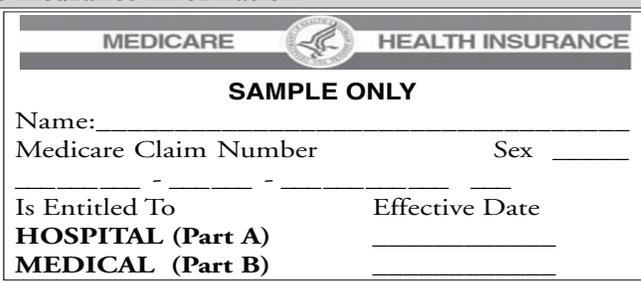


HEALTH NET SENIORITY PLUS EMPLOYER (HMO) ENROLLMENT REQUEST FORM

Please contact Health Net Seniority Plus Employer (HMO) if you need information in another language or format (Braille).

To Enroll in Health Net Seniority Plus Employer (HMO), Please Provide the following Information:			
Employer or Union 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	Home Phone Number: ()	
Permanent Residence Street Address (P.O. Box is not allowed):			
City:		State:	ZIP Code:
Mailing Address (only if different from your Permanent Residence Address):			
Street Address:		City:	State: ZIP Code:
Please Provide Your Medicare Insurance Information			
<p>Please take out your Medicare card to complete this section.</p> <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 Social Security or the Railroad Retirement Board. <p>You must have Medicare Part A and Part B to join a Medicare Advantage plan.</p>		 <p>MEDICARE HEALTH INSURANCE</p> <p>SAMPLE ONLY</p> <p>Name: _____</p> <p>Medicare Claim Number _____ Sex _____</p> <p>Is Entitled To _____ Effective Date _____</p> <p>HOSPITAL (Part A) _____</p> <p>MEDICAL (Part B) _____</p>	
Please read and answer these important questions			
<p>1. Are you the retiree? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, retirement date (month/day/year): _____</p> <p>If no, name of retiree: _____</p>		<p>2. Are you covering a spouse or dependents under this employer or union plan? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, name of spouse: _____</p> <p>Name of dependents: _____</p>	
3. Do you or your spouse work? <input type="checkbox"/> Yes <input type="checkbox"/> No			
4. Do you have End Stage Renal Disease (ESRD)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<p>If you have had a successful kidney transplant and/or you don't need regular dialysis any more, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.</p>			
5. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits, or State pharmaceutical assistance programs.			
<p>Will you have other <u>prescription</u> drug coverage in addition to Health Net Seniority Plus Employer (HMO)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:</p> <p>Name of other coverage: _____ ID # for Coverage: _____</p>			
6. Are you a resident in a long-term care facility, such as a nursing home? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<p>If "yes" please provide the following information:</p> <p>Name of Institution: _____</p> <p>Address & Phone Number of Institution (number and street): _____</p>			
7. Do you receive Medicaid benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide your Medicaid number: _____			
8. 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 program? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please Choose a Primary Care Physician (PCP), clinic or health center:			
<p>Please check one of the boxes below if you would prefer that we send you information in a language other than English or in another format: <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Braille, audio tape or large print</p> <p>Please contact Health Net Seniority Plus Employer (HMO) Member Services at 1-800-275-4737 if you need information in another format or language than what is listed above. Our office hours are 8:00 a.m. – 8:00 p.m., 7 days a week. TTY users should dial 1-800-929-9955.</p>			

Please Read and Sign Below

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

Health Net Seniority Plus Employer (HMO) is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (Example: Annual Enrollment Period from October 15 – December 7), or under certain special circumstances.

Health Net Seniority Plus Employer (HMO) serves specific service area. If I move out of the area that Health Net Seniority Plus Employer (HMO) serves, I need to notify the plan so that I can disenroll and find a new plan in my new area. Once I am a member of Health Net Seniority Plus Employer (HMO), 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 Employer (HMO) when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for the limited coverage near the U.S. border.

I understand that beginning on the date Health Net Seniority Plus Employer (HMO) coverage begins, I must get all of my health care from Health Net Seniority Plus Employer (HMO), except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Health Net Seniority Plus Employer (HMO) and other services contained in my Health Net Seniority Plus Employer (HMO) 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 EMPLOYER (HMO) WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Health Net Seniority Plus Employer (HMO), he/she may be paid based on my enrollment in Health Net Seniority Plus Employer (HMO).

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. I also acknowledge that Health Net Seniority Plus Employer (HMO) will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. 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 my behalf under the laws of the State where I live) 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 from Medicare.

Signature:	Today's Date:
If you are the authorized representative, you must sign above and provide the following information:	
Name: _____	
Address: _____	
Phone Number: (____) _____-_____	
Relationship to Enrollee: _____	

Office Use Only		
Name of staff member/agent/broker (if assisted in enrollment): _____	Rep ID: _____	
Plan ID #: _____		
Group #: _____	ICEP/IEP: _____	[OEP: _____]
Effective Date of Coverage: _____	AEP: _____	SEP (type): _____
Not Eligible: _____		