

MEDICAL, DENTAL, VISION, CHIROPRACTIC, ACUPUNCTURE ENROLLMENT APPLICATION

This page MUST be submitted or application will be considered incomplete.

SECTION 4 (continued): DEPENDENT ENROLLMENT GRID

Complete this section ONLY for those family members who are enrolling in one or more plans. Please cross section out if NOT enrolling any dependents.

	SPOUSE/DOMESTIC PARTNER	DEPENDENT #1	DEPENDENT #2	DEPENDENT #3
LAST NAME:				
FIRST NAME:				
SOCIAL SECURITY NUMBER:	- -	- -	- -	- -
DATE OF BIRTH:	/ /	/ /	/ /	/ /
GENDER:	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
RELATIONSHIP TO EMPLOYEE:	<input type="checkbox"/> SP or <input type="checkbox"/> DP			
DISABLED [#]	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
FULL-TIME STUDENT [#]	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
DEPENDENT ENROLLING IN: ** (Only check plans that are offered)	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Chiro/Acu	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Chiro/Acu	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Chiro/Acu	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Chiro/Acu
If you are declining yourself or any dependents for coverages being offered, you must complete the Declination Section on page 4.				
IF HEALTH NET: PRIMARY CARE PHYSICIAN (PCP)* NAME, PHYSICIAN ID# & CITY:				
CURRENT PATIENT OF PCP?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
IF KAISER, DO YOU HAVE AN MRN?: MEDICAL RECORD #:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

[#]For full-time students (age 19 or over) or disabled dependent enrollees, please submit an Over Age Dependent or Disabled Dependent Certification in addition to this form.

If Last Name of spouse/domestic partner or dependent is different from Employee's Last Name, please explain:

If Address of spouse/domestic partner or dependent is different from Employee's Address, please list here:

* For Health Net Primary Care Physician (PCP), please know that if you have not selected a PCP above or your PCP is not contracted with Health Net, a PCP will be assigned to you. For Kaiser enrollees no PCP selection is required; instead please use your medical record number.

** Vision and Chiro/Acu enrollment must match medical enrollment for all enrollees. If vision is a stand alone plan then 100% participation is required.

SECTION 5: OTHER HEALTH INSURANCE (This section is required).

Is anyone listed in Section 4 eligible for Medicare? Yes No If Yes, who? _____

Are you or have you and/or any of your eligible family members been covered by other medical coverage within the last 6 months? Yes No

If Yes, complete the section below to receive pre-existing condition credit. Please list all current or prior medical coverage.

Attach additional sheets if necessary.

COVERED PERSON'S NAME	POLICY HOLDER NAME(S) (i.e. Company Name)	INSURANCE COMPANY NAME(S)	TYPE OF COVERAGE	POLICY/ GROUP #	EFFECTIVE DATE	TERMINATION DATE
			<input type="checkbox"/> Health <input type="checkbox"/> Other: _____			
			<input type="checkbox"/> Health <input type="checkbox"/> Other: _____			

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SECTION 6: YOUR LEGAL ACKNOWLEDGEMENT (Please Read, Sign and Date Below)

American Specialty Health Plans Enrollees: I understand that American Specialty Health Plans (“ASHP”) uses binding arbitration to settle disputes, including to settle any claim of medical malpractice against ASHP. In addition, I understand that any claims I might have against an ASHP participating provider, including a claim for medical malpractice, will not be subject to ASHP’s arbitration procedures, except to the extent I and the participating provider agree to follow and/or be bound by those procedures.

I also understand that California Health and Safety Code Section 1363.1 requires ASHP to include the statements set forth above in this Application Form as well as the following statement, which is substantially the wording provided by Section 1295(a) of the California Code of Civil Procedure:

It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under the ASHP agreement under which I receive chiropractic and/or acupuncture services were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, and any dispute as to the delivery of services under that agreement will, to the extent described above, be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provided for judicial review of arbitration proceedings. I understand that, by signing this Application Form or otherwise becoming a member under that agreement, ASHP and I are giving up any constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting use of arbitration.

MetLife Dental, Blue View Vision, & Vision Service Plan Enrollees: Employee Statement - I request coverage under my employer’s group insurance plan as noted and also verify the accuracy of the employee section. Furthermore, I authorize my employer to deduct from my earnings any payment, if applicable for this coverage.

Premier Access Plan Enrollees: As more fully set out in the Policy and Certificate, I agree that binding arbitration is the final process for the resolution of any dispute arising out of or relating to the Policy. If a face-to-face hearing is involved in the arbitration, the hearing shall be conducted in Sacramento, CA. By enrolling in this plan, Employer and Covered Persons waive their constitutional right to a trial before a jury or judge. Any dispute alleging the malpractice, negligence and/or wrongful act of a provider, shall not include Premier and shall include only the provider subject to the allegation.

Health Net Enrollees: Explanation of Authorization to Obtain or Release Medical Information: The authorization below to obtain and release medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act, effective January 1, 1980, Section 56 et seq. of the California Civil Code. Your cooperation is requested. **Authorization to Obtain or Release Medical Information:** I hereby authorize my physician, health care practitioner, hospital, clinic or other medically related facility to furnish an agent, designees or representatives of Health Net or Health Net Life, any and all records pertaining to medical history, services rendered or treatment given to anyone enrolled hereunder, or added hereunder for purpose of review, investigation, or evaluation of an application or a claim. I authorize Health Net, Health Net Life, or its agents designees or representatives to disclose to a hospital or health care service plan, self-insurer, and such medical information obtained if such disclosure if necessary to allow the processing of any claim. This authorization shall become effective immediately and shall remain in effect as long as is necessary to enable Health Net or Health Net Life to process claims and benefits. **Arbitration Agreement:** I understand that any dispute or controversy, except medical malpractice, that may arise regarding the performance, interpretation or breach of the agreement between myself (and/or any enrolled family member) and Health Net. Health Net Life Insurance Company or any Participating Medical Group/Independent Physicians Association, whether arising in contract, tort or otherwise, must be submitted to arbitration in lieu of a jury or court trial.

California Law prohibits an HIV test from being required or used by Health Companies as a condition of obtaining insurance coverage.

Any person who with intent to defraud or knowing he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Please sign and date this application below. Your signature indicates that you have completed all requested information as accurately as possible and that you read the Plan information and understand all agreements, including your agreement to submit disputes to binding arbitration.

Preexisting Conditions and Creditable Coverage -Your coverage under this plan may be subject to preexisting condition limitations for a maximum period of six months from the effective date of your enrollment. In accordance with state and federal law, Health Net will credit any prior coverage that you document at the time you apply to enroll in PPO or Flex Net, provided the prior coverage qualifies as “creditable coverage” as defined under federal and state law. Creditable coverage will be applied to offset (in part or whole) the preexisting condition limitation, which may apply to your coverage under this policy. If you’re unable to provide documentation of bona fide creditable coverage at enrollment time, Health Net may provide assistance in obtaining the necessary documentation upon request. Note: Prior coverage which is interrupted by a period of 63 days (or 181 days if your previous employer terminated the coverage) or more does not qualify as creditable coverage.

Kaiser Permanente Enrollees: Kaiser Foundation Health Plan Arbitration Agreement: I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with Employee Retirement Income Security Act (ERISA) regarding certain benefit related disputes) and dispute between myself, or my heirs, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the full Arbitration provision is contained in the Evidence of Coverage.

SIGNATURE FOR MEDICAL, DENTAL, VISION OR CHIROPRACTIC/ACUPUNCTURE COVERAGE

EMPLOYEE SIGNATURE X	DATE
PRINT NAME	

INSURANCE COVERAGE DECLINATION FORM

Please complete this form only if you do not want coverage for yourself and/or your dependents. Please note that **Chiropractic and Vision coverage cannot be waived when enrolling for Medical coverage.**

SECTION A: PERSONAL INFORMATION (to be completed by Employee)

Name of Company		Employer Phone Number () -	
Employee Last Name	Employee First Name	Middle Initial	
Date of Hire	Employee Social Security Number		

SECTION B: TYPE OF WAIVER (check all that apply and include names of dependents which is required)

I am declining coverage for:	Medical	Dental	Vision	Chiro or Chiro/Acu
<input type="checkbox"/> Myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Spouse or <input type="checkbox"/> Registered DP Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Child(ren) Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION C: REASON FOR DECLINING COVERAGE (must be filled out completely)

Other Group Coverage (list below & attach proof of coverage) Company Sponsor

Medical Carrier Name: _____ Group #: _____

Dental Carrier Name: _____ Group #: _____

Vision Carrier Name: _____ Group #: _____

Chiropractic Carrier Name: _____ Group #: _____

Individual Coverage: Medicare Medi-Cal **Individual Policy** _____
Carrier Name & Policy #

Other Reason: _____ (explanation required)

SECTION D: YOUR LEGAL ACKNOWLEDGEMENT (Please Read, Sign and Date Below)

By signing, I understand that by failing to elect coverage now, I will be subject to up to a 12 month period of exclusion should I request coverage at a later date.

This waiver provision will not apply if: 1) Court orders coverage of a spouse or child and the request for enrollment occurs within 30 days of the court order; or 2) Employee meets ALL of the following: A) Was covered under another employer-sponsored health plan at the time of initial eligibility; B) Lost Coverage as a result of termination of employment, change in employment status, involuntary termination of other plan's coverage, cessation of employer's contribution, or death or divorce of spouse/domestic partner; C) Requests enrollment within 30 days of loss of coverage.

EMPLOYEE SIGNATURE TO WAIVE COVERAGE X _____	DATE
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