



Health Net®

NEW JERSEY HEALTHCARE SOLUTIONS
New Case Submission Checklist

General Information

Contact Info: _____ Date Submitted: _____
Group Name: _____ Effective Date: _____
Group Email Address: _____
Group Contact Information: _____

Agent Information

Submitted by: _____ Phone: _____ Ext: _____
Agent/Agency: _____ General Agency: _____
Contact: _____ GA #: _____
Address: _____ Licensed in the following states:
Email: _____ [] CT [] NY [] NJ
Fax: _____

Coverages: (please check all that apply)

Outlook Charter
[] HMO [] POS [] HSA [] PPO [] HMO [] POS

Policy Holder Documentation Needed

- Fully completed Master Application
Quoted Rates and Census Used
Fully completed Member Enrollment forms and Waivers for each employee waiving coverage, Full-Time Student Verification forms, if applicable (Waivers should include Employee Name, Social Security Number, Signature and Reason for Waiving Coverage.)
If applicable, HSA Employer & Employee Enrollment Forms, HSA HIPAA Release Form, and copy of prior Carrier Invoice and/or Attestation Form for plans with Pre-existing Condition Clause.
All applicable state forms (list below)
Deposit check (make checks payable to Health Net, Inc.)

Applicable State Forms

Table with 2 columns: State (NJ) and Description (For groups with 6-50 employees, a NJ State Certification document is required. For groups with 2-5 employees, a NJ State Certification document and a current WR-30 is required. If not available, a Spousal Business Statement, payroll records or W-4 with a letter from the accountant may be submitted. In addition, K-1 or Schedule C Earnings for partners and proprietors along with copies of Incorporation papers will be accepted. For requests to cover dependents up to age 30, a Health Net HINT Supplemental Enrollment Information Form is required.)

Submission Deadline:

Effective Dates may be the first or fifteenth of the month only. All required paperwork must be received by Health Net at least 15 days prior to requested effective date. For submissions after the 15th of the month, please include a Late Case Submission Form.

Additional Information:

Please complete below if the following individual(s) is different from the contact person listed above:

VIP Correspondent: _____ Email: _____
Title: _____ Phone: _____
Billing Correspondent: _____ Email: _____
Title: _____ Phone: _____
Benefit Correspondent: _____ Email: _____
Title: _____ Phone: _____

Submission Instructions

Completed paperwork, including enrollment forms and deposit check, should be mailed to:
For US Mail and Overnight Mail: Health Net, One Far Mill Crossing, MS 900-03-61, P.O. Box 904, Shelton, CT 06484-0904
We will accept completed paperwork and enrollment forms emailed to HCSNewBusiness@healthnet.com.
If submitting via e-mail, deposit checks (payable to Health Net, Inc.) should be sent to the address above and must clearly indicate the group name on the front of the check.
NOTE: Coverage does not become effective until required information is received and processed by the home office.
This form may be updated as deemed necessary by Health Net

OTHER ITEMS REQUIRED WITH SUBMISSION OF POLICY

WR30

ATTACH A COPY OF YOUR WR30 (WAGE & PAYROLL) FOR THE LASTEST QUARTER OR APPROPRIATE TAX DOCUMENTATION

- ✓ *OXFORD REQUIRES NO WR30*
- ✓ *AETNA REQUIRES WR30 FOR LESS THAN 5 ENROLLING, BUT IT IS A 6 EE ELIGIBLE GROUP*
- ✓ *ALL OTHER CARRIERS REQUIRE WR30 2-5 ELIGIBLE. IN OTHER WORDS IF THE GROUP HAS 6 ELIGIBLE EMPLOYEES, BUT ONLY 3 ENROLLING, WR30 IS NOT NECESSARY UNLESS UNDERWRITING COMES BACK AND MAKES A REQUEST TO SEE IT.*

CARRIER BILL

A COPY OF YOUR LAST BILLING STATEMENT SHOWING ALL THE EMPLOYEES ENROLLED FROM YOUR PREVIOUS CARRIER

PREMIUM CHECK

ALL NEW CASES MUST SUBMIT A CHECK MADE OUT TO THE CARRIER WITH THE ESTIMATED MONTHLY PREMIUM AMOUNT FROM THE QUOTE. THIS MUST BE A COMPANY BUSINESS CHECK

QUOTE

ATTACH A COPY OF THE QUOTED ESTIMATED PREMIUM. PLEASE CIRCLE THIS PLAN DESIGN AND AMOUNT AND HAVE THE CLIENT SIGN THEIR NAME ANYWHERE WITHIN THE PLAN DESCRIPTION OR BY THE RATES. THIS IS AN ACKNOWLEDGEMENT OF PLAN DESIGN/RATES QUOTED.

TERMINATION OF PRIOR CARRIER

DON'T FORGET TO SEND A LETTER OFF TO THE PRIOR CARRIER, CANCELLING THE COVERAGE. PLEASE DO NOT DO SO UNTIL YOU RECEIVE APPROVAL ON THE COVERAGE THAT YOU ARE APPLYING FOR. PLEASE NOTE THAT ALL CARRIERS REQUIRE YOU TO CANCEL PRIOR OR 30 DAYS BEFORE YOUR EFFECTIVE DATE OF YOUR RENEWAL. OTHERWISE, THEY HAVE THE RIGHT TO BILL YOU. SO, YOU MAY WANT TO PUSH OUT YOUR NEW COVERAGE EFFECTIVE DATE. PLEASE CONSULT YOUR BROKER TO CHECK ON TIMEFRAMES.



Health Net

APPLICATION FOR A SMALL GROUP HEALTH BENEFITS POLICY

Please print or type

Policy number (Health Net Use Only):

New Policy Change in Policy

Requested Effective Date

Note: The Effective Date will be on or after the date Health Net approves the application.

SECTION I: POLICYHOLDER INFORMATION

1. Policyholder (full legal name of company):

2. Tax Identification Number:

3. Main Address: Street City State Zip

Mailing Address: Street City State Zip

Telephone: () Facsimile: ()

4. Name of Correspondent:

5. Type of organization: Corporation Partnership Proprietorship Other (explain):

6. Nature of business (specify): SIC Code

7. Number of eligible employees in your company: Refer to the New Jersey Small Employer Certification for the definition of an eligible employee

8. Number of eligible employees to be insured:

9. Class or classes to be excluded:

10. Insurance Requested For: Employees Only Employees & Dependents
Should the plan provide coverage for domestic partners as permitted by NJ Stat Sec. 17B:27-46.1bb? Yes No
If yes, should the plan provide coverage for coverage of children of a covered domestic partner? Yes No

11. Is the employer subject to the requirements of COBRA? Yes No

12. Is the employer subject to the requirements of Medicare as Secondary Payor Rules for eligibility due to age? Yes No
disability? Yes No

13. Waiting period before employees become insured: (may not exceed 6 months)
Present employees: New or Rehired Employees:

14. What percentage of the premium will the employer pay?

15. Deposit \$ Premium Paid: Monthly Quarterly Automatic checking withdrawal
Premium will be due as of the effective date. The premium for the first month of coverage must be attached.

Affiliates, subsidiaries or branches (Must be included for purposes of participation)

Table with 3 columns: Legal Name & Location, No. eligible employees in this company, No eligible employees to be insured

SECTION II: SPECIFICATIONS FOR COVERAGE

HEALTH BENEFITS

- NJ HMO: Plan Option: _____ RX Option: _____
- NJ Cost Share HMO: Plan Option: _____ RX Option: _____
- NJ POS: Plan Option: _____ RX Option: _____
- NJ POS In-Network Cost Share: Plan Option: _____ RX Option: _____
- NJ HSA: Plan Option: _____ RX Option: _____
- NJ PPO: Plan Option: _____ RX Option: _____
- Other: Plan Option: _____ RX Option: _____

Deductible - \$ _____ High Deductible Options: \$ _____ \$ _____

Co-Payment (Options for HMO Plans Only): \$5 \$10 \$15 \$20

Managed Care Delivery System: HMO PPO POS None

RATES: PLEASE ATTACH ACTUAL RATE QUOTES FROM QUOTING VENDORS OR HEALTH NET WEBSITE

SECTION III: ALL QUESTIONS MUST BE ANSWERED

1. Is there any Group Health Plan:
- now in force and to be continued? Yes No
 - currently being applied for? Yes No

If "Yes" identify the name of the Group Health Plan, give a description of the plan(s) and name of insurance carrier(s)

2. Name of present or prior group carrier _____
- Effective date of prior coverage: _____
- Cancellation/termination date: _____
- Is the coverage applied for in this application replacing other group insurance? Yes No
- If "Yes" give reason _____
- Plan being replaced: A B C D E HMO HMO-POS
- Dual Contract POS Other: _____

3. Has your firm been uninsured for 3 or more months prior to application? Yes No

4. What forms of insurance are now or were in force? Health Benefits Prescription Drugs
(attach copies of Booklet / Certificate and most recent Billing Statement)

5. Are extended benefits provided in case of termination of health benefits? Yes No

6. To the best of your knowledge are there any current or former employees or their eligible dependents whose health insurance is being continued? Yes No

Please provide the following information for each current/former employee or dependent on health continuations.
If additional space is needed, attach a separate sheet, signed and dated.

Name of Employee/ Dependent	Date of Birth	Type of Continuation State/Federal/ Extended Benefits	Reason for Termination Disability /Other	Continuation Dates	
				Start	End

7. To the best of your knowledge:
- a. Are any employees or dependents presently incapacitated? Yes No
- b. Are any dependent children incapable of self-support due to a physical or mental disability? Yes No

Additional space to explain if Items 1, 2 or 3 were answered "Yes". Refer to the question number, and give details including names, where appropriate.

8. Does the employer participate in an arrangement with a Professional Employer Organization? Yes No
 (Refer to Advisory Bulletin 00-SEH-02 if you need information concerning what constitutes a Professional Employer Organizations.)

SECTION IV: AGENT/PRODUCER INFORMATION

Agent / Broker Name: _____

Health Net Agent Number / Tax ID / SSN: _____

Agency Name: _____ % of Credit: _____

Phone Number: (____) _____ Fax Number : (____) _____

Address: _____

City: _____ State: _____ Zip: _____

Signature: _____ Date: _____ Email Address: _____

Agent / Broker Name: _____

Health Net Agent Number / Tax ID / SSN: _____

Agency Name: _____ % of Credit: _____

Phone Number: (____) _____ Fax Number : (____) _____

Address: _____

City: _____ State: _____ Zip: _____

Signature: _____ Date: _____ Email Address: _____

General Agent Name: _____

Health Net Agent Number / Tax ID / SSN: _____

Agency Name: _____ % of Credit: _____

Phone Number: (____) _____ Fax Number : (____) _____

Address: _____

City: _____ State: _____ Zip: _____

Signature: _____ Date: _____ Email Address: _____

SECTION V: SIGNATURE

It is understood that, except as provided under applicable regulations, no individual shall become insured while not actively at work on a full-time basis, and only full-time employees are eligible. A full-time employee is one who regularly works at least 25 hours per week at his employer's place of business.] It is further understood that no agent has power on behalf of Health Net to make or modify any request or application for insurance or to bind Health Net by making any promise or representation or by giving or receiving any information.

It is further understood that no insurance will be effective unless and until the application is accepted in writing by Health Net. Final rates will be based on enrollment data as of the Policy effective date. No contract of insurance is to be implied in any way on the basis of the completion and/or submission of this application.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Dated at _____ on _____

Print name of Officer, Partner or Proprietor

Signature of Officer, Partner or Proprietor

Witness to Signature

Note: If there are any modifications to the statements and answers given in this application (i.e., crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.



Health Net

EMPLOYER CERTIFICATION

Legal Name and Address of Company	Group Policy Number or Group Number (if a current customer)
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Group Health Benefits Policy Participation

Please indicate below the number of employees by work location/State. All employees must be included, regardless of whether or not they currently have medical coverage and through whom that coverage is provided.

<u>Work Location (list by State)</u>	Number of Employees				
	<u>Full-time</u>	<u>Part-time</u>	<u>Retired</u>	<u>COBRA or State Continuees</u>	<u>Other</u>

(For Existing Small Employer Groups in the State of New Jersey OR New Applicants)

An Eligible Employee is one who works on a full-time basis with a normal work week of 25 or more hours for compensation. An employee who works less than 25 hours per week on a temporary or substitute basis, or an employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement is not an eligible employee.

Total # Eligible Employees _____

Total # Eligible Employees applying/enrolling for health benefits coverage _____

Total # Eligible Employees waiving health benefits coverage under the policy with coverage under their spouse's coverage, other than individual coverage, or any other Health Benefits Plan offered by the employer _____

Total # Eligible employees waiving health benefits coverage under the policy without coverage under a spouse's coverage, other than individual coverage; or any other Health Benefits Plan offered by the employer _____

Total # Employees in an ineligible class or classes _____

Is your firm subject to Working Aged Provisions of federal law (TEFRA/DEFRA)? Yes No
 (You *may* be subject to the law if you employed 20 or more employees for 20 weeks in the current or prior calendar year)

Is your firm subject to the requirements of the federal COBRA law? Yes No
 (You *may* be subject to the law if you employed 20 or more employees during 50% or more of the working days during the previous calendar year.)

NJ36647 (4/07) 6013207

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Any person who includes any false or misleading information on an application or enrollment form or certification for a health benefits plan is subject to criminal and civil penalties.

COMPLETE THIS SECTION ONLY IF YOU HAVE CERTIFIED THAT YOU ARE A SMALL EMPLOYER IN THE STATE OF NEW JERSEY.

***EMPLOYEE CENSUS INFORMATION**

Please include the following persons in the following list:

- a employees, owners, partners, officers, and independent contractors who are actively working for the employer on a regular basis, and are paid by the employer on a regular basis, whether or not they are eligible to be covered under the policy.
- b employees, owners, partners, officers, and independent contractors who are not working, but who are currently covered under the employer's health benefits plan for reasons such as continuation of coverage or total disability.

Please use the following letters to indicate Status:

- F:** Full-time employee who works 25 or more hours per week
- P:** Part-time employee who works less than 25 hours per week
- T:** Temporary employee
- I:** Independent Contractor
- D:** Totally Disabled employee
- C:** Continuee under state or federal law
- U:** Employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement.

Name	Job Title	Date of Employment	Hours worked per week	Status	Work Location (State)	Gender	Date of Birth
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							

*If additional space is needed, attach a separate sheet.

Date: _____ (must not exceed requested effective date)

Re: _____
(name of company)

We understand the normal deadline to submit applications for a first of the next month's effective date is the fifteenth of the current month. Due to circumstances beyond our control we are submitting the applications late, but still request the 1st of the next month as our effective date. We understand it will take approximately two weeks to receive our I.D. cards and to appear in the PHS claims system.

We agree to advise employees to bring a copy of their enrollment application to the attending physician's office if treatment is required prior to receiving their I.D. card as proof of pending coverage. Further we understand that if a prescription is required prior to receiving the I.D. cards the employee must pay the full cost of the RX and submit for reimbursement after the I.D. card is received.

Understood and agreed to by:

(Owner/Office of Company)

(date)

(Broker)

(date)

Note: In order for exception to be made, the case must be submitted in its entirety, with no missing forms or pieces of information and is subject to all other normal underwriting guidelines.



Health Net® Enrollment/Change Request

Employer Group Information – To be completed by employer.

Group Name _____
 Group Number _____
 Class Code _____

A. TYPE OF ACTIVITY – To be completed by employer. Refer to instructions on back before completing this form. Print clearly.

1. Enrollment <input type="checkbox"/> New Enrollee Effective Date _____ Date of Hire _____	2. Change – Check all that apply <input type="checkbox"/> Add Spouse _____ <input type="checkbox"/> Add Domestic Partner _____ <input type="checkbox"/> Add Dependent Child _____ <input type="checkbox"/> Name Change _____ <input type="checkbox"/> Change Plan _____ <input type="checkbox"/> Other _____	3. Remove or Terminate – Check all that apply <input type="checkbox"/> Remove Spouse* _____ <input type="checkbox"/> Remove Domestic Partner _____ <input type="checkbox"/> Remove Dependent Child* _____ <input type="checkbox"/> Employee Withdrawal/Termination _____ Note: Employee must be enrolled for spouse/dependent to have coverage. *Please complete <i>Add/Change/Remove</i> and <i>Name</i> columns in Section D.	4. Continuation of Coverage , i.e. COBRA, State, total disability. Not all options are available or applicable. Contact [Employer] for available options. Coverage for: <input type="checkbox"/> Employee <input type="checkbox"/> Dependents Length of Continuation: <input type="checkbox"/> 12 mos <input type="checkbox"/> 18 mos <input type="checkbox"/> 29 mos <input type="checkbox"/> 36 mos <input type="checkbox"/> total disability* Date of Loss of Coverage: _____ Date of Qualifying Event: _____ * Attach proof of total disability
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B. EMPLOYEE INFORMATION – Complete Sections B-H

Last Name, First Name, M.I. _____ Social Security Number _____ Home Telephone _____
 Home address _____ Apt. No _____ City, State _____ Zip Code _____
 Employer Name _____ Work Telephone _____
 Work address _____ City, State _____ Zip Code _____
 Date of Employment: ____/____/____ Hours worked per week: _____

C. PLAN OPTION – Your selection must be offered by your Employer

Check one:
 Charter HMO Passport HMO Charter POS Passport POS PPO Other: _____
Type of Contract: (Select one):
 Single Husband/Wife Domestic Partner Adult & Child(ren) Family

D. INDIVIDUALS COVERED – List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. Attach proof if full-time post-secondary student. Attach proof of disability

	(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex M F	Birth date MM DD YYYY	Social Security Number	Other Health Coverage	Other Rx Drug Coverage	Primary Office ID Number	Previous Coverage Check if yes
Employee			<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Domestic Partner			<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Spouse			<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Child			<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Child			<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Child			<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Child			<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Child			<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>

E. PRE-EXISTING CONDITIONS STATEMENT

NOTE: This information may ONLY be used to determine if a condition is a pre-existing condition.

You CANNOT be denied coverage under a health benefits plan on the basis of accurate responses to the following questions. Carriers can only use the information to expedite the processing of claims.

Yes No 1. During the past 6 months, have you or any dependent to be covered had or been diagnosed as having any of the following? If "Yes," check appropriate box(es) below.

- | | |
|---|---|
| <input type="checkbox"/> a. Alcoholism or Drug Abuse | <input type="checkbox"/> g. Gastro or Intestinal Disorder |
| <input type="checkbox"/> b. Arthritis | <input type="checkbox"/> h. Heart Disorder or Condition or Chest Pain |
| <input type="checkbox"/> c. Blood Disorder | <input type="checkbox"/> i. High Blood Pressure |
| <input type="checkbox"/> d. Back or Neck Disorder, Injury or Pain | <input type="checkbox"/> j. Kidney or Liver Disorder |
| <input type="checkbox"/> e. Cancer or Tumors | <input type="checkbox"/> k. Lung or Respiratory Disorder |
| <input type="checkbox"/> f. Diabetes | <input type="checkbox"/> l. Mental or Nervous Disorder |
| | <input type="checkbox"/> m. Paralysis, Stroke or Epilepsy |

2. During the past 6 months, have you or any dependent to be covered:
Yes No

- a. been examined or treated by a physician or other health care provider for any condition, illness, or injury, other than as stated above?
- b. been advised to have treatment or surgery or testing that has not been done?
- c. been admitted to a hospital or other health care facility as an inpatient?
- d. taken prescribed medication?

Please give details for "Yes" answers to any part of Questions 1 or 2 on a separate sheet of paper. This separate sheet should be signed and dated.

F. OTHER/PREVIOUS INSURANCE

Is your spouse employed? Yes No If "yes" give name and add your spouse's employer _____
If "yes" to Other Health Coverage (Section D), give name(s) and policy number(s) of insurance carrier, HMO, or other source.

If enrolled in Medicare Parts A and/or B identify the coverage and provide the Medicare ID # _____
If "yes" to Other Rx Drug Coverage (Section D), give name and policy number of insurance carrier, HMO, or other source.

If "yes" to Previous Coverage, identify name(s) of persons, give effective date and date coverage terminated, name of previous carrier and plan number, and submit a copy of the Certificate of Creditable Coverage that was issued by the previous carrier, if available.

G. DEPENDENT INFORMATION

Does any dependent listed in Section D live at a different address than the Employee. Yes No If "Yes" who and at what address? Explain the circumstances. _____

If any dependent's last name differs from yours, explain the circumstances. _____

H. EMPLOYEE SIGNATURE

If you have questions concerning the benefits and services provided by or excluded under this Agreement, contact a Customer Contact Center representative at 800- 441- 5741 before signing this form.

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the reverse side of the employee copy of this enrollment/change request. I authorize deductions from my earnings for any required contributions.

Employee Signature –Required X _____ Date ____/____/____.

I. EMPLOYER VERIFICATION – To be completed by Employer

Employer Signature –Required X _____ Title _____ Date ____/____/____.

Employee copy may be used as a temporary ID card for 30 days from the effective date if authorized by employer. Coverage must be verified with Health Net prior to visiting a specialist or admission to a hospital.



Health Net® Enrollment/Change Request

INSTRUCTIONS

EMPLOYER

- Complete the Employer Group information on the upper right hand corner of the form.
- Section A –
Type of Activity: Check boxes indicating reason(s) for submitting application.
- Complete Section I – Employer Verification of the form.
- Employer must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date the Enrollment/Change Request in order for it to be processed.

EMPLOYEE – COMPLETE SECTIONS B-H

Section B – Employee Information:

- Complete all information in order for your application to be processed.

Section C – Plan Option:

- Check one Plan Option box, indicate Plan Option Name (where applicable) and check one Copay and/or Individual Deductible Amount (if applicable).
- Select only an option offered by your employer.

Section D – Individuals Covered:

- Add/Change/Remove – Use “A”, “C”, or “R” to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependents, if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
- If a dependent is a full-time post-secondary student, you must attach a current course schedule or a letter from the school or its authorized representative confirming full-time student status. If dependent is disabled and being continued beyond the limiting age, attach proof of disability
- If you or your dependent(s) have other Health or Rx drug coverage, check off the “ Yes” box(es) and complete Section F – Other/Previous Insurance.
- From the appropriate provider directory, locate the office ID number for the primary care physician, ob/gyn (if applicable) and/or dentist (if applicable). Indicate office ID number selection(s) on the form.
- If you are a current patient, please check the “ Current Patient” box.

Section E – Pre-Existing Conditions Statement:

- Complete this section for all new enrollments. Exceptions: For Small Employer Group coverage, this section must be completed only by persons enrolling in group coverage in a group of 2–5 employees and by late entrants.

Section F Other / Previous Insurance

- Complete this section for all new enrollments or coverage changes. Coverage includes group coverage, governmental coverage, a church plan or Medicare.

Section G – Dependent Information

- Complete this section for all new enrollments or coverage changes

Section H – Employee Signature:

- Complete this section for all new enrollments, coverage changes and terminations.
- Employee must sign and date the Enrollment/Change Request Form in order for it to be processed.

Section I – Employer Verification:

- Employer must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date the Enrollment/Change Request Form in order for it to be processed.

CONDITIONS OF ENROLLMENT

Applicant Acknowledgement and Agreements

On behalf of myself and the dependents listed on the reverse side I agree to or with the following:

- a) I authorize the sources stated below to give to Health Net , or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition. Authorized sources are any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.
b) I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which Health Net has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
c) I know that I have a right to receive a copy of the authorization if I request one.
d) I agree that a photocopy of this authorization is as valid as the original.
 - I acknowledge by enrolling in a Health Net plan or group policy coverage is provided by Health Net in accordance with the contract.
 - Enrollment of myself and of the listed dependents into the plan is effective on acceptance by Health Net.
 - Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. My employer is hereby authorized to withhold payments from my wages, as appropriate.
- ### Misrepresentation
- Any person who includes any false or misleading information on an Enrollment/Change Request Form for a health benefits plan is subject to criminal and civil penalties.



Health Net®

New Enrollee Pre-existing Conditions Information Form

The information on this form will be used to update our system with appropriate creditable coverage* information which may be used to satisfy (fully or partially) the pre-existing conditions limitation on your group health plan. Please complete fully and accurately, attach the most recent invoice from your company's current health plan(s), and submit with your employees' enrollment applications.

Company Name _____

Company Address _____

Check here if all enrollees being added to Health Net have creditable coverage and are listed on the prior carrier invoice.
If this box is not checked, please complete the information below.

New Enrollee Name	Social Security Number	Creditable Coverage dates for past 12 months (from/to). If more than one carrier, please list:	Prior Carrier (if applicable)	Coverage Level (Contract Type) –Single, Family, etc.	Comments: List only employees who are (1) new hires on your group's health plan effective date, or (2) any other employee eligible for coverage not listed on the prior carrier invoice.

NY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

CT and NJ: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Completed by (print name): _____ Date _____

Approved by (Officer signature): _____ Title _____ Date _____

Important Note: Please remember to attach a copy of the invoice(s) from your company's current health plan(s). We will not process this information without the invoice.

* Most health coverage is creditable coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO, individual health insurance policy, Medicaid and Medicare. Creditable coverage does not include coverage consisting solely of excepted benefits, such as coverage solely for limited-scope dental or vision benefits.



Health Net®
A Better Decision

STUDENT VERIFICATION FORM

Employee Information	Last Name		First Name	
	Address			
	City		State	Zip
Employer Information	Name			
Dependent Information	Identification # (listed on ID card)		Billing Code (03, 04, etc. listed on ID card)	
	Last Name		First Name	
School Information	Name of School (Accredited Institution)			
	City			State

I certify that my dependent is a full-time student. I understand that it is my responsibility to notify Health Net within 31 days if my dependent becomes ineligible due to marriage or loss of full-time student status.

Signature of Employee

Date

Health Net of the Northeast, Inc.
One Far Mill Crossing
PO Box 904
Shelton, CT 06484-0944
www.healthnet.com
Ph: 1-800-848-4747
Fax: 1-203-225-4000

NE36654 (4/07) 6013196

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Health Net®

Request for Waiver of Coverage

Group and Employee Information

Employer Name _____

Address _____

Employee Name SSN# _____

Spouse (If applicable) SSN# _____

Domestic Partner (If applicable) SSN# _____

Dependent Child(ren) SSN# _____

Request for Waiver of Coverage

I decline to enroll in the health plan offered by my employer for the following reason:

- Existence of other coverage
- Coverage not desired

I decline coverage for:

- Myself
- Myself and all my eligible dependents
- My spouse
- My spouse and eligible child(ren)
- My domestic partner (if applicable)
- My domestic partner and his/her eligible dependents (if applicable)

Notice of enrollment rights: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the Health Net plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in the Health Net Plan within 30 days [or within 31 days as defined in your contract] after the marriage, birth, adoption, or placement for adoption. If you fail to timely enroll, you may be treated as a late entrant.

I the undersigned have been offered and declined coverage under the Health Net benefit plan as indicated above.

Signature _____ Date _____



Health Net[®] Temporary HINT Supplemental Enrollment Information Form
 Implementing P.L. 2005, c. 375

A. Group & Employee Information

Group Name: _____
 Group Number: _____
 Employee Name: _____
 Employee ID Number: _____

B. Type of Activity (see Important Explanatory Information below)

Date of Event _____ Change – Check all that apply

 Add dependent over the limiting age, but less than 30
 Remove dependent over the limiting age, but less than 30
 Reason(s): _____

_____/_____/_____
 Continuation of Coverage pursuant to P.L. 2005, c. 375
 Coverage is being effected: During an Open Enrollment
 Within 30 days prior to attainment of limiting age
 Within 30 days after eligibility for other reasons
 During special 12-month enrollment
 Billing: Employee payroll deduction (w/ employer consent)
 Direct bill dependent (add billing address):

C. Over-age Dependent Information

Name (last, first, MI): _____ Sex: M F
 Birthdate: (MM, DD, YY) ____/____/____ SSN: _____
 Other Health Coverage: Yes No Other Rx Drug Coverage: Yes No
 Primary Office ID Number: _____ Ob/Gyn Office ID Number: _____
 Current Patient: Yes No Current Patient: Yes No N/A
 Previous Coverage: Yes No If yes, provide the following information AND submit a copy of the
 certificate of Creditable Coverage that was issued by the previous carrier, if available:
 Effective date of prior coverage: ____/____/____
 Termination date of prior coverage: ____/____/____
 Name of prior carrier: _____
 Prior plan number: _____

D. Signature

_____ Employee	_____ Dependent
_____ Date	_____ Date

Employer Consent to Payroll Deduction: Yes No

Name & Title Date

IMPORTANT EXPLANATORY INFORMATION

An adult child may request to continue as a dependent on his or her parent's coverage even after the child reaches the limiting age under the terms of the policy if the adult child:

- is not yet 30 years old
- is unmarried
- has no children
- lives in New Jersey or, if not a New Jersey resident, is a full-time student at an accredited institution of higher education
- is not eligible for Medicare and is not actually covered under another group or individual health plan.

An adult child may make the request to continue as a dependent on his or her parent's coverage either:

- when he or she first reaches the limiting age
- when he or she first becomes eligible for a reason other than reaching the limiting age (for example, the adult child becomes a full-time student in another state, or returns to live in New Jersey after residing elsewhere), or
- during the open enrollment period for the group of which the parent is a member.

In addition, adult children who reached the limiting age under the parent's coverage prior to May 12, 2006 may make an enrollment request at any time from May 12, 2006 through May 11, 2007. The adult child or covered employee may be required to pay up to 102% of the cost of the dependent premium.



Health Net of the Northeast, Inc.
One Far Mill Crossing
Post Office Box 904
Shelton, Connecticut 06484-0944
www.healthnet.com

Dear Member:

The State of New Jersey has enacted legislation that gives eligible dependents who have reached the standard limiting age of their medical policy the option to continue coverage until age 30. This change in dependent eligibility is effective for group medical plans issued or renewed on or after May 12, 2006, or certain dependents who met the limiting age prior to May 12, 2006. Should you choose to enroll a dependent who is eligible for this extended coverage, please do the following:

1. Complete the attached standard New Jersey enrollment form. To avoid delays, provide all requested information.
2. Complete the attached supplemental information form. To avoid delays, provide all requested information.
3. Obtain the appropriate group number from your benefits administrator to list on the supplemental information form.
4. Check the billing box on the supplemental information form that indicates “direct bill dependent” and add billing address.
5. Submit both forms to your employer.

Eligible dependents will be enrolled as an individual and billed directly rather than through a payroll deduction. This is why it’s important to select that box on the supplemental information form.

In addition, charges incurred by the dependent are separated from those charges incurred by other members of the family covered on the policy. Therefore, the dependent’s covered charges **do not** apply toward meeting the following:

- Family deductible
- Maximum Out-of-Pocket (MOOP)
- Other cost-sharing requirements or limitations applicable to other family members as a unit

Instead, the dependent’s covered charges are applied toward meeting a deductible, MOOP or other cost-sharing requirements and limitations as if the dependent had single coverage under the group contract.

Once enrolling under this option, we will provide your dependent with an ID card with a unique identification number.

If you have any questions regarding how to enroll, contact your group administrator. For questions regarding dependent eligibility, refer to page 2 of the supplemental information form.

BULLETIN NO. 08-16

TO: ALL NEW JERSEY LICENSED INSURERS TRANSACTING HEALTH INSURANCE BUSINESS; HOSPITAL, MEDICAL HEALTH AND DENTAL SERVICE CORPORATIONS; DENTAL PLAN ORGANIZATIONS, PREPAID PRESCRIPTION PLANS AND HEALTH MAINTENANCE ORGANIZATIONS; ALL NEW JERSEY LICENSED HEALTH INSURANCE PRODUCERS

FROM: STEVEN M. GOLDMAN, COMMISSIONER

RE: PRODUCER COMPENSATION DISCLOSURES

P.L. 2008, c. 38 (the Act), was approved on July 8, 2008 and becomes effective on January 5, 2009. Among other things, section 25 of the Act amends the New Jersey Producer Licensing Act of 2001 (codified at N.J.S.A. 17:22A-26 et seq.) by requiring licensed insurance producers to disclose to health insurance purchasers any compensation received from the sale of such policies or contracts. Section 25 of the Act states:

a. An insurance producer licensed pursuant to P.L. 2001, c. 210 (C. 17:22A-26 et seq.) who sells, solicits, or negotiates health insurance policies or contracts to residents of this State shall notify the purchaser of the insurance, in writing, of the amount of any commission, service fee, brokerage, or other valuable consideration that the producer will receive as a result of the sale, solicitation or negotiation of the health insurance policy or contract. If the commission, fee, brokerage, or other valuable consideration is based on a percentage of premium, the insurance producer shall include that information in the notification to the purchaser.

b. The commissioner may specify, by regulation, the information that shall be provided by an insurance producer in the notification to a purchaser of health insurance and the procedure for providing the notification.

N.J.S.A. 17:22A-28 defines an "insurance producer" as a person required to be licensed under the laws of this State to sell, solicit or negotiate insurance. The term includes insurance brokers, agents and consultants, and general agents.

The purpose of this Bulletin is to notify producers, and carriers who compensate producers, of the requirements of Section 25 of the Act and to clarify the Department's position concerning implementation of this section pending the Department's proposal of regulations.

- **Scope of Disclosure:** Disclosure is required for any insurance contract that meets the definition of "health insurance" at N.J.S.A. 17B:17-4 and for any contract sold by non-insurance health carriers, such as hospital, medical, health and dental service corporations; dental plan organizations, prepaid prescription plans and health maintenance organizations. Disclosure is not required for health coverage that is an incidental part of a life or annuity contract.

- **What must be Disclosed:** Any valuable consideration, including but not limited to commissions or service fees, must be disclosed. Consideration must be disclosed even if its amount cannot be calculated or estimated. However, the precise nature of the compensation (e.g., commission vs. service fee) does not need to be disclosed. In the case of standard

commission rates, the commission percentage or the per employee amount of commission in connection with a rate proposal, binder or bill may be disclosed.

- **Who Provides Disclosure:** The Act requires that the producer provide the disclosure to the insurance purchaser, however in many cases it may be more efficient for the carrier to provide the disclosure.

- **Timing of Disclosure:** The Act does not imply that disclosure must be made at the time of proposal or prior to a contract becoming effective. Disclosure should be made no later than the effective date of the contract.

- **Form of Disclosure:** Attached is a suggested form that may be used for compliance with the Act's compensation disclosure requirements. Use of an alternate form is acceptable so long as the Act's written compensation disclosure requirements are met.

10/01/08
Date

/s/ Steven M. Goldman, Commissioner
Steven M. Goldman, Commissioner

Inoord/bbProducerComp



**DISCLOSURE OF A FINANCIAL INTEREST
IN THE SALE OF HEALTH INSURANCE POLICIES**
For New Jersey Groups with 2 - 50 lives

New Jersey law (N.J.S.A. 17:22A-41.1) requires disclosure of the compensation a licensed agent or broker (producer) receives from your purchase or renewal of health coverage. Compensation may be in the form of a commission, fee(s), or possibly other valuable consideration, or a combination of all three.

The per employee dollar amount(s) or percentage(s) of premium are in the table below. All amounts and/or percentages are additive. If something does not apply, it is marked "None" or "NA". If there is compensation, whether or not in addition to the compensation shown, whose amount cannot be determined, enter "CBD" (cannot be determined) on the appropriate line. Use the "Other" line for all other compensation, whether or not the amount is determinable.

	Agent/Producer	
	Percentage (%)	Amount in Dollars (\$) (per employee basis)
Commission of Issuing Agent	5%	
Commission of General Agent		
Consultant Fee		
Brokerage Fee		
Other:		

PRODUCER INFORMATION

Agent Name: _____

General Agent Name: _____

CARRIER INFORMATION

Company Name: _____

Agent/Producer Signature

Date

NJ57463 (01/09) 6018839
Coverage is provided by subsidiaries of Health Net of the Northeast, Inc. and Health Net Life Insurance Co. Coverage may be provided by Health Net of New York, Inc. or Health Net Insurance of New York, Inc. in New York; Health Net of New Jersey, Inc. or Health Net Life Insurance Co. in New Jersey; and Health Net of Connecticut, Inc. or Health Net Life Insurance Co. in Connecticut. Health Net® is a registered service mark of Health Net, Inc. Both Outlooksm and A Better Decisionsm are service marks of Health Net, Inc. All rights reserved.