Health Net®

Supplemental Dependent

Oregon Enrollment *and* Change Form

Employer name:	Group number:	Effective date:

Please print clearly.

Employee information

Social Security number:	Last name:	First name:	MI:

Dependent information

List member information below. Incorrect or omitted information may delay enrollment or affect payment of claims.		Birth date	Medicare	All EPO[1] and Triple Option Plan enrollees must designate a Primary Care Provider (PCP). Each family member may choose a different PCP. Our website and provider directories list participating providers.		
Dependent ☐ M ☐ F ☐ Add ☐ Delete	Last name: First name: MI:	mm/dd/yy:	☐ Part A ☐ Part B	☐ Disabled ☐ Full-time student ☐ Out-of-area	Primary Care Provider: (last, first name)	Current patient? ☐ Yes ☐ No
	Residence address: (if different from employee) City, state, ZIP:				PCP number:	
Dependent ☐ M ☐ F ☐ Add ☐ Delete	Last name: First name: MI:	mm/dd/yy:	☐ Part A ☐ Part B	☐ Disabled ☐ Full-time student ☐ Out-of-area	Primary Care Provider: (last, first name)	Current patient? ☐ Yes ☐ No
	Residence address: (if different from employee) City, state, ZIP:				PCP number:	
Dependent ☐ M ☐ F ☐ Add ☐ Delete	Last name: First name: MI:	mm/dd/yy:	☐ Part A ☐ Part B	☐ Disabled ☐ Full-time student ☐ Out-of-area	Primary Care Provider: (last, first name)	Current patient? ☐ Yes ☐ No
	Residence address: (if different from employee) City, state, ZIP:				PCP number:	
Dependent ☐ M ☐ F ☐ Add ☐ Delete	Last name: First name: MI:	mm/dd/yy:	☐ Part A ☐ Part B	☐ Disabled ☐ Full-time student ☐ Out-of-area	Primary Care Provider: (last, first name)	Current patient? ☐ Yes ☐ No
	Residence address: (if different from employee) City, state, ZIP:				PCP number:	
Dependent ☐ M ☐ F ☐ Add ☐ Delete	Last name: First name: MI:	mm/dd/yy:	☐ Part A ☐ Part B	☐ Disabled ☐ Full-time student ☐ Out-of-area	Primary Care Provider: (last, first name)	Current patient? ☐ Yes ☐ No
	Residence address: (if different from employee) City, state, ZIP:				PCP number:	

[1]Exclusive Provider Organization

Health Net Health Plan of Oregon, Inc., 13221 SW 68th Pkwy., Ste. 200, Tigard, OR 97223 • 1-888-802-7001 • www.healthnet.com

Definition: "Credible Coverage" means health care coverage under a group or individual Health Benefit Plan, Medicare, Medicaid, military-sponsored health care, a medical care program of the Indian Health Service or of a tribal organization, a state health benefits risk pool, a Federal Employees' Health Benefit Plan (FEHBP), a public health plan, or a Health Benefit Plan under the Peace Corps Act, except coverage consisting solely of coverage of benefits for which credit is not required under applicable law. Coverage is creditable only if there has not been a gap in coverage exceeding 63 days.

IMPORTANT: THE FOLLOWING TERMS ARE A PART OF THIS APPLICATION. YOU MUST READ THEM CAREFULLY. DO NOT SIGN THE FRONT OF THE APPLICATION UNTIL YOU UNDERSTAND THESE TERMS.

I, the applicant (employee) on my behalf and on behalf of every covered dependent listed on this form or added in the future, hereby:

1. Agree that in the event any health care benefits provided to me or any covered dependent by Health Net Health Plan of Oregon, Inc. (Health Net of Oregon) and/or its representatives 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 of Oregon and/or its representatives and will execute such assignments, liens or other documents which may be necessary to enable Health Net of Oregon and/or its representatives to recover the value of services provided. I further agree that in the event I, or 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 of Oregon and/or its representatives to the full extent of services provided by Health Net of Oregon and/or its representatives in accordance with the group contract/policy; and
2. 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 agree that all my rights are as specifically set forth in the group contract/policy; and
3. 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; and
4. Acknowledge that I have selected a Primary Care Physician/Provider from the current Health Net of Oregon participating provider network, (for Exclusive Provider Organization (EPO) and Triple Option/POS plans); that this list identifies participating providers as of the date of publication; and that changes in a provider's status, and additions to or deletions from this list may occur, that Health Net of Oregon and/or its representatives neither warrants nor guarantees the availability of any specific participating provider; and
5. Acknowledge that Health Net of Oregon and/or its representatives' benefits are only available if obtained in compliance with all provisions of the group contract/policy; and
6. Acknowledge that all participating providers are independent contractors and are not agents, servants, officers, employees, partners or joint ventures of or with and are not controlled by Health Net of Oregon and/or its representatives; 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 of Oregon and/or its representatives is not and will not be responsible for the deliberate or negligent acts or omissions of any such participating provider or any nonparticipating provider; and
7. Acknowledge that information about me or an enrolling family member may be obtained from medical records as indicated in the medical information release portion of the application form. Other than that from medical records, personal information will not be collected from any sources other than the applicant or individuals proposed for coverage.

Send this application to:

Health Net Health Plan of Oregon, Inc.
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Tigard, OR 97223

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