Health Net®

Washington Eligibility/Enrollment Inquiry

Group information

Group name:	Agent:
Renewal date:	Rep:
Today's date:	Date needed by:

Are you a wholly-owned division of another company? ☐ Yes ☐ No

If "Yes," please provide parent company name and location: _____

The total number of employees of entire company[1] (if more than 50, you may estimate): _____

[1]ENTIRE COMPANY means the parent company and all its wholly-owned divisions, including yours.

Employer contributions for health insurance: For employees: _____ For dependents: _____

Total number of employees on your payroll: _____	Number in other states: _____
Includes part-time employees and your employees in other states. Does not include temps, contractors or seasonal employees.	If you have employees working in other states, please attach a sheet or census indicating their locations.

Average number of **your** owners/employees working 20 hours or more per week: _____

Note: An employee eligible for insurance coverage is one who has satisfied the probation period and works the number of hours per week required.

Hours per week required to be considered eligible for insurance coverage: _____

Probation period required to be considered eligible for insurance coverage: _____

Total number of **your** employees ***eligible for insurance coverage***: _____

Multiple carrier enrollment/eligibility inquiry

Do you offer another medical health plan besides Health Net Health Plan of Oregon? _____

If you answered "Yes," please enter the carrier information and complete the attached census. If there are more than two other carriers, please attach an additional sheet.

Carrier #2: _____	**Carrier #3:** _____
Employer contributions: _____	Employer contributions: _____
Number of employees covered: _____	Number of employees covered: _____
Anniversary date: _____	Anniversary date: _____
Current rates:	Current rates:
_____	_____
Emp only / Emp & Spouse / Emp & Child / Emp & Family	Emp only / Emp & Spouse / Emp & Child / Emp & Family
Renewal rates:	Renewal rates:
_____	_____
Emp only / Emp & Spouse / Emp & Child / Emp & Family	Emp only / Emp & Spouse / Emp & Child / Emp & Family
Benefit design: _____	Benefit design: _____
_____	_____
_____	_____
You may also attach a carrier plan summary.	You may also attach a carrier plan summary.