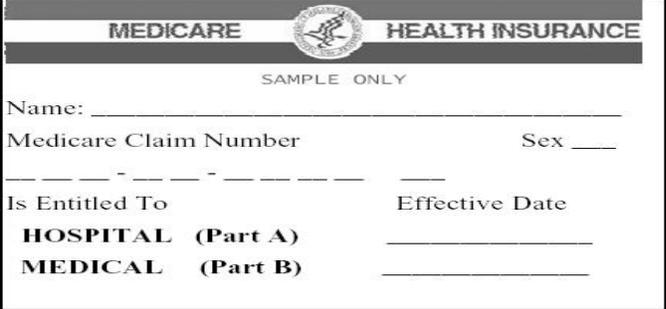




Health Net Group Enrollment Form Pearl Private Fee-For-Service Plan

Please return to: Health Net Enrollment, P.O. Box 870500, Surfside Beach, SC 29587-8711
Please keep the pink copy of this form as your temporary ID card.

To enroll in Health Net Pearl, please provide the following information:					
Employer Name:			Group #:		
Last name		First name		Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Birth Date: (mm/dd/yyyy)		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number (optional):		Home Phone Number: ()
Permanent Residence Street Address:			Apt#:	City:	State: ZIP
Mailing Address (only if different from above):			Apt#:	City:	State: ZIP
Please provide Your Medicare Insurance Information Please take out your Medicare Card to complete this section. <ul style="list-style-type: none"> • Please fill in these blanks so they match your red, white and blue Medicare Card - OR - • Attach a copy of your Medicare Card or your letter from the Social Security Administration or Railroad Retirement Board You must have Medicare Part A and Part B to join a Medicare Advantage plan.					
			Please read and answer these important questions: NOTE: Medicare eligible spouse or dependent(s) must fill out separate forms		
Are you the retiree? <input type="checkbox"/> Y <input type="checkbox"/> N		Are you covering a spouse or dependents under this plan? <input type="checkbox"/> Y <input type="checkbox"/> N			
If yes, retirement date (mm/dd/yy):		If yes, name of spouse: _____			
If no, name of retiree:		Name of dependents: _____			
Do you or your spouse work? <input type="checkbox"/> Y <input type="checkbox"/> N					
Do you receive Medicaid benefits? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, please provide your Medicaid number: _____					
Have you had Medicare prescription drug coverage or other drug coverage that was at least as good as standard Medicare drug coverage since you became eligible to join a Medicare drug plan? <input type="checkbox"/> Y <input type="checkbox"/> N					
If no, you may have to pay a penalty. Health Net may ask you to provide evidence that some or all of your previous drug coverage was at least as good as Medicare drug coverage. If you have questions about the enrollment penalty, call Health Net at 1-800-596-6565, 8:00am-8:00pm, 7 days a week.					
Do you have End Stage Renal Disease (ERSD)? <input type="checkbox"/> Y <input type="checkbox"/> N					
If you answered "yes" to this question and you do not need regular dialysis anymore, or have had a successful kidney transplant, please attach a note or records from your doctor showing you do not need dialysis or have had a successful kidney transplant.					
Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits, or State pharmaceutical assistance programs.					
Will you have other <u>prescription</u> drug coverage in addition to Health Net Pearl? <input type="checkbox"/> Y <input type="checkbox"/> N					
If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:					
Name of other coverage:			ID# for coverage:		
Are you a resident in a long-term care facility, such as a nursing home? <input type="checkbox"/> Y <input type="checkbox"/> N					
If "yes" please provide the following information:					
Name of institution: _____					
Address & Phone Number of institution: _____					
Name(s) of your current physician(s) or clinic(s): [optional]*					
Physician/Clinic Name		Specialty		City	
Phone Number					
*Providing this information will allow us to send educational materials to your physician(s)/clinic(s) about how your plan works.					
Please Read the Reverse Side and Sign Below					
Your Signature:			Today's Date:		
If you are the authorized representative, you must provide the following information:					
Name:			Relationship to Enrollee:		
Address:			Phone Number:		
Office Use Only					
Name of HN Rep (if assisted in enrollment):			ICEP/IEP:		Rep ID:
Group #:			AEP:		OEP:
Effective Date of Coverage:			SEP(type):		

HEALTH NET PFFS ENROLLMENT FORM

FORMS

By completing this enrollment application, I agree to the following:

Health Net Pearl is a Medicare Advantage plan and I will need to keep my Parts A and B. I can only be in one Medicare Advantage plan at a time. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to Health Net Pearl or by calling 1-800-Medicare. TTY users should call 1-877-486-2048.

Health Net Pearl serves a specific service area. If I move out of the area that Health Net Pearl serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Health Net Pearl, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Health Net Pearl when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan.

I understand that beginning on the date Health Net Pearl coverage begins, I must get all of my health care from Health Net Pearl, with the exception of emergency or urgently needed services or out-of-area dialysis services. Medicare beneficiaries are generally not covered under Medicare while out of the county except for limited coverage in Canada and Mexico. Services authorized by Health Net Pearl and other services contained in my Health Net Pearl Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HEALTH NET PEARL WILL PAY FOR THE SERVICES.**

I understand that if I am injured through the actions of a third party and am entitled to a recovery from this injury, I will cooperate with Health Net Pearl in obtaining recovery. I will reimburse Health Net Pearl for provided services from the proceeds of any liability insurance settlement, no matter how the settlement is delineated (drafted or outlined).

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Health Net Pearl or by Medicare.