



Health Net Seniority Plus Group Enrollment Form

Please keep the pink copy of this form as your temporary ID card.

Please return to: Health Net Enrollment Services, P.O. Box 10420, Van Nuys, CA 91410-0420

To enroll in Health Net Seniority Plus, 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.

- 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.

MEDICARE				HEALTH INSURANCE	
SAMPLE ONLY					
Name: _____					
Medicare Claim Number _____				Sex _____	

Is Entitled To			Effective Date		
HOSPITAL (Part A)			_____		
MEDICAL (Part B)			_____		

Provider Selection	Language Preference	Participating Physician Group (PPG)	Primary Care Physician (PCP) Name
	<input type="checkbox"/> English	_____	_____
	<input type="checkbox"/> Spanish	PPG ID# _____	PCP ID# _____
	<input type="checkbox"/> Other		

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 employer 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? Y N

NOTE: Medicare eligible spouse or dependent(s) must fill out separate forms

Do you receive Medicaid benefits? Y N If yes, please provide your Medicaid number: _____

Do you have End Stage Renal Disease (ERSD)? Y 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 prescription drug coverage in addition to Health Net Seniority Plus? Y 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? Y N
 If "yes" please provide the following information:
 Name of institution: _____
 Address & Phone Number of institution: _____

Please Read the Reverse Side and Sign Below

Your Signature:	Today's Date:
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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):

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

Health Net Seniority Plus 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 Seniority Plus or by calling 1-800-Medicare. TTY users should call 1-877-486-2048.

Health Net Seniority Plus serves a specific service area. If I move out of the area that Health Net Seniority Plus 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 Seniority Plus, 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 Seniority Plus 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 Seniority Plus coverage begins, I must get all of my health care from Health Net Seniority Plus, 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 Seniority Plus and other services contained in my Health Net Seniority Plus Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HEALTH NET SENIORITY PLUS 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 Seniority Plus in obtaining recovery. I will reimburse Health Net Seniority Plus 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 Seniority Plus or by Medicare.