Health Net Health Plan of Oregon, Inc., "Health Net"

Large Group

Enrollment and Change Application

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

Medical insurance plans are provided by Health Net Health Plan of Oregon, Inc., "Health Net". Life and AD&D plans are underwritten by Health Net Life Insurance Company. Dental PPO insurance plans are underwritten by Health Net Health Plan of Oregon, Inc. and administered by Dental Benefit Providers, Inc. (DBP). Vision plans are underwritten by Health Net Health Plan of Oregon, Inc. and serviced by Envolve Vision, Inc. Envolve Vision, Inc. and Health Net Health Plan of Oregon, Inc. are subsidiaries of Centene Corporation.

WELCOME TO HEALTH NET

Simple steps for completing the form:

1. Review the materials enclosed in your enrollment packet. Be sure that you understand the coverage options that are available to you by your employer.

2a. **If you are *declining* coverage** for yourself and/or your dependents, section 6 is required. Do not fill out any other sections.

2b. **If you are *accepting* coverage** for yourself and/or your dependents, sections 1, 2, 3, 5, and 7 are required.

The Affordable Care Act (ACA) requires Health Net to provide to the IRS confirmation of health care coverage for yourself, as the subscriber, and your covered dependents. The IRS uses this information to confirm each member has minimum essential coverage. Please ensure that the Social Security number (SSN) is accurate for yourself and each dependent you are enrolling. For more information about the individual shared responsibility payment provision, go to http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision.

3. If you choose to enroll in the EPO, POS or CommunityCare plans, **you must select your primary care physician (PCP).** Be sure to fill in the names and 10-digit enrollment ID numbers as they appear in Health Net's online ProviderSearch tool.

   Note: If you do not select a PCP, one will be selected for you.

4. If you choose to enroll in a PPO insurance plan, you are not required to select a PCP to enroll.

5. Make a copy of the completed application for your records. **If a correction is needed, cross out and initial each correction. Please do not use a white-out product.**

For employer use only:

Existing Group
Submit to Membership Accounting:

Email: HNOregon_Enrollment@healthnet.com
Fax: 1-855-607-0982

New Group
Please send all completed paperwork to your designated account executive or broker.

health net™

TO BE COMPLETED BY EMPLOYER	
Employer name:	
Requested effective date:	Employer group number *(medical)*:
Employee eligibility date: ☐ Same as hire date ☐ Other: _____	

Important: Please print all sections in black ink. You are entitled to see a Summary of Benefits and Coverage (SBC) before you choose a plan. Please contact your employer if you do not have the SBC for the plan you have selected.

1. Health plan information (Please select your coverage and print the plan name in the space provided.)

MEDICAL

☐ PPO: _____
☐ CommunityCare 1T[1]: _____
☐ CommunityCare 3T[1]: _____
☐ Other: _____
☐ EPO: _____
☐ POS/Triple Option: _____

Complete this section only if you are electing a PPO or CommunityCare plan with an Integrated Health Savings Account (HSA):

☐ *(Opt in)* Employer-Sponsored HSA ☐ *(Opt out)* Employer-Sponsored HSA

DENTAL

☐ Plus: _____
☐ Preferred Value: _____
☐ Essentials
☐ Value: _____
☐ Preferred Plus: _____

VISION

☐ Elite 1010-1
☐ Preferred 1025-2
☐ Plus 20-1
☐ Exam Only
☐ Supreme 010-2
☐ Preferred 1025-3
☐ Preferred Value 10-3

2. Reason for application

☐ Plan change
☐ Change address/name
☐ Delete dependent *(list names below)*
☐ Other: _____

☐ New hire ☐ Rehire ☐ Open Enrollment

Special Enrollment Period

Qualifying event date: _____

Add dependent:
☐ Marriage
☐ Newborn/Adoption/Legal guardianship/Court order/Assumption of parent-child relationship
☐ Loss of prior coverage ☐ Other *(specify)*: _____

☐ **COBRA**
Effective date: _____
Qualifying event: _____
Qualifying event date: _____

3. Employee personal information

Last name:	First name:	MI:	☐ Male ☐ Female
Residence address:	City:	State:	ZIP:
Date of birth *(mm/dd/yyyy)*:	Social Security #/Tax ID #:	Marital status: ☐ Single ☐ Married ☐ Domestic partner	
Telephone #:	Work phone #:	Email address:	
Date of hire:	Dept. #:	Job title:	☐ Salary ☐ Hourly ☐ Retired

Entering eligible class? ☐ Part-time to full-time ☐ Temporary to permanent ☐ Hourly to salaried

If available, I would prefer to receive communication and plan information in Spanish: ☐ Yes ☐ No

Primary care physician *(For EPO, POS, CommunityCare plans only)*:

PCP enrollment ID # *(10-digit PCP number)*: | Is this your current PCP? ☐ Yes ☐ No

[1]Available to employer groups located in Multnomah, Clackamas, Washington, Clatsop, Columbia, and Tillamook counties. Available to employees in Multnomah, Clackamas, Washington, Clatsop, Columbia, and Tillamook counties, and Clark County, WA.

Employee name: ______________________________

4. Family information – please list all eligible family members to be enrolled
(Attach additional sheets if necessary.)

Spouse/Domestic partner ☐ M ☐ F	Last name:	First name:	MI:
Residence address: ☐ Check here if same as subscriber	City:	State:	ZIP:
Date of birth *(mm/dd/yyyy)*:	Social Security #/Tax ID #:		
Primary care physician *(For EPO, POS, CommunityCare plans only)*:	PCP enrollment ID # *(10-digit PCP number)*:		
Is this your current PCP? ☐ Yes ☐ No			

☐ Son ☐ Daughter	Last name:	First name:	MI:
Residence address: ☐ Check here if same as subscriber	City:	State:	ZIP:
Date of birth *(mm/dd/yyyy)*:	Social Security #/Tax ID #:		
Primary care physician *(For EPO, POS, CommunityCare plans only)*:	PCP enrollment ID # *(10-digit PCP number)*:		
Is this your current PCP? ☐ Yes ☐ No			

☐ Son ☐ Daughter	Last name:	First name:	MI:
Residence address: ☐ Check here if same as subscriber	City:	State:	ZIP:
Date of birth *(mm/dd/yyyy)*:	Social Security #/Tax ID #:		
Primary care physician *(For EPO, POS, CommunityCare plans only)*:	PCP enrollment ID # *(10-digit PCP number)*:		
Is this your current PCP? ☐ Yes ☐ No			

☐ Son ☐ Daughter	Last name:	First name:	MI:
Residence address: ☐ Check here if same as subscriber	City:	State:	ZIP:
Date of birth *(mm/dd/yyyy)*:	Social Security #/Tax ID #:		
Primary care physician *(For EPO, POS, CommunityCare plans only)*:	PCP enrollment ID # *(10-digit PCP number)*:		
Is this your current PCP? ☐ Yes ☐ No			

Employee name: ______________________________

5. Do you or your dependents have other health care coverage (including Medicare)?

☐ Yes, if "Yes," please complete this section.
☐ No, If "No," please proceed to Section 6.

☐ Self	Name:		Name of other insurance carrier:		Prior coverage start date *(mm/dd/yy)*:	
Prior coverage end date *(mm/dd/yy)*:	Reason for ending coverage:		Group #/Policy ID #:	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:

☐ Spouse ☐ Domestic partner	Name:			Name of other insurance carrier:	Prior coverage start date *(mm/dd/yy)*:	
Prior coverage end date *(mm/dd/yy)*:	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? ☐ Yes ☐ No	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:

☐ Son ☐ Daughter	Name:			Name of other insurance carrier:	Prior coverage start date *(mm/dd/yy)*:	
Prior coverage end date *(mm/dd/yy)*:	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? ☐ Yes ☐ No	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:

☐ Son ☐ Daughter	Name:			Name of other insurance carrier:	Prior coverage start date *(mm/dd/yy)*:	
Prior coverage end date *(mm/dd/yy)*:	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? ☐ Yes ☐ No	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:

☐ Son ☐ Daughter	Name:			Name of other insurance carrier:	Prior coverage start date *(mm/dd/yy)*:	
Prior coverage end date *(mm/dd/yy)*:	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? ☐ Yes ☐ No	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:

Employee name: _____

6. Declination of coverage (Complete this section if any coverage is being declined by you or your eligible dependents.)

Waiving coverage for:	Person(s) waiving coverage (First, MI, Last Name):
☐ Medical ☐ Dental ☐ Vision	Employee: Reason for waiver: ☐ Individual ☐ Employer group ☐ Medicare ☐ Other: _____
☐ Medical ☐ Dental ☐ Vision	Spouse/Domestic Partner:
☐ Medical ☐ Dental ☐ Vision	Dependent Child:
☐ Medical ☐ Dental ☐ Vision	Dependent Child:
☐ Medical ☐ Dental ☐ Vision	Dependent Child:

IF YOU ARE DECLINING COVERAGE – STOP AND READ CAREFULLY

I have decided to decline coverage for myself and/or my dependent(s). I acknowledge that my dependents and I may have to wait to be enrolled until the next annual Open Enrollment Period or Special Enrollment Period due to a qualifying event. The available coverages have been explained to me by my employer, and I have been given the chance to apply for the available coverages. Additionally, by signing below, I certify, to the best of my knowledge or belief, that the reason I am declining coverage is accurate as indicated by the check marks above.

Employee signature: _____ **Date:** _____
(Sign only if declining coverage. If signed in error, please cross out and initial.)

7. Acceptance of coverage (Signature required.)

In applying for enrollment as indicated on this enrollment form, I declare that, to the best of my knowledge, all of the information on this form is true and complete, and all of the persons for whom I am requesting enrollment are eligible for coverage. I, the applicant (employee), on my behalf and on behalf of every covered Dependent listed on this form or added in the future, agree that in the event any health care benefits provided to me or any covered Dependent by Health Net are the primary responsibility of Medicare or of any coverage for work-related injuries, illness or conditions, or of any third party on account of any injury, illness, condition, or damage, I will fully inform Health Net and will execute such assignments, liens or other documents which may be necessary to enable Health Net to recover the value of services provided. I further agree that in the event I, any Dependent or any of my family members collect benefits, damages or reimbursement from Medicare, or any other third party with respect to such injury, illness, condition, or damage, I will immediately reimburse Health Net to the full extent of services provided by Health Net in accordance with the group plan contract.

I also agree to be bound by each and every provision of the group plan contract (including all schedules and attachments which are a part of the group plan contract) as now in effect and as may be amended in the future, and agree that all my rights are as specifically set forth in the group plan contract. I authorize my employer to deduct from my earnings any amount required to cover my share of the premiums or prepayment fees, if any, payable under the group contract. I acknowledge that I have selected a Primary Care Physician/Provider from the current Health Net participating provider network, (for Exclusive Provider Organization (EPO), Triple Option/POS and CommunityCare plans); that this list identifies participating providers as of the date of publication; that changes in a provider's status, and additions to, or deletions from, this list may occur; and that Health Net and/or its representatives neither warrants nor guarantees the availability of any specific participating provider. I acknowledge that Health Net's benefits are only available if obtained in compliance with all provisions of the group plan contract. I acknowledge that all participating providers are independent contractors and are not agents, servants, officers, employees, partners, or joint venturers of or with, and are not controlled by, Health Net; that the participating providers, including primary care physicians, are responsible for the delivery of, or arrangement for, all medical services to me and my Dependents; and Health Net is not and will not be responsible for the deliberate or negligent acts or omissions of any such participating provider or any nonparticipating provider.

Employee signature: _____ **Date:** _____
(Sign only if accepting coverage. If signed in error, please cross out and initial.)

Please contact the Health Net Customer Contact Center at the toll-free number below if you need assistance in completing this form or if you have questions about your coverage:

Medical: 1-888-802-7001

If you have questions about your dental, vision or life coverage, please call:

Dental: 1-877-410-0176
Vision: 1-866-392-6058
Life: 1-800-865-6288

You can print a temporary ID card to use until you receive your permanent ID card. To print a temporary ID card, create a Member Portal Account at www.healthnetoregon.com by selecting "Members" and "Register."

Emergency and urgently needed care:

- **If your situation is life-threatening or an emergency:** Call 911 or go to the nearest hospital.
- **If your situation is not so severe:** If you cannot call your primary care physician or physician group, or you need medical care right away, go to the nearest hospital or urgent care center.
- **If you are outside your physician group's service area:** Go to the nearest hospital or medical center, or call 911. In all cases, contact your primary care physician or participating physician group as soon as possible to inform them about your condition.
- **Call the number on your ID card within 48 hours of being admitted, or as soon as possible.**

Prior authorization:

You, the member, are responsible for obtaining prior authorization for certain services. Please check your plan certificate for a list of services requiring prior authorization.

For prior authorization, please call 1-888-802-7001.

Declination of coverage:

If you are declining enrollment for yourself or your Dependents (including your spouse or Domestic Partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this plan if you or your Dependents lose eligibility for the other coverage (or if your employer stops contributing toward your or your Dependents' other coverage). However, you must request enrollment within 30 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If you previously declined enrollment in this plan for yourself or your Dependents because of coverage under a Medicaid plan or CHIP plan, you can enroll within 60 days of loss of such coverage. If you become eligible for premium assistance under a Medicaid plan or CHIP plan, you or your Dependents can enroll in this plan within 60 days of becoming eligible for premium assistance.

Health Net Health Plan of Oregon, Inc., 13221 SW 68th Pkwy., Ste. 500, Tigard, Oregon 97223 · 1-888-802-7001 · www.healthnetoregon.com