Health Net®

Large Business Application

for Group Enrollment and Change (Oregon)

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 administrative use only:	
Existing Business/Group PO Box 9103 Van Nuys, CA 91409-9103 www.healthnet.com	**New Business/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 *(new hire only)*: ☐ Same as hired 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 (Select coverage.)

EPO

☐ CommunityCare 1T:[1] _____ ☐ CommunityCare 3T:[1] _____

☐ Other: _____

PPO

☐ PPO: _____ ☐ HDHP: _____

☐ PPO Integrated HSA: _____ ☐ PPO Integrated HRA: _____

☐ Other: _____

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

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

Dental

☐ Plus: _____ ☐ Value: _____

☐ Preferred Value: _____ ☐ Preferred Plus: _____

☐ Essentials

Vision

☐ Elite 1010-1 ☐ Supreme 010-2

☐ Preferred 1025-2 ☐ Preferred 1025-3

☐ Plus 20-1 ☐ Preferred Value 10-3

☐ Exam Only

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 # *(required for all applicants)*:	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

Employee name: ____ Last 4 digits of Social Security #: __ __ __ __

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 # *(required for all applicants)*:		
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 # *(required for all applicants)*:		
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 # *(required for all applicants)*:		
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 # *(required for all applicants)*:		
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: ____ Last 4 digits of Social Security #: __ __ __ __

5. Do you or your dependents have other health care coverage?

☐ No ☐ Yes If "Yes," please complete this section, including Medicare.

☐ 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 #:

[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: _____ Last 4 digits of Social Security #: __ __ __ __

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

Employee personal information

Last name:	First name:	MI:	Social Security #/Tax ID #:

Declining medical coverage for:
☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent(s)
Name(s): _____

Reason: ☐ Other group coverage through this employer ☐ Individual coverage
☐ Other group coverage by another group *(e.g., spouse's employer)*
☐ Other: _____

Declining dental coverage for:
☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent(s)
Name(s): _____

Reason: ☐ Other group coverage through this employer ☐ Individual coverage
☐ Other group coverage by another group *(e.g., spouse's employer)*
☐ Other: _____

Declining vision coverage for:
☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent(s)
Name(s): _____

Reason: ☐ Other group coverage through this employer ☐ Individual coverage
☐ Other group coverage by another group *(e.g., spouse's employer)*
☐ Other: _____

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

If you have questions about your PCP, contact Health Net Provider Services at 1-800-641-7761.

You can use your copy of the Health Net enrollment form as your temporary ID card until you receive your permanent ID card.

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 1-800-977-7282.

Products/Entities:

Health Net Health Plan of Oregon, Inc. offers the following products: CommunityCare, EPO and PPO.

Health Net Life Insurance Company underwrites: Life and AD&D insurance.

Health Net Health Plan of Oregon, Inc. offers the following products administered by Dental Benefit Providers, Inc.: Dental PPO (DPPO).

Health Net Health Plan of Oregon, Inc. offers the following products administered by Envolve Vision, Inc.: PPO Vision.

Declination of coverage:

If you are declining enrollment for yourself or your Dependents (including your spouse or Registered 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.

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 us at the number listed on your ID card. Employer group members please call 1-888-802-7001 (TTY: 711).

Arabic
خدمات اللغة مجانية. يمكنك الحصول على مترجم فوري. ويمكنك الحصول على وثائق مقروءة لك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة الهوية. يرجى من أعضاء مجموعة أصحاب العمل الاتصال على الرقم 1-888-802-7001 (TTY: 711).

Chinese
免費語言服務。您可使用口譯員。您可請人將文件內容唸給您聽。如需協助，請致電您會員卡上所列的電話號碼與我們聯絡。雇主團體的會員請致電 1-888-802-7001 (TTY: 711) 。

Cushite (Oromo)
Waa Lacag la'aan Adeegyada Luuqada. Waxaad heli kartaa turjubaan. Waxaad heli kartaa in waraaqaha laguu aqriyo. Wixii caawin ah, naga soo wac lambarka ku qoran kaarka Aqoonsigaaga. Xubnaha kooxda badrooniga fadlan soo wac 1-888-802-7001 (TTY: 711).

French
Services linguistiques sans frais. Vous pouvez obtenir un interprète. Les documents peuvent vous être lus. Pour obtenir de l'aide, appelez-nous au numéro indiqué sur votre carte d'identité. Membres du groupe employeur veuillez composer le 1-888-802-7001 (TTY: 711).

German
Kostenloser Sprachendienst. Dolmetscher sind verfügbar. Dokumente können Ihnen vorgelesen werden. Wenn Sie Hilfe benötigen, rufen Sie uns unter der Nummer auf Ihrer ID-Karte an. Arbeitgeber-Gruppenmitglieder rufen bitte unter 1-888-802-7001 (TTY: 711) an.

Japanese
無料の言語サービス。通訳をご利用いただけます。文書をお読みします。援助が必要な場合は、IDカードに記載されている番号までお電話ください。雇用主を通じた団体保険のメンバーの方は、1-888-802-7001 (TTY: 711) までお電話ください。

Korean
무료 언어 서비스. 통역 서비스를 받을 수 있습니다. 문서 낭독 서비스를 받으실 수 있습니다. 도움을 원하시면, 보험 ID에 수록된 번호로 전화해 주십시오. 고용주 그룹 가입자분은 1-888-802-7001 (TTY: 711)번으로 전화해 주십시오.

Khmer
សេវាភាសាដោយឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ អ្នកអាចស្តាប់គេអានឯកសារឱ្យអ្នក។ សម្រាប់ជំនួយ សូមទាក់ទងយើងខ្ញុំតាមរយៈទូរស័ព្ទដែលមាននៅលើកាតសម្គាល់ខ្លួនរបស់អ្នក។ សមាជិកក្រុមនិយោជក សូមទាក់ទងទៅលេខ បេក្ខជន សូមទាក់ទងទៅលេខ 1-888-802-7001 (TTY: 711)។

Romanian
Servicii lingvistice gratuite. Puteţi obţine un interpret. Puteţi avea documente citite pentru dvs. Pentru asistenţă telefonaţi-ne la numărul indicat pe cardul de membru. Membrii grupului angajatorilor să telefoneze la 1-888-802-7001 (TTY: 711).

Persian (Farsi)

خدمات زبان به طور رایگان. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید که اسناد برای شما قرائت شوند. برای کسب اطلاعات، با ما به شماره ای که در کارت شناسایی شما قید شده تماس بگیرید. اعضای گروه کارفرما لطفاً با شماره 1-888-802-7001 (TTY: 711) تماس بگیرید.

Russian

Бесплатная помощь переводчиков. Вы можете получить помощь устного переводчика. Вам могут прочитать документы. За помощью обращайтесь к нам по телефону, приведенному на вашей идентификационной карточке участника плана. Если вы участник коллективного плана, предоставляемого работодателем, звоните по телефону 1-888-802-7001 (TTY: 711).

Spanish

Servicios de idiomas sin costo. Puede solicitar un intérprete. Puede obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación. Los afiliados del grupo del empleador deben llamar al 1-888-802-7001 (TTY: 711).

Thai

ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังได้ สำหรับความช่วยเหลือ โทรหาเราตามหมายเลขที่ให้ไว้บนบัตรประจำตัวของคุณ สมาชิกกลุ่มนายจ้าง กรุณาโทร 1-888-802-7001 (TTY: 711)

Ukrainian

Безплатні послуги перекладу. Ви можете скористуватися послугами перекладача. Вам можуть прочитати ваші документи. Щоб отримати допомогу, телефонуйте нам за номером, який вказаний на вашій ідентифікаційній картці (ID). Учасників групового страхового плану від працедавця просимо телефонувати за номером 1-888-802-7001 (TTY: 711).

Vietnamese

Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu cầu được đọc cho nghe tài liệu. Để nhận trợ giúp, hãy gọi cho chúng tôi theo số được liệt kê trên thẻ ID của quý vị. Các thành viên thuộc chương trình theo nhóm của chủ sử dụng lao động vui lòng gọi số 1-888-802-7001 (TTY: 711).

Health Net complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health Net does not exclude people or treat them differently because of race, color, national origin, 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 http://www.hhs.gov/ocr/office/file/index.html.