA 90046</b>	Phone number: <b>(323) 876-4782</b> <hr/> Fax Number: <b>(323) 876-4170</b> <hr/> Email address: <b>mike@binsure.com</b> <hr/> / /		
Writing Agents Signature/Number (if different from Broker ID)		Date Signed (required)	
Writing Agent Certification Are you aware of any information not disclosed in this application that might have a bearing on the risk?  If "Yes," please explain: _____ _____	Yes    No <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 type="checkbox"/>		





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

### SIMPLE PAYMENT OPTION (Automatic Bank Draft)

Monthly premium charge can be withdrawn directly to 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. I understand that the Premium withdrawn from my account can be for the future bill period plus any past due balances and my first month's withdraw maybe for multiple periods if I did not submit a binder check or due to the timing of the set up. 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, I will be charged a \$25 service charge for each occurrence. I understand 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
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