HEALTH NET Healthcare Solutions
UNDERWRITING GUIDELINES: New York

FOR EMPLOYER GROUPS 50 AND UNDER

The following represents the highlights of the underwriting guidelines for Healthcare Solutions products in New York. For additional details or clarification, please refer to the Broker Resource Manual in your Healthcare Solutions Producer Kit.

PLAN DESIGN

Two portfolios of products are available - **Charter** and **Outlook**SM. Outlook is a new portfolio of products providing lower cost options and limited rider selections. For some plans, the coverage for pre-existing conditions may be limited. All plans are sold with prescription plans (no carve-out).

DUAL AND TRIPLE OPTION

Groups with three or more lives may offer three options; two-life groups may offer two options as long as one employee is enrolled in each plan. If one of the options is the HMO, and the group does not meet the minimum participation, the group may select the HMO product as a single option.

There are no restrictions on the approved plan combinations that can be offered under a dual or triple option. The Outlook Portfolio products may be offered alongside Charter Portfolio products if the Outlook-based participation requirements (see below) are met. However, the medical plans must be distinguishable; the prescription plan cannot be the only differentiation between the plan offerings.

ELIGIBILITY

The following are included as eligible employees: as listed on the Quarterly Wage and Tax statement (Form NYS-45) working a minimum of 20 hours per week, proprietors, shareholders and partners in sub-chapter S corporations, Limited Liability Partnerships (LLP) and Limited Liability Corporations (LLC), regardless of state.

Retirees, independent contractors and other employees whose compensation is reported on IRS 1099 are not eligible for coverage, nor counted as eligible for purposes of determining small group status and participation requirements. Union employees are not included if the employer contributes toward their coverage under a separate health and welfare plan.

PARTICIPATION

Charter Portfolio Products: Health Net of the Northeast, Inc. requires 60 percent participation for the POS product; there is no minimum participation for the HMO product. Employees with spousal waivers, Medicare waivers and waivers due to other group coverage plus those enrolled in Health Net Healthcare Solutions all count as participating. A signed waiver must be supplied for any employee choosing to waive the offer of coverage, except for groups offering the HMO only.

Outlook Portfolio Products: Health Net of the Northeast, Inc. requires 60 percent participation for the Outlook products. Participation is calculated after spousal and Medicare waivers.

MINIMUM PARTICIPATION ENROLLMENT EXAMPLE FOR CHARTER POS:	
Total eligible employees*	50
Times the required participation percent	.60
Minimum prior to valid (qualified) waivers	30
Less valid (qualified) waivers	5
Equals the minimum enrollment	25

*Includes waivers

MINIMUM PARTICIPATION ENROLLMENT EXAMPLE FOR OUTLOOK:	
Total eligible employees*	50
Less valid (qualified) waivers	5
Equals net eligible employees	45
Times the required participation percent	.60
Equals the minimum enrollment	27

*Includes waivers

OUT-OF-AREA PPO REQUIREMENTS

The below percentages are based on eligible employees (not enrolled).

For products with in-network benefits only (HMO/EPO), all out-of-area employees must be covered by an out-of-area PPO plan.

Charter Portfolio POS Products: Out-of-area PPO coverage is recommended for any out-of-area employees. Groups with 20 percent or more of their employees residing outside of Health Net's service area must be issued an out-of-area PPO product. Out-of-area employees cannot exceed 50 percent of the group.

Outlook Portfolio POS Products: All out-of-area employees must be covered by an out-of-area PPO; out-of-area employees cannot exceed 30 percent of the group.

EMPLOYER CONTRIBUTION

The minimum employer contribution is either 75 percent of the single premium or 50 percent of the total premium.

Health Net®
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Health Net of the Northeast, Inc.
One Far Mill Crossing, Shelton, CT 06484
www.healthnet.com

NY37420 (4/07) 6013167

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HEALTH NET Healthcare Solutions
UNDERWRITING GUIDELINES: Small Group

GUIDELINES	CONNECTICUT	NEW YORK	NEW JERSEY
Minimum Case Size	1	2	2
Months in Business	N/A	N/A	N/A
Rates	4-tier (gender/age-banded)	4-tier (community)	4-tier (adjusted community)
Dual/Triple Options	Allowed for all sizes groups, however, at least one person must enroll in each option.	Allowed for all sizes groups, however, at least one person must enroll in each option.	Allowed for all sizes groups, however, at least one person must enroll in each option.
Business Documentation	New Business: Certification Form Renewal: Recertification Form	New Business: Certification Form Renewal: Recertification Form	New Business: Certification Form Renewal: Recertification Form
• **Sole Proprietors**	Schedule C or CPA notification	Schedule C or CPA notification (groups 2-50)	Schedule C or CPA notification (groups 2-50)
• **Partner Documentation**	K1 (Schedule E for 2 person spousal or related individuals)	K1 & Schedule E	K1 & Schedule E
Wage & Tax Reports	Required: UC-5A	Required: NYS-45	Required: WR30 for less than 6 life groups
Eligibility	Listed on Wage and Tax Statement (UC-5A), working a minimum of 30 hours per week.	Listed on Wage and Tax Statement (NYS-45), working a minimum of 20 hours per week.	Listed on Wage and Tax Statement (WR-30), working a minimum of 25 hours per week.
• **Retirees**	Not Eligible	Not Eligible	Not Eligible
• **Union Employees**	Can be considered eligible	Can be considered eligible	Can be considered eligible
• **1099's**	Not Eligible	Not Eligible	Eligible at PH request - all or none could be eligible
Participation	75% after valid waivers	60% counting valid waivers for Charter POS 60% after valid waivers for Outlook No minimum participation for Charter HMO	75% counting valid waivers
• **Valid Waivers**	Spousal/Civil Union, Medicare and Husky	Charter: Spousal, Medicare and other group coverage Outlook: Spousal & Medicare only	Spousal/Civil Union, Medicare, Medicaid, NJ FamilyCare and other group coverage
Employer Contribution	75% of employee only premium or 50% of total premium	75% of employee only premium or 50% of total premium	10% State-mandated
Out-of-Area Allowance	Charter: < 20% PPO recommended > 20% PPO required (max 50%) Outlook: PPO required (max 30%)	Charter: < 20% PPO recommended > 20% PPO required (max 50%) Outlook: PPO required (max 30%)	Charter: < 20% PPO recommended > 20% PPO required (max 50%) Outlook: PPO required (max 50%)
Pre-Existing Conditions Provision	Charter: No Outlook POS: Yes	Charter: No Outlook: Yes	Charter: Yes (under 6 lives) Outlook: Yes (under 6 lives)
Effective Dates	1st & 15th, however, the anniversary/bill date automatically reverts to the 1st	1st & 15th, however, the anniversary/bill date automatically reverts to the 1st	1st & 15th, however, the anniversary/bill date automatically reverts to the 1st

Health Net®
A Better Decision

Health Net of the Northeast, Inc.
One Far Mill Crossing, Shelton, CT 06484
www.healthnet.com

NE40370 (06/07) 6013910

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HEALTH NET NEW YORK

Group New Case Submission Checklist
For Small Business Groups with 2-50 Lives

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

☐ HMO/EPO ☐ POS ☐ HSA PPO ☐ HSA HMO ☐ HRA

Charter

☐ HMO ☐ POS ☐ PPO

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. Please note: Waivers not required for NY HMO Business.)
- ☑ 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.)*
- ☑ Health Net Submission Report from the quoting vendor

Applicable State Forms

NY	To verify certification under 51 lives, a current NYS45 is required. If not available, you may submit payroll records or W-4 with a letter from the accountant. In addition, K-1 or Schedule C Earnings for partners and proprietors along with copies of Incorporation papers will be accepted.

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.

Submission Instructions

Completed paperwork should be sent to Health Net by either email, fax or US Postal Service.

MAIL	EMAIL	FAX
Health Net of the Northeast, Inc. ATTN: Small Business New Business Office One Far Mill Crossing P.O. Box 904 CT-900-03-61 Shelton, CT 06484	SBGNewBusiness@healthnet.com	1-203-225-3274

Deposits checks should be made payable to Health Net, Inc. and sent to Health Net using the mailing address above.

NOTE: Coverage does not become effective until required information is received and processed by the home

NY58176 (03/09) 6018964

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Health Net of the Northeast, Inc.
One Far Mill Crossing
Shelton, CT 06484

Application for Group Health Coverage And Plan Specifications – New York

Please Print	Plan Number (Health Net Use only):
☐ New Plan ☐ Change of Plan	Requested Effective Date:

SECTION I: PLANHOLDER INFORMATION

Planholder (full legal name of company) Tax ID#:

Mailing Address (street, apt/suite):

Mailing Address (city, state, zip):

Email Address: Fax #: ( ) Phone #: ( )

Name of Contact: Title: Phone #: ( )

Type of organization: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other (explain):

Total # of employees: Total # of full-time employees: Total # of full-time employees to be insured:

Amount of Binder Check: $ (one month's premium) Nature of Business (specify): Date established: SIC:

Waiting Period for future employees: ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ 120 days ☐ 180 days

Do you have any affiliates, subsidiaries or branches? ☐ Yes ☐ No

Affiliate, subsidiaries or branches (legal name & location)	Nature of business	# of full-time employees in company	# of full-time employees to be insured

A Full-time employee means one who regularly works the number of hours in the normal workweek established by this planholder (not less than 20 hours per week for groups with 2-50 employees) at the planholder's normal place of business.

Are all full-time employees to be included? ☐ Yes ☐ No If "no" indicate class or classes to be excluded:

Percentage of employer contributions for medical coverage: Employee Coverage: _________ % Dependent Coverage: ________ %

# of Eligible Employees: ________ # of Employees on COBRA: ______ # of Total Employees: ________

# of Covered Employees: ______ # of Waivers: ________

SECTION II: SUPPLEMENTARY INFORMATION (*All questions must be answered)*

1) Has this planholder or any of its affiliates, either under its present name or any other name, ever applied for group insurance with Health Net? ☐ Yes ☐ No If "yes," furnish year, name of employer, plan number and date of cancellation:

2) If present carrier provided life insurance, are extended benefits provided in case of disability? ☐ Yes ☐ No

3) Does your planholder have any other insurance plan:
   a) Now in force and to be continued? ☐ Yes ☐ No
   b) That you are currently applying for? ☐ Yes ☐ No
   If "yes," give description of plan and name of carrier(s):

4) Name of prior group health carrier: Cancellation date:

5) To the best of your knowledge, are there any current and former employees or their eligible dependents whose health insurance is being continued? ☐ Yes ☐ No
   Please provide the following information on health continuation for each current/former employee or dependent:

Employee/Dependent	Date of Birth	Continuation State/Federal	Continuation due to Disability / Non-Disability	Continuation Dates Start / Expiration

Be certain to read this entire application/plan specification: then sign, date, and have it witnessed on page 3.

SECTION III: AGENT/PRODUCER INFORMATION

Agent / Broker Name: ________________________ Health Net Agent Number / Tax ID / SSN: ___________________________

Agency Name: ______________________________ % of Credit: ____

Phone #: (_____)______________ ______________ Fax #: (_____)____

Address: ____________________________________ City: __________________ State: _______ Zip: __________

Signature: ___________________________________ Date: _______________ Email Address: ____________________________

Agent / Broker Name: ________________________ Health Net Agent Number / Tax ID / SSN: ___________________________

Agency Name: ______________________________ % of Credit: ____

Phone #: (_____)_____________________________ Fax #: (_____)____

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 IV: CERTIFICATION: *(For Groups of 2-50 Employees Only)*

A Small Employer is any person, firm, corporation, partnership or association actively engaged in business with corporate headquarters located in the State of New York who, on their APPLICATION DATE of coverage, employed AT LEAST TWO, BUT NOT MORE THAN FIFTY eligible employees. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return will be considered a single employer. Please be advised that the total number of employees should also include you as the employer.

COMPLETE IF YOU DO MEET THE DEFINITION OF A SMALL GROUP EMPLOYER:
I certify that **I qualify** as a Small Group Employer in that on the date of application for Major Medical coverage, we employ no less than two and no more than fifty employees.
I have reviewed the statements made by me on the supplement, and to the best of my knowledge and belief, they are true and complete.

Initial of Officer, Partner or Proprietor: ______________

-------------- WE MUST HAVE A COPY OF YOUR MOST RECENT STATE/FEDERAL QUARTERLY WAGE REPORT ----------------------

COMPLETE IF YOU DO NOT MEET THE DEFINITION OF A SMALL GROUP EMPLOYER:

I certify that **I am not** a Small Employer in the State of New York in accordance with New York AB 12350-A.

Initial of Officer, Partner or Proprietor: ______________

Please check the appropriate reason why you do not meet the definition of a Small Employer:

☐ Employs less than two or more than 50 employees
☐ Corporate Headquarters is located outside of the State of New York
☐ Other (please explain): ____
____

It is understood that only full-time employees shall be eligible. **For medical coverage only:** Full-time employees means one who regularly works the number of hours in the normal week established by this planholder *(not less than 20 hours per week for groups that qualify as a Small Group Employer and not less than 30 hours per week for groups that do not qualify as a Small Group Employer)* at the planholder's normal place of business. **For all other coverages**: Full-time employees means one who regularly works the number of hours in the normal work week established by this placeholder (but not less than 30 hours per week) at the planholder's normal place of business. It is further understood that no agent has power on behalf of Health Net to make or modify any request of application for insurance, or to bind said Insurance Company by making any promise or representation or by giving and receiving any information.

It is further understood that: (a) no insurance will be effective until the final offer of plan and rates by Health Net is accepted, in writing, by the employer; and (b) for coverages other than medical coverage, no individual shall become insured while not actively at work. No contract of insurance is to be implied in any way on the basis of completion and submission on this application.

Applicable to Accident and Health Coverages:
"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 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."*

I have reviewed the statements made by me on this application, and to the best of my knowledge and belief, they are true and complete.

____ ________________________
Signature of Title of Officer, Partner, Proprietor Date

____
Please print name of Title of Officer, Partner, Proprietor

____ ________________________
Signature of Witness Date

SECTION V: MEDICAL PLANS

SELECTED MEDICAL PLANS CODE (input selected plan e.g., Outlook POS TWAE51)	SELECTED PRESCIPTION RIDERS CODE (input selected rider – e.g. G40):
☐ PLAN 1 ____________ ☐ PLAN 2 ____________ ☐ PLAN 3 ____________	☐ PLAN 1 ____________ ☐ PLAN 2 ____________ ☐ PLAN 3 ____________

ADDITIONAL RIDERS *(if applicable)*
☐ HIAA Buy-Up ☐ Pharmacy ☐ Vision ☐ Increase Dependent Age

Indicate whether the benefits listed below will be administered on a contributory or non-contributory basis:

EMPLOYEE COVERAGES	CONTRIB.	NON-CONTRIB.	DEPENDENT COVERAGE	CONTRIB.	NON-CONTRIB.
MEDICAL			MEDICAL		

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

SECTION VI: REMARKS (Use this section for any additional information needed for Plan Specifications)

FOR HEALTH NET USE ONLY	
PLAN CODE: ______________________ Passport/HMO	**PLAN CODE: ________________________ Charter/HMO**
PLAN CODE: ______________________ Passport/POS	**PLAN CODE: ________________________ Charter/POS**
PLAN CODE: ______________________ PPO	**PLAN CODE: ________________________ Indemnity**

Please complete below if the following individual(s) is different from the contact person listed on page 1 of application:

VIP Correspondent: ______________________ Email: ______________________
Title: ______________________ Phone: ______________________

Billing Correspondent: ______________________ Email: ______________________
Title: ______________________ Phone: ______________________

Benefit Correspondent: ______________________ Email: ______________________
Title: ______________________ Phone: ______________________

CONTINGENCIES:

- We reserve the right to change rates during the policy year to account for federal or state mandates that may be enacted.
- Signature of this application implies that all information on the application is accurate to the best of your knowledge.
- Coverage is not in effect until this application is accepted by Health Net. Coverage is subject to all of the terms and conditions of all the plan documents.

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® is a registered service mark of Health Net, Inc. All rights reserved.

Date: _____________ (must not exceed requested effective date)

Re: _______________________________
(Name of Group)

We understand the normal deadline to submit applications for a 1st of the next month's effective date is the 15th of the current month. Due to circumstances beyond our control, we are submitting the applications late. However, we are still requesting the 1st of next month as our effective date.

We agree to advise employees to be covered to bring a copy of their enrollment application to the attending physician's office, as proof of pending coverage, if they require treatment prior to receiving their I.D. card. Further, we understand that if our employee(s) require a prescription prior to receiving their I.D. card, they must pay the full cost of the prescription and submit for reimbursement after they receive their I.D. card.

Understood and agreed to by:

_____________________ ____
(Owner/Officer 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. This request is not binding until approved at Health Net's home office.

NE37806 (4/07) 6013331
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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 ______________________________

NE36660 (4/07) 6013204
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HEATLH NET CUSTOMER SERVICE PHONE NUMBER

Toll-free: 1-800-441-5741

NY CHARTER II ADVANTAGE PLATINUM ENROLLMENT FORM

Please complete this application in full, including your signature.
Use blue or black ink only and be sure all copies are printed legibly.

ENROLLEE INFORMATION (please print clearly)

Last Name: | First Name: | M.I.: | Social Security Number:

COMPLETE HOME ADDRESS | Street: | City: | State: | ZIP Code:

☐ Single (S) ☐ Married (M) ☐ Widowed (W) ☐ Separated (L) ☐ Divorced (D) ☐ Other_______ (O) | Home Phone: ( ) | Business Phone: ( )

EMPLOYMENT INFORMATION

Check box if you are actively employed ☐
Check box if you are retired ☐
Union Affiliation:
Average Number of Hours Worked Per Week: ☐ Under 20 Hours ☐ 20-24 Hours ☐ 25-29 Hours ☐ 30+ Hours

OTHER HEALTH COVERAGE INFORMATION

Will you be covered by another health plan when Health Net coverage starts? ☐ Yes ☐ No	If yes, list name and address of other carrier:	Spouse's Social Security Number:
Is your spouse employed? ☐ Yes ☐ No	If yes, list employer's name and address:	Spouse's Daytime Phone Number: Spouse's Date of Birth: MO / DAY / YR
Will your spouse be covered by another health plan when Health Net coverage starts? ☐ Yes ☐ No	If yes, list name and address of other carrier:	Policy/Contract #:
Will your dependents be covered by another health plan when Health Net coverage starts? ☐ Yes ☐ No	If yes, list name and address of other carrier:	Policy/Contract #:

MEDICARE INFORMATION

Are you covered by Medicare? ☐ Yes ☐ No	Medicare #:	Effective Dates: Part A Part B
Is your spouse covered by Medicare? ☐ Yes ☐ No	Medicare #:	Effective Dates: Part A Part B
Are other dependents covered by Medicare? ☐ Yes ☐ No	Name(s): Medicare #:	Effective Dates: Part A Part B

STUDENT INFORMATION

If dependent children listed are age 19 or older, do they attend school on a full-time basis? ☐ Yes ☐ No	If yes, list first name of child and school	If no, is the dependent child disabled? ☐ Yes ☐ No

List yourself and any eligible dependents to be covered. Attach extra sheet if necessary.

	Last Name	First Name	M.I.	Social Security #	Sex: M/F	Date of Birth MO DAY YR	Primary Care Physician's Name	*Physician's Access Number
Self								
Spouse								
Child								
Child								
Child								

*This number appears in your provider directory below physician address and telephone number.

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 to five thousand dollars and the stated value of the claim for each such violation.

AGREEMENT (please sign and date): I understand the Health Net benefits and coverage as summarized in the Health Net plan materials and that these benefits are administered strictly as specified in the Health Net plan documents.

I authorize any physician, hospital, insurer or other organization or person having any records or information concerning the health and treatment (including psychiatric, substance abuse, and confidential HIV related information) of me and my family member(s) to furnish such records as may be requested by Health Net Insurance of New York, Inc., or its authorized representative for purposes relating to coverage. A photocopy or digital image of this authorization shall be considered as valid as the original. This authorization shall renew upon any subsequent renewal of coverage under this policy.

I certify that all dependents listed above are eligible for coverage under the terms of the Health Net plan documents. I agree to notify Health Net and my employer within 31 days when such eligibility ceases. I understand that Health Net is not liable to provide coverage to ineligible dependents.

If I am required to contribute, I authorize my employer to deduct from my wage the amount required for the coverage selected. I certify that all the information above is correct to the best of my knowledge.

This authorization is valid for 24 months and you may revoke the authorization at any time by sending a letter to that effect to the address listed below.

Signature ____________ Date ____________

HEALTH INFORMATION I acknowledge that health care providers may disclose health information about me or my dependents, including information regarding substance abuse or mental/emotional conditions, to Health Net. The plans use and disclose this information for purposes of treatemt, payment and health plan operations, including but not limited to utilization management, quality improvement, disease or case management programs.

TO BE COMPLETED BY EMPLOYER

Name of employer or employing office:	Reason for Enrollment: MO DAY YR ☐ New Hire Date of Hire: / / ☐ COBRA Enrollment ☐ 18 months ☐ 36 months Date of Elig: ☐ Open Enrollment ☐ Other_______	Effective Date of Coverage:	Group #:	Subgroup:	Plan Code:

Company Signature ____________ Date ____________

HEATLH NET CUSTOMER SERVICE PHONE NUMBER

Toll-free: 1-800-441-5741

NY CHARTER II ADVANTAGE PLATINUM ENROLLMENT FORM

Please complete this application in full, including your signature.
Use blue or black ink only and be sure all copies are printed legibly.

ENROLLEE INFORMATION (please print clearly)

Last Name:	First Name:	M.I.:	Social Security Number:
COMPLETE HOME ADDRESS	Street: City:	State:	ZIP Code:
☐ Single (S) ☐ Married (M) ☐ Widowed (W) ☐ Separated (L) ☐ Divorced (D) ☐ Other______ (O)		Home Phone: ( )	Business Phone: ( )

EMPLOYMENT INFORMATION

Check box if you are actively employed ☐ Check box if you are retired ☐	Union Affiliation:	Average Number of Hours Worked Per Week: ☐ Under 20 Hours ☐ 20-24 Hours ☐ 25-29 Hours ☐ 30+ Hours

OTHER HEALTH COVERAGE INFORMATION

Will you be covered by another health plan when Health Net coverage starts? ☐ Yes ☐ No	If yes, list name and address of other carrier:	Spouse's Social Security Number:
Is your spouse employed? ☐ Yes ☐ No	If yes, list employer's name and address:	Spouse's Daytime Phone Number: Spouse's Date of Birth: MO / DAY / YR
Will your spouse be covered by another health plan when Health Net coverage starts? ☐ Yes ☐ No	If yes, list name and address of other carrier:	Policy/Contract #:
Will your dependents be covered by another health plan when Health Net coverage starts? ☐ Yes ☐ No	If yes, list name and address of other carrier:	Policy/Contract #:

MEDICARE INFORMATION

Are you covered by Medicare? ☐ Yes ☐ No	Medicare #:	Effective Dates: Part A Part B
Is your spouse covered by Medicare? ☐ Yes ☐ No	Medicare #:	Effective Dates: Part A Part B
Are other dependents covered by Medicare? ☐ Yes ☐ No	Name(s): Medicare #:	Effective Dates: Part A Part B

STUDENT INFORMATION

If dependent children listed are age 19 or older, do they attend school on a full-time basis? ☐ Yes ☐ No	If yes, list first name of child and school	If no, is the dependent child disabled? ☐ Yes ☐ No

List yourself and any eligible dependents to be covered. Attach extra sheet if necessary.

	Last Name	First Name	M.I.	Social Security #	Sex: M/F	Date of Birth MO DAY YR	Primary Care Physician's Name	*Physician's Access Number
Self								
Spouse								
Child								
Child								
Child								

*This number appears in your provider directory below physician address and telephone number.

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 to five thousand dollars and the stated value of the claim for each such violation.

AGREEMENT (please sign and date): I understand the Health Net benefits and coverage as summarized in the Health Net plan materials and that these benefits are administered strictly as specified in the Health Net plan documents.

I authorize any physician, hospital, insurer or other organization or person having any records or information concerning the health and treatment (including psychiatric, substance abuse, and confidential HIV related information) of me and my family member(s) to furnish such records as may be requested by Health Net Insurance of New York, Inc., or its authorized representative for purposes relating to coverage. A photocopy or digital image of this authorization shall be considered as valid as the original. This authorization shall renew upon any subsequent renewal of coverage under this policy.

I certify that all dependents listed above are eligible for coverage under the terms of the Health Net plan documents. I agree to notify Health Net and my employer within 31 days when such eligibility ceases. I understand that Health Net is not liable to provide coverage to ineligible dependents.

If I am required to contribute, I authorize my employer to deduct from my wage the amount required for the coverage selected. I certify that all the information above is correct to the best of my knowledge.

This authorization is valid for 24 months and you may revoke the authorization at any time by sending a letter to that effect to the address listed below.

Signature ______________ Date ______________

HEALTH INFORMATION I acknowledge that health care providers may disclose health information about me or my dependents, including information regarding substance abuse or mental/emotional conditions, to Health Net. The plans use and disclose this information for purposes of treatemt, payment and health plan operations, including but not limited to utilization management, quality improvement, disease or case management programs.

TO BE COMPLETED BY EMPLOYER

Name of employer or employing office:	Reason for Enrollment: MO DAY YR ☐ New Hire Date of Hire: / / ☐ COBRA Enrollment ☐ 18 months ☐ 36 months Date of Elig: ☐ Open Enrollment ☐ Other______	Effective Date of Coverage:	Group #:	Subgroup:	Plan Code:

Company Signature ______________ Date ______________

Health Net Insurance of New York, Inc.
Health Net: One Far Mill Crossing, P.O. Box 904, Shelton, CT 06484-0944
White Copy–Health Net • Yellow Copy–Employer • Pink Copy–Subscriber

PA220-02NYHIPPA

HEATLH NET CUSTOMER SERVICE PHONE NUMBER

Toll-free: 1-800-441-5741

NY CHARTER II ADVANTAGE PLATINUM ENROLLMENT FORM

Please complete this application in full, including your signature.
Use blue or black ink only and be sure all copies are printed legibly.

ENROLLEE INFORMATION (please print clearly)

Last Name: | First Name: | M.I.: | Social Security Number:

COMPLETE HOME ADDRESS | Street: | City: | State: | ZIP Code:

☐ Single (S) ☐ Married (M) ☐ Widowed (W) ☐ Separated (L) ☐ Divorced (D) ☐ Other_______ (O) | Home Phone: ( ) | Business Phone: ( )

EMPLOYMENT INFORMATION

Check box if you are actively employed ☐
Check box if you are retired ☐
Union Affiliation:
Average Number of Hours Worked Per Week: ☐ Under 20 Hours ☐ 20-24 Hours ☐ 25-29 Hours ☐ 30+ Hours

OTHER HEALTH COVERAGE INFORMATION

Question		
Will you be covered by another health plan when Health Net coverage starts? ☐ Yes ☐ No	If yes, list name and address of other carrier:	Spouse's Social Security Number:
Is your spouse employed? ☐ Yes ☐ No	If yes, list employer's name and address:	Spouse's Daytime Phone Number: Spouse's Date of Birth: MO / DAY / YR
Will your spouse be covered by another health plan when Health Net coverage starts? ☐ Yes ☐ No	If yes, list name and address of other carrier:	Policy/Contract #:
Will your dependents be covered by another health plan when Health Net coverage starts? ☐ Yes ☐ No	If yes, list name and address of other carrier:	Policy/Contract #:

MEDICARE INFORMATION

Question		
Are you covered by Medicare? ☐ Yes ☐ No	Medicare #:	Effective Dates: Part A Part B
Is your spouse covered by Medicare? ☐ Yes ☐ No	Medicare #:	Effective Dates: Part A Part B
Are other dependents covered by Medicare? ☐ Yes ☐ No	Name(s): Medicare #:	Effective Dates: Part A Part B

STUDENT INFORMATION

If dependent children listed are age 19 or older, do they attend school on a full-time basis? ☐ Yes ☐ No	If yes, list first name of child and school	If no, is the dependent child disabled? ☐ Yes ☐ No

List yourself and any eligible dependents to be covered. Attach extra sheet if necessary.

	Last Name	First Name	M.I.	Social Security #	Sex: M/F	Date of Birth MO DAY YR	Primary Care Physician's Name	*Physician's Access Number
Self								
Spouse								
Child								
Child								
Child								

*This number appears in your provider directory below physician address and telephone number.

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AGREEMENT (please sign and date): I understand the Health Net benefits and coverage as summarized in the Health Net plan materials and that these benefits are administered strictly as specified in the Health Net plan documents.

I authorize any physician, hospital, insurer or other organization or person having any records or information concerning the health and treatment (including psychiatric, substance abuse, and confidential HIV related information) of me and my family member(s) to furnish such records as may be requested by Health Net Insurance of New York, Inc., or its authorized representative for purposes relating to coverage. A photocopy or digital image of this authorization shall be considered as valid as the original. This authorization shall renew upon any subsequent renewal of coverage under this policy.

I certify that all dependents listed above are eligible for coverage under the terms of the Health Net plan documents. I agree to notify Health Net and my employer within 31 days when such eligibility ceases. I understand that Health Net is not liable to provide coverage to ineligible dependents.

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TO BE COMPLETED BY EMPLOYER

Name of employer or employing office:	Reason for Enrollment:	Effective Date of Coverage:	Group #:	Subgroup:	Plan Code:
	☐ New Hire Date of Hire: MO / DAY / YR ☐ COBRA Enrollment ☐ 18 months ☐ 36 months Date of Elig: ☐ Open Enrollment ☐ Other________				

Company Signature ____________ Date ____________

Health Net Insurance of New York, Inc.
Health Net: One Far Mill Crossing, P.O. Box 904, Shelton, CT 06484-0944
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PA220-02NYHIPPA

HEALTH NET CUSTOMER SERVICE PHONE NUMBER

Toll-free: 1-800-441-5741

NY CHARTER/POS ADVANTAGE PLATINUM ENROLLMENT FORM

Please complete this application in full, including your signature. Use blue or black ink only and be sure all copies are printed legibly.

Health Net®

ENROLLEE INFORMATION (please print clearly)

Last Name:	First Name:	M.I.:	Social Security Number:
COMPLETE HOME ADDRESS — Street:	City:	State:	ZIP Code:
☐ Single (S) ☐ Married (M) ☐ Widowed (W) ☐ Separated (L) ☐ Divorced (D) ☐ Other______ (O)		Home Phone: ( )	Business Phone: ( )

EMPLOYMENT INFORMATION

Check box if you are actively employed ☐ Check box if you are retired ☐	Union Affiliation:	Average Number of Hours Worked Per Week: ☐ Under 20 Hours ☐ 20-29 Hours ☐ 30+ Hours

OTHER HEALTH COVERAGE INFORMATION

Will you be covered by another health plan when Health Net coverage starts? ☐ Yes ☐ No	If yes, list name and address of other carrier:	Spouse's Social Security Number:
Is your spouse employed? ☐ Yes ☐ No	If yes, list employer's name and address:	Spouse's Daytime Phone Number: Spouse's Date of Birth: MO / DAY / YR
Will your spouse be covered by another health plan when Health Net coverage starts? ☐ Yes ☐ No	If yes, list name and address of other carrier:	Policy/Contract #:
Will your dependents be covered by another health plan when Health Net coverage starts? ☐ Yes ☐ No	If yes, list name and address of other carrier:	Policy/Contract #:

MEDICARE INFORMATION

Are you covered by Medicare? ☐ Yes ☐ No	Medicare #:	Effective Dates: Part A Part B
Is your spouse covered by Medicare? ☐ Yes ☐ No	Medicare #:	Effective Dates: Part A Part B
Are other dependents covered by Medicare? ☐ Yes ☐ No	Name(s): Medicare #:	Effective Dates: Part A Part B

STUDENT INFORMATION

If dependent children listed are age 19 or older, do they attend school on a full-time basis? ☐ Yes ☐ No	If yes, list first name of child and school	If no, is the dependent child disabled? ☐ Yes ☐ No

List yourself and any eligible dependents to be covered. Attach extra sheet if necessary.

	Last Name	First Name	M.I.	Social Security #	Sex: M/F	Date of Birth MO DAY YR	Primary Care Physician's Name	*Physician's Access Number
Self								
Spouse								
Child								
Child								
Child								

*This number appears in your provider directory below physician address and telephone number.

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AGREEMENT (please sign and date): Your Evidence of Coverage and Certificate of coverage, respectively, are herein after, collectively referred to as your "Health Net contracts". I understand that in New York, coverage under the in-network portion of the Point-of-Service Plan is provided by Health Net of New York, Inc. The out-of-network coverage for the Point-of-Service Plan is underwritten by Health Net Insurance of New York, Inc.

I understand the Health Net benefits and coverage as summarized in the Health Net plan materials and that these benefits are administered strictly as specified in the Health Net contracts. I authorize any physician, hospital, insurer or other organization or person having any records or information concerning the health and treatment (including psychiatric, substance abuse, and confidential HIV related information) of me and my family member(s) to furnish such records as may be requested by Health Net or its authorized representative for purposes relating to coverage. A photocopy or digital image of this authorization shall be considered as valid as the original. I certify that all dependents listed above are eligible for coverage under the terms of the Health Net contracts. I agree to notify Health Net and my employer within 31 days when such eligibility ceases. I understand that Health Net is not liable to provide coverage to ineligible dependents. If I am required to contribute, I authorize my employer to deduct from my wage the amount required for the coverage selected. I certify that all the information above is correct to the best of my knowledge.

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TO BE COMPLETED BY EMPLOYER

Name of employer or employing office:	Reason for Enrollment: ☐ New Hire Date of Hire: MO / DAY / YR ☐ COBRA Enrollment ☐ 18 months ☐ 36 months ☐ Open Enrollment ☐ Other______	Effective Date of Coverage:	Group #:	Subgroup:	Plan Code:

Company Signature ____________ Date ____________

Health Net: One Far Mill Crossing, P.O. Box 904, Shelton, CT 06484

White Copy–Health Net • Yellow Copy–Employer • Pink Copy–Subscriber

HEALTH NET CUSTOMER SERVICE PHONE NUMBER

Toll-free: 1-800-441-5741

NY CHARTER/POS ADVANTAGE PLATINUM ENROLLMENT FORM

Please complete this application in full, including your signature. Use blue or black ink only and be sure all copies are printed legibly.

ENROLLEE INFORMATION (please print clearly)

Last Name: First Name: M.I.: Social Security Number:

COMPLETE HOME ADDRESS Street: City: State: ZIP Code:

☐ Single (S) ☐ Married (M) ☐ Widowed (W) ☐ Separated (L) ☐ Divorced (D) ☐ Other______ (O)

Home Phone: ( ) Business Phone: ( )

EMPLOYMENT INFORMATION

Check box if you are actively employed ☐

Check box if you are retired ☐

Union Affiliation:

Average Number of Hours Worked Per Week: ☐ Under 20 Hours ☐ 20-29 Hours ☐ 30+ Hours

OTHER HEALTH COVERAGE INFORMATION

Will you be covered by another health plan when Health Net coverage starts? ☐ Yes ☐ No	If yes, list name and address of other carrier:	Spouse's Social Security Number:
Is your spouse employed? ☐ Yes ☐ No	If yes, list employer's name and address:	Spouse's Daytime Phone Number: Spouse's Date of Birth: MO / DAY / YR
Will your spouse be covered by another health plan when Health Net coverage starts? ☐ Yes ☐ No	If yes, list name and address of other carrier:	Policy/Contract #:
Will your dependents be covered by another health plan when Health Net coverage starts? ☐ Yes ☐ No	If yes, list name and address of other carrier:	Policy/Contract #:

MEDICARE INFORMATION

Are you covered by Medicare? ☐ Yes ☐ No	Medicare #:	Effective Dates: Part A Part B
Is your spouse covered by Medicare? ☐ Yes ☐ No	Medicare #:	Effective Dates: Part A Part B
Are other dependents covered by Medicare? ☐ Yes ☐ No	Name(s): Medicare #:	Effective Dates: Part A Part B

STUDENT INFORMATION

If dependent children listed are age 19 or older, do they attend school on a full-time basis? ☐ Yes ☐ No	If yes, list first name of child and school	If no, is the dependent child disabled? ☐ Yes ☐ No

List yourself and any eligible dependents to be covered. Attach extra sheet if necessary.

	Last Name	First Name	M.I.	Social Security #	Sex: M/F	Date of Birth MO DAY YR	Primary Care Physician's Name	*Physician's Access Number
Self								
Spouse								
Child								
Child								
Child								

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TO BE COMPLETED BY EMPLOYER

Name of employer or employing office:	Reason for Enrollment: ☐ New Hire Date of Hire: MO / DAY / YR ☐ COBRA Enrollment ☐ 18 months ☐ 36 months ☐ Open Enrollment ☐ Other______	Effective Date of Coverage:	Group #:	Subgroup:	Plan Code:

Company Signature ____________ Date ____________

Health Net: One Far Mill Crossing, P.O. Box 904, Shelton, CT 06484

White Copy–Health Net • Yellow Copy–Employer • Pink Copy–Subscriber

HEALTH NET CUSTOMER SERVICE PHONE NUMBER

Toll-free: 1-800-441-5741

NY CHARTER/POS ADVANTAGE PLATINUM ENROLLMENT FORM

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ENROLLEE INFORMATION (please print clearly)

Last Name: | First Name: | M.I.: | Social Security Number:

COMPLETE HOME ADDRESS | Street: | City: | State: | ZIP Code:

☐ Single (S) ☐ Married (M) ☐ Widowed (W) ☐ Separated (L) ☐ Divorced (D) ☐ Other________ (O) | Home Phone: ( ) | Business Phone: ( )

EMPLOYMENT INFORMATION

Check box if you are actively employed ☐

Check box if you are retired ☐

Union Affiliation:

Average Number of Hours Worked Per Week: ☐ Under 20 Hours ☐ 20-29 Hours ☐ 30+ Hours

OTHER HEALTH COVERAGE INFORMATION

Will you be covered by another health plan when Health Net coverage starts? ☐ Yes ☐ No	If yes, list name and address of other carrier:	Spouse's Social Security Number:
Is your spouse employed? ☐ Yes ☐ No	If yes, list employer's name and address:	Spouse's Daytime Phone Number: Spouse's Date of Birth: MO / DAY / YR
Will your spouse be covered by another health plan when Health Net coverage starts? ☐ Yes ☐ No	If yes, list name and address of other carrier:	Policy/Contract #:
Will your dependents be covered by another health plan when Health Net coverage starts? ☐ Yes ☐ No	If yes, list name and address of other carrier:	Policy/Contract #:

MEDICARE INFORMATION

Are you covered by Medicare? ☐ Yes ☐ No	Medicare #:	Effective Dates: Part A Part B
Is your spouse covered by Medicare? ☐ Yes ☐ No	Medicare #:	Effective Dates: Part A Part B
Are other dependents covered by Medicare? ☐ Yes ☐ No	Name(s): Medicare #:	Effective Dates: Part A Part B

STUDENT INFORMATION

If dependent children listed are age 19 or older, do they attend school on a full-time basis? ☐ Yes ☐ No	If yes, list first name of child and school	If no, is the dependent child disabled? ☐ Yes ☐ No

List yourself and any eligible dependents to be covered. Attach extra sheet if necessary.

	Last Name	First Name	M.I.	Social Security #	Sex: M/F	Date of Birth MO DAY YR	Primary Care Physician's Name	*Physician's Access Number
Self								
Spouse								
Child								
Child								
Child								

*This number appears in your provider directory below physician address and telephone number.

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Name of employer or employing office:	Reason for Enrollment: ☐ New Hire Date of Hire: MO / DAY / YR ☐ COBRA Enrollment ☐ 18 months ☐ 36 months ☐ Open Enrollment ☐ Other________	Effective Date of Coverage:	Group #:	Subgroup:	Plan Code:

Company Signature _______________ Date _______________

Health Net: One Far Mill Crossing, P.O. Box 904, Shelton, CT 06484

White Copy–Health Net • Yellow Copy–Employer • Pink Copy–Subscriber

PA214-02 NYHIPPA

Health Net®
A Better Decision

NY OUTLOOK EPO ADVANTAGE PLATINUM ENROLLMENT FORM

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HEALTH NET CUSTOMER SERVICE PHONE NUMBER
Toll-free: 1-800-441-5741

ENROLLEE INFORMATION (please print clearly)

Last Name: | First Name | M.I. | Social Security Number:

COMPLETE HOME ADDRESS: Street: | City: | State: | ZIP Code:

❑ Single (S) ❑ Married (M) ❑ Widowed (W) ❑ Separated (L) ❑ Divorced (D) ❑ Other ________ (O)

Home Phone: ( ) | Business Phone: ( )

EMPLOYMENT INFORMATION*

Check box if you are actively employed ❑
Check box if you are retired ❑
Union Affiliation:
Average Number of Hours Worked Per Week: ❑ Under 20 Hours ❑ 20-29 Hours ❑ 30+ Hours

OTHER HEALTH COVERAGE INFORMATION

Will you be covered by another health plan when Health Net coverage starts? ❑ Yes ❑ No	If yes, list name and address of other carrier:	Spouse's Social Security Number:
Is your spouse employed? ❑ Yes ❑ No	If yes, list employer's name and address:	Spouse's Daytime Phone Number: Spouse's Date of Birth: MO / DAY / YR
Will your spouse be covered by another health plan when Health Net coverage starts? ❑ Yes ❑ No	If yes, list name and address of other carrier:	Policy/Contract #:
Will your dependents be covered by another health plan when Health Net coverage starts? ❑ Yes ❑ No	If yes, list name and address of other carrier:	Policy/Contract #:

MEDICARE INFORMATION

Are you covered by Medicare? ❑ Yes ❑ No	Medicare #:	Effective Dates: Part A Part B
Is your spouse covered by Medicare? ❑ Yes ❑ No	Medicare #:	Effective Dates: Part A Part B
Are other dependents covered by Medicare? ❑ Yes ❑ No	Name(s): Medicare #:	Effective Dates: Part A Part B

STUDENT INFORMATION

If dependent children listed are age 19 or older, do the attend school on a full-time basis? ❑ Yes ❑ No	If yes, list name of child and school:	If no, is the dependent child disabled? ❑ Yes ❑ No

List yourself and any eligible dependents to be covered. **If you or any enrollee had previous health care coverage, enter start and end date of coverage next to name.

	Dates of Prev. Coverage**	Last Name First Name M.I.	Social Security #	Sex M/F	Date of Birth MO DAY YR	Primary Care Physician's Name	*Physician's Access Number
Self							
Spouse							
Child							
Child							
Child							

*This number appears in your provider directory below physician address and telephone number.

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Company Signature ____________ Date ____________

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NY46967 (2/08) 6016101

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. All rights reserved.

NY OUTLOOK POS ADVANTAGE PLATINUM ENROLLMENT FORM

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HEALTH NET CUSTOMER SERVICE PHONE NUMBER

Toll-free: 1-800-441-5741

ENROLLEE INFORMATION (please print clearly)

Last Name: | First Name: | M.I. | Social Security Number:

COMPLETE HOME ADDRESS — Street: | City: | State: | ZIP Code:

❑ Single (S) ❑ Married (M) ❑ Widowed (W) ❑ Separated (L) ❑ Divorced (D) ❑ Other (O) ________ | Home Phone: ( ) | Business Phone: ( )

EMPLOYMENT INFORMATION*

Check box if you are actively employed ❑
Check box if you are retired ❑
Union Affiliation:
Average Number of Hours Worked Per Week: ❑ Under 20 Hours ❑ 20-29 Hours ❑ 30+ Hours

OTHER HEALTH COVERAGE INFORMATION

Will you be covered by another health plan when Health Net coverage starts? ❑ Yes ❑ No	If yes, list name and address of other carrier:	Spouse's Social Security Number
Is your spouse employed? ❑ Yes ❑ No	If yes, list employer's name and address:	Spouse's Daytime Phone Number: Spouse's Date of Birth: MO / DAY / YR
Will your spouse be covered by another health plan when Health Net coverage starts? ❑ Yes ❑ No	If yes, list name and address of other carrier:	Policy/Contract #:
Will your dependents be covered by another health plan when Health Net coverage starts? ❑ Yes ❑ No	If yes, list name and address of other carrier:	Policy/Contract #:

MEDICARE INFORMATION

Are you covered by Medicare? ❑ Yes ❑ No	Medicare #:	Effective Dates: Part A Part B
Is your spouse covered by Medicare? ❑ Yes ❑ No	Medicare #:	Effective Dates: Part A Part B
Are other dependents covered by Medicare? ❑ Yes ❑ No	Name(s): Medicare #:	Effective Dates: Part A Part B

STUDENT INFORMATION

If dependent children listed are age 19 or older, do the attend school on a full-time basis? ❑ Yes ❑ No	If yes, list the name of child and school	If no, is this dependent child disabled? ❑ Yes ❑ No

List yourself and any eligible dependents to be covered. **If you or any enrollee had previous health care coverage, enter start and end date of coverage next to name.

	Dates of Prev. Coverage**	Last Name First Name M.I.	Social Security #	Sex M/F	Date of Birth MO DAY YR	Primary Care Physician's Name	*Physician's Access Number
Self							
Spouse							
Child							
Child							
Child							

*This number appears in your provider directory below physician address and telephone number.

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.

AGREEMENT (please sign and date): Your Evidence of Coverage and Certificate of coverage, respectively, are herein after, collectively referred to as your "Health Net contracts." I understand that in New York, coverage under the In-network portion of the Point-of-Service Plan is provided by Health net of New York, Inc.. The out-of-network coverage for the Point-of-Service Plan is underwritten by Health Net Insurance of New York, Inc.
I understand the Health Net benefits and coverage as summarized in the Health Net plan materials and that these benefits are administered strictly as specified in the Health Net Group Subscriber Contract. I authorize any physician, hospital, insurer or other organization or person having any records or information concerning the health and treatment (including psychiatric, substance abuse, and confidential HIV related information) or me and my family member(s) to furnish such records as may be requested by Health Net of the Northeast, Inc. or its authorized representative for purposes relating to coverage. A photocopy or digital image of this authorization shall be considered as valid as the original. This authorization shall renew upon any subsequent renewal of coverage under this policy. I understand that Health Net is not liable to provide coverage to ineligible dependants. If I am required to contribute, I authorize my employer to deduct from any compensation the amount required the amount required for the coverage selected. I certify that all information above is correct to the best of my knowledge.

Signature ____________ Date ____________

HEALTH INFORMATION I acknowledge that health care providers may disclose health information about me or my dependents, including information regarding substance abuse or mental/emotional conditions to Health Net. The plans use and disclose this information of treatment, payment and health plan operations, including but not limited to utilization management, quality improvement, disease or case management programs.

TO BE COMPLETED BY EMPLOYER

Name of employer or employing office:	Reason for Enrollment: ❑ New Plan ❑ COBRA Enrollment ❑ 18 Months ❑ 36 months ❑ Open Enrollment ❑ Other Date of Hire: MO / DAY / YR	Effective Date of Coverage:	Group #:	Subgroup:	Plan Code:

Company Signature ____________ Date ____________

Health Net: One Far Mill Crossing, P.O. Box 904, Shelton, CT 06484-0944 White Copy-Health Net • Yellow Copy-Employer • Pink Copy-Subscriber
NY46807 (2/08) 6016099

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.
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PPO ENROLLMENT FORM

Health Net Insurance Of New York, Inc. ENROLLMENT FORM
PRODUCT: PPO ADVANTAGE PLATINUM
Please complete this application full, including your signature.
Use blue or black ink only and be sure all copies are printed legibly.

HEALTH NET CUSTOMER SERVICE PHONE NUMBER

Toll-free: 1-800-441-5741

ENROLLEE INFORMATION (please print clearly)	Last Name: First Name: M.I.		Social Security Number:
	COMPLETE HOME ADDRESS Street: City: State: ZIP Code:		
	❑ Single (S) ❑ Married (M) ❑ Widowed (W) ❑ Separated (L) ❑ Divorced (D) ❑ Other ________ (O)	Home Phone: ( )	Business Phone: ( )
EMPLOYMENT INFORMATION*	Check box if you are actively employed ❑ Check box if you are retired ❑	Union Affiliation:	Average Number of Hours Worked Per Week: ❑ Under 20 Hour ❑ 20-29 Hour ❑ 30+ Hours
OTHER HEALTH COVERAGE INFORMATION	Will you be covered by another health plan when Health Net coverage starts? ❑ Yes ❑ No	If yes, list name and address of other carrier:	Spouse's Social Security Number
	Is your spouse employed? ❑ Yes ❑ No	If yes, list employer's name and address:	Spouse's Daytime Phone Number: Spouse's Date of Birth: MO / DAY / YR
	Will your spouse be covered by another health plan when Health Net coverage starts? ❑ Yes ❑ No	If yes, list name and address of other carrier:	Policy/Contract #:
	Will your dependents be covered by another health plan when Health Net coverage starts? ❑ Yes ❑ No	If yes, list name and address of other carrier:	Policy/Contract #:
MEDICARE INFORMATION	Are you covered by Medicare? ❑ Yes ❑ No	Medicare #:	Effective Dates: Part A Part B
	Is your spouse covered by Medicare? ❑ Yes ❑ No	Medicare #:	Effective Dates: Part A Part B
	Are other dependents covered by Medicare? ❑ Yes ❑ No	Name(s): Medicare #:	Effective Dates: Part A Part B
STUDENT INFORMATION	If dependent children listed are age 19 or older, do they attend school on a full-time basis? ❑ Yes ❑ No	If yes, list first name of child and school:	If no, is the dependent child disabled? ❑ Yes ❑ No

List yourself and any eligible dependents to be covered. **If you or any enrollee had previous health care coverage, enter start and end date of coverage next to name.

	Dates of Prev. Coverage**	Last Name First Name M.I.	Social Security #	Sex M/F	Date of Birth MO DAY YR
Self					
Spouse					
Child					
Child					
Child					

Please attach a copy of the certificate of creditable coverage, if any, for each person listed.

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.

AGREEMENT (please sign and date): I understand the Health Net Insurance of New York, Inc. (Health Net INY) benefits and coverage as summarized in the Health Net INY plan and materials and that these benefits are administered strictly as specified in the Health Net INY plan documents.

I authorize any physician, hospital, insurer or other organization or person having any records or information concerning the health and treatment (including psychiatric, substance abuse, and confidential HIV related information) or me and my family members(s) to furnish such records as may be requested by Health Net INY or its authorized representative for purposes relating to coverage. A photocopy or digital image of this authorization shall be considered as valid as the original. This authorization shall renew upon any subsequent renewal or coverage under this policy. I certify that all dependents listed above are eligible for coverage under the terms of the Health Net INY plan documents. I agree to notify Health Net INY and my employer within 31 days when such eligibility ceases. I understand that Health Net INY is not liable to provide coverage to ineligible dependents. If I am required to contribute, I authorize my employer to deduct from my wage the amount required for the coverage selected. I certify that all information above is correct to the best of my knowledge. This authorization is valid for 24 months and you may revoke the authorization at any time by sending a letter to that effect to the address listed below.

Signature ______________________ Date ____________

HEALTH INFORMATION I acknowledge that health care providers may disclose health information about me or my dependents, including information regarding substance abuse or mental/emotional conditions to Health Net. The plans use and disclose this information of treatment, payment and health plan operations, including but not limited to utilization management, quality improvement, disease or case management programs.

TO BE COMPLETED BY EMPLOYER	Name of employer or employing office:	Reason for Enrollment: MO DAY YR ❑ New Plan Date of Hire: / / ❑ COBRA Enrollment ❑ 18 Months ❑ 36 months Date of Elig: ❑ Open Enrollment ❑ Other	Effective Date of Coverage:	Group #:	Subgroup:	Plan Code:
	Company Signature ____________ Date ____________					

Health Net: One Far Mill Crossing, P.O. Box 904, Shelton, CT 06484-0944

You must complete the Pre-existing Condition Questionnaire on the reverse of this page. Please send the signed original of this form to your employer, and retain a copy for your records.

NY46966 (2/08) 6016100

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Health Net Insurance of New York,Inc.
Pre-existing Condition Questionnaire

1. Do you or your dependent(s) have a physical or mental condition for which medical service, diagnosis, care or treatment was received or recommended within the six months prior to completing and signing this enrollment form? ❑ Yes ❑ No

2. During the past six months, have you or any dependent to be covered:

a. been examined or treated by a physician or other health care provider for any condition, illness or injury? ❑ Yes ❑ No

b. been advised to have treatment, surgery or testing that has not been done? ❑ Yes ❑ No

c. been admitted to a hospital or other health care facility as an inpatient? ❑ Yes ❑ No

d. taken prescribed medications? ❑ Yes ❑ No

Please give details for any "Yes" answers to questions 1 or 2. Attach a separate sheet if more space is needed for answers. The separate sheet should be signed and dated.

Question # and letter	Name or Person	Relationship to Subscriber	Condition	Duration of Symptoms, Treatment Degree or Recovery	Date	Name & Address of Hospitals, Practitioners

Date: ______________________________________

Signature of Subscriber: ____________________________________ Subscriber's Social Security Number: ______________________________