



State Continuation Election Form

NOTICE TO MEMBER:

To elect Oregon State Continuation Coverage, complete this election form and return it to your employer.

You must request state continuation coverage within either ten days after the event that triggered your loss of eligibility for coverage or ten days after the date you were provided the State Continuation Notice from Health Net Health Plan of Oregon, Inc. (Health Net), whichever is later. If you do not submit a completed election form within the required time period, you may lose your right to continuation coverage.

1. Employee personal information	
Employer name (<i>print</i>):	Group number:
Employee name (<i>print</i>):	Social Security number:
2. Eligible dependents information (attach additional sheets if necessary)	
List all dependents to be covered with the employee and/or dependent-only applicants, as allowed. (Required)	
Oregon registered and non-registered domestic partners are eligible for state continuation coverage under an Oregon group employer plan.	
<input type="checkbox"/> Spouse <input type="checkbox"/> Registered domestic partner <input type="checkbox"/> Non-registered domestic partner Dependent name:	Social Security number:
Dependent name:	Social Security number:
Dependent name:	Social Security number:
Dependent name:	Social Security number:
3. Loss of coverage	
Loss of coverage reason: <input type="checkbox"/> A reduction of hours <input type="checkbox"/> The employee's termination of employment <input type="checkbox"/> The employee's dependents lose coverage because of employee's death <input type="checkbox"/> The employee's dependent spouse or domestic partner loses coverage due to divorce or termination of domestic partnership <input type="checkbox"/> The employee is now eligible for Medicare <input type="checkbox"/> The dependent child is no longer eligible for coverage under the group policy	Date of event: _____

(continued)

4. Acceptance or declination of coverage (signature required)

I understand that I am eligible to self-pay my present Health Net Health Plan of Oregon, Inc. group medical coverage for up to nine months if I have been covered under the group contract, or similar predecessor contract, for at least three consecutive months.

Yes, I want to continue my group medical insurance through Oregon State Continuation.

1. I am not eligible for Medicare. I will notify the subscriber group if I become eligible for Medicare.
2. I am not eligible for any other group medical insurance coverage. I will notify the subscriber group if I become eligible for any other group medical insurance coverage.
3. I understand I must pay any owed premium to my subscriber group administrator each month in advance of the coverage effective date. Premium for the first month is included with this form.
4. I understand that ACA-compliant individual plans through the Federal Health Insurance Marketplace, Health Net and other carriers are available to me and my eligible dependents.
5. I wish to remain insured by my present group coverage:
 Self only Self and currently covered family members Currently covered dependents

Signature: _____ Date: _____

No, I am not interested in continuing my group medical insurance through Oregon State Continuation.

Signature: _____ Date: _____

Employer Use Only

Return this form to Health Net via email or mail it to the address below. Keep a copy for your files.

Mail: Health Net Health Plan of Oregon, Inc.

Attn: Membership Accounting

PO Box 9103

Van Nuys, CA 91409

Email: HNOregon_Enrollment@healthnet.com

Nondiscrimination Notice

Health Net Health Plan of Oregon, Inc. (Health Net) complies with applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, sexual orientation, age, disability, or sex.

HEALTH NET

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at 1-888-802-7001 (TTY: 711).

If you believe that Health Net has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by calling the number above and telling them you need help filing a grievance; Health Net's Customer Contact Center is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

Complaint forms are available at <https://www.hhs.gov/ocr/complaints/index.html>.

English

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call the Customer Contact Center at the number on your ID card or call 1-888-802-7001 (TTY: 711).

Amharic

ለቋንቋ አገልግሎት ምንም ክፍያ የለውም። አስተርጓሚ ማግኘት ይቻላል። የተነበበልዎትን እና የተወሰኑ በቋንቋዎ የተላኩልዎትን ሰነዶች ማግኘት ይቻላል። ለእርዳታ፣ ለደንበኞች ግንኙነት ማዕከል በምታወቁያ ካርድዎ ላይ ያለውን ቁጥር ይደውሉ ወይም በ 1-888-802-7001 (TTY: 711) ይደውሉ።

Arabic

الخدمات اللغوية المجانية. يمكنك الاستعانة بمترجم فوري، كما يمكنك طلب قراءة المستندات عليك وإرسال بعض منها إليك بلغتك. للحصول على المساعدة، يمكنك الاتصال بمركز اتصالات العملاء على الرقم الموجود على بطاقة معرف العضوية الخاصة بك أو الاتصال على 1-888-802-7001 (TTY: 711).

Chinese

免費語言服務。您可以取得口譯服務。我們可以把文件朗讀給您聽，也可以把部分翻譯成您語言的文件寄送給您。如需協助，請撥打會員卡上的電話號碼聯絡客戶聯絡中心，或撥打電話 1-888-802-7001 (聽障專線 (TTY) : 711)。

Cushite (Oromo)

Tajajjila afaaniif kaffaltii hin qabu. Turjubaana argachuu ni dandeessu. Sanadii isiniif dubbifamee fi afaan keessaniin muraasaan isniif ergame argachuu ni dandeessu. Gargaarsaaf, Wiirtuu Qunnamtii Maamilaa tiif lakkoofsicha kaardii enyummaa keessan irra jirutti bilbilaa ykn 1-888-802-7001 (TTY: 711) itti bilbilaa.

German

Es stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Sie können einen Dolmetscher hinzuziehen. Die Dokumente können Ihnen vorgelesen werden und einige sind in Ihrer Muttersprache erhältlich. Für Unterstützung rufen Sie bitte unser Kundendienstzentrum unter der auf Ihrer Versicherungskarte angegebenen Nummer oder unter der Rufnummer 1-888-802-7001 (TTY: 711) an.

Japanese

無料の言語支援サービス。通訳をご利用いただけます。日本語で文書を読み上げたり、文書によっては日本語版をお届けすることも可能です。支援をご希望の方は、IDカードに記載の番号にてカスタマーコンタクトセンターまでお電話いただくか、1-888-802-7001 (TTY: 711)までお電話ください。

Korean

무료 언어 서비스. 귀하는 통역사를 이용하실 수 있습니다. 귀하에게 편한 언어로 서류 낭독 서비스 및 번역 서비스를 받으실 수 있습니다. 도움이 받으시려면 본인의 ID 카드에 기재된 고객 서비스 센터 안내번호 또는 1-888-802-7001 (TTY: 711)번으로 전화해 주십시오.

Cambodian (Khmer)

សេវាកម្មភាសាភីឡែ ឥតគិតថ្លៃ អ្នកអាចទទួលបានអ្នកបកប្រែបាន។ អ្នកអាចឱ្យគេអានឯកសារស្តីអ្នក និងស្នើឯកសារខ្លះស្តីអ្នក ជាភាសាប្រសើរ។ សំរាប់ជំនួយ ទូរស័ព្ទទៅមជ្ឈមណ្ឌលទំនាក់ទំនងអភិវឌ្ឍន៍ តាមលេខនៅលើ ID របស់អ្នក ឬលេខ 1-888-802-7001 (TTY: 711)។

Laotian

ການບໍລິການດ້ານພາສາທີ່ບໍ່ເສຍຄ່າ. ທ່ານສາມາດຂໍນາຍແປພາສາ. ທ່ານສາມາດອ່ານເອກະສານ ແລະ ຈຳນວນໜຶ່ງໄດ້ຮັ່ງໃຫ້ທ່ານເປັນພາສາຂອງທ່ານແລ້ວ. ເພື່ອຂໍຄວາມ ຊ່ວຍເຫຼືອ, ໂທຫາສູນຕິດຕໍ່ລູກຄ້າໄດ້ທີ່ເລກໜາຍຢູ່ເທິງບັດ ID ຂອງທ່ານ ຫຼື ໂທ 1-888-802-7001 (TTY: 711).

Punjabi

ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਲਈ ਕੋਈ ਲਾਗਤ ਨਹੀਂ। ਤੁਸੀਂ ਦੁਆਰੀਆ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਤੁਹਾਨੂੰ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਦਸਤਾਵੇਜ਼ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਕੁਝ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਤੁਹਾਨੂੰ ਭੇਜੇ ਗਏ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ID ਕਾਰਡ 'ਤੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ 1-888-802-7001 (TTY: 711)।

Russian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика. Вам могут прочесть документы на русском языке и выслать переводы некоторых из них. Если вам требуется помощь, звоните в Центр обслуживания клиентов по номеру, указанному на вашей идентификационной карте, или по номеру 1-888-802-7001 (линия TTY: 711).

Spanish

Servicios de Idiomas Sin Costo. Usted puede solicitar un intérprete. Puede solicitar que se le lean los documentos y que algunos de ellos se le envíen en su idioma. Para obtener ayuda, llame al Centro de Comunicación con el Cliente al número que se encuentra en su tarjeta de identificación o llame al 1-888-802-7001 (TTY: 711).

Tagalog

Mga Walang Bayad na Serbisyo sa Wika. Maaari kayong kumuha ng tagasaling-wika (interpreter). Maaaring basahin sa inyo ang mga dokumento at ipadala sa inyo ang ilan nang nakasalin sa inyong wika. Para sa tulong, tumawag sa Customer Contact Center sa numero sa inyong ID card o tumawag sa 1-888-802-7001 (TTY: 711).

Ukrainian

Безкоштовні послуги перекладу. Ви можете скористатися послугами перекладача. Вам можуть прочитати документи на українській мові та надіслати переклади деяких із них. Якщо вам потрібна допомога, телефонуйте у Центр обслуговування клієнтів за номером, вказаним на вашій ідентифікаційній карті, або за номером 1-888-802-7001 (лінія TTY: 711).

Vietnamese

Dịch vụ ngôn ngữ miễn phí. Quý vị có thể yêu cầu phiên dịch viên. Quý vị có thể yêu cầu đọc các tài liệu và gửi một số tài liệu cho quý vị bằng ngôn ngữ của quý vị. Để được trợ giúp, hãy gọi đến Trung tâm Liên lạc Hội viên theo số điện thoại trên thẻ nhận dạng của quý vị hoặc gọi đến số 1-888-802-7001 (TTY: 711).