Small Group

2026 Enrollment and Change Application

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

Medical insurance plans are offered by Health Net Health Plan of Oregon, Inc. (Health Net). Life/AD&D insurance 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 EyeMed Vision Care, LLC. Health Net Health Plan of Oregon, Inc. and Health Net Life Insurance Company 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 from your employer.

2a. **If you are *declining* coverage** for yourself and/or your dependents, section 7 is required. Do not fill out any other sections.
Reminder: If you wish to decline dental and/or vision coverage for an eligible dependent, you must complete the ***Declination of Coverage*** section of this form.

2b. **If you are accepting coverage** for yourself and/or your dependents, sections 1, 2, 3, 5, and 8 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 and is not subject to the ACA's individual shared responsibility payment provision. 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 www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision.

3. 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:

Submit to Membership Accounting:
Email: HNOregon_Enrollment@healthnet.com
Fax: 855-607-0982

health net

To be completed by employer	
Employer name:	Administrative Email:
Requested effective date: _____	Employer group number (medical):
Employee eligibility date: ☐ Same as hire date ☐ Other: _____	

Important: 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 (All medical plans include pediatric vision coverage and alternative care benefits. Pediatric dental coverage is included with all medical plans, with the exception of the Health Net Oregon Standard PPO plans.)

PPO

Platinum	☐ P10-250-1-3500DX PD	☐ P10-500-1-3500DX PD	☐ P10-750-1-3500DX PD	
Gold	☐ P25-500-2-8750DX PD	☐ P15-1000-2-8750DX PD	☐ P15-1500-2-8750DX PD	☐ P15-2000-2-8750DX PD
	☐ P25-2000-2-7000DX PD	☐ P15-2500-2-8750DX PD	☐ P15-3000-2-8750DX PD	
Silver	☐ P40-3000-3-9200ES PD	☐ P35-4500-3-9200ES PD	☐ P40-6000-3-9200ES PD	
Bronze	☐ P8250-0-8250ES PD			

HIGH DEDUCTIBLE PPO

Silver	☐ HD3400-3-6750 PD	☐ HD4000-3-6750 PD
Bronze	☐ HD7100-0-7100 PD	

HEALTH NET OREGON STANDARD PPO
(Alternative care benefits related to this plan include chiropractic, acupuncture, and naturopathy.)

☐ Health Net Oregon Standard Silver Plan ☐ Health Net Oregon Standard Bronze Plan

Dental		Vision		
☐ Plus D25-1855-2000	☐ Plus D50-1855-1500	☐ Elite 1010-1	☐ Preferred 1025-2	☐ Preferred 1025-3
☐ Plus D50-185-1000	☐ Value D50-185-1500V			
☐ Preferred Plus DP50-1855-1500	☐ Essentials D50-16-500			

Notice for ACA-compliant plans: The health care reform law requires pediatric dental services to be covered as one of the 10 required Essential Health Benefits. Pediatric dental must be available either as part of your Health Net plan or with another qualified plan offered by your employer.

2. Reason for application

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

☐ New hire ☐ Rehire ☐ Open Enrollment ☐ **State Continuation**

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/yy)*:	Social Security #:	Marital status: ☐ Single ☐ Married ☐ Domestic partner	
Telephone #:	Work phone #:	Email address:	
Date of hire:	Dept. #: / Job title:	☐ Salary ☐ Hourly	

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

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 #:		

☐ 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 #:		

☐ 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 #:		

☐ 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 #:		

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 start 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 start 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 start 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 start 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 #:

6. Group term life insurance (Complete this section only if your Employer is offering life insurance.)

Life/AD&D coverage: ☐ Yes ☐ No

Life beneficiary (full name):	Relationship:	%
Life beneficiary (full name):	Relationship:	%
Life beneficiary (full name):	Relationship:	%
Life beneficiary (full name):	Relationship:	%

Employee name: _____

7. 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.)

8. Acceptance of coverage (Signature required.)

Note: The premium you must pay for this insurance will be determined in part by the consolidated experience of all members of the group in which you participate.

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 I 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 in accordance with the group contract/policy.

I also agree to be bound by each and every provision of the group contract/policy (including all schedules and attachments which are a part of the group contract/policy) as now in effect and as may be amended in the future, and I agree that all my rights are as specifically set forth in the group contract/policy. 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 Health Net's benefits are only available if obtained in compliance with all provisions of the group contract/policy. 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: 888-802-7001

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

Dental: 877-410-0176
Vision: 866-392-6058
Life: 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 888-802-7001.

Declination of coverage:

If you are declining enrollment for yourself or your Dependents 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 that other coverage (or if your employer stops contributing toward your or your Dependents' other coverage). However, you must request enrollment within 31 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, guardianship, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 31 days after the marriage, birth, guardianship, 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.

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 ይችላሉ። የተነበበልዎትን እና የተወሰኑ በቋንቋዎ የተላኩልዎትን ሰነዶች መግኘት ይችላሉ። ለእርዳታ፣ ለደንበኞች ግንኙነት ማዕከል በመታወቂያ ካርድዎ ላይ ያለውን ቁጥር ይደውሉ ወይም በ 1-888-802-7001 (TTY: 711) ይደዉሉ።

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 (TTY: 711) 1-888-802-7001.

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)
Tajaajila 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 전화해주십시오.

Cambodian (Khmer)
សេវាភាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលអ្នកបកប្រែបាន។ អ្នកអាចឱ្យគេអានឯកសារជូនអ្នក និងឆ្លើឯកសារខ្លះជូនអ្នក ជាភាសារបស់អ្នក។ សំរាប់ជំនួយ ទូរស័ព្ទទៅមជ្ឈមណ្ឌលទំនាក់ទំនងអតិថិជន តាមលេខនៅលើប័ណ្ណ D របស់អ្នក ឬហៅលេខ 1-888-802-7001 (TTY: 711)។

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

Punjabi
ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਲਈ ਕੋਈ ਲਾਗਤ ਨਹੀਂ। ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਆ 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).