

**Please print out the form below and
mail your completed form to:**

**Health Net Enrollment Services
PO Box 10420
Van Nuys, CA 91410-0420**



HEALTH NET MEDICARE PROGRAMS INDIVIDUAL ENROLLMENT FORM

Please follow these simple instructions to enroll in Health Net Medicare Programs.

ARE YOU ELIGIBLE?

You are eligible to enroll in Health Net Medicare Programs if:

- You are entitled to Medicare Part A (hospital insurance) and enrolled in Part B (medical insurance). For Dual Eligible Seniority Plus Amber I and Seniority Plus Amber II you need to be enrolled in Medi-Cal plans.
- You reside in one of the Health Net Medicare Programs plans service areas.
- You do not have end-stage renal disease (ESRD) – kidney failure,¹ **or** if you had ESRD but have had a transplant within the last 36 months that restored kidney function and you no longer require a regular course of dialysis to maintain life (documentation from your physician is required).
¹There are exceptions to this eligibility requirement. It does not apply if:
 - You have ESRD and are just becoming entitled to Medicare Parts A and B, or
 - You had ESRD and were enrolled in a Medicare Managed Care plan that left the Medicare program or stopped providing coverage in your area after December 31, 1998.

COMPLETE THE ENROLLMENT FORM

1. Tell us about yourself

Please complete all the fields in this section.

2. Your Medicare information

Fill in the areas about your Medicare benefits exactly as they appear on your Medicare card. If you have not yet received your Medicare card, you can attach a copy of your Letter of Verification from the Social Security Administration or Railroad Retirement Board.

3. Your plan premium option

Please complete the field in this section. If “Automatic Bank Draft” is chosen in this field, please proceed to *Section 4: Automatic Bank Draft Billing Information*.

4. Automatic bank draft billing information

Please complete all the fields in this section only if “Automatic Bank Draft” is chosen in *Section 3: Your Plan Premium Option*.

5. Choose your plan

Please make your plan choice and be sure to choose only *one* plan. If you are applying for a Seniority

Plus or a Healthy Heart plan, proceed to *Section 6: For Seniority Plus and Healthy Heart Plans Only*. If you are applying for a Health Net Seniority Plus Amber I or Amber II (Dual Eligible Special Needs) plan, please provide a copy of your Medi-Cal card or entitlement letter.

6. For Seniority Plus and Healthy Heart plans only

If you chose a Seniority Plus or Healthy Heart plan in *Section 5: Choose Your Plan*, select your provider group, doctor and dental provider. Be sure to fill in the names and numbers as they appear in the directories, or call us at the numbers below and we can help you.

7. Please read and answer these questions

Read and answer all the questions in this section.

8. Please read this important information and sign

Before signing and dating the enrollment form, please read the “Important section,” “Please read below,” and “Release of information” sections on the back of this form. After making sure all sections on the front of the form have been filled out completely, sign and date in the spaces provided. **Mail us your completed enrollment form in the envelope provided.** Your effective date of coverage depends on when you return this form to us.

We will be in touch soon. We’ll send you a letter confirming your effective date of enrollment. We’ll also send a welcome kit with your ID card. Until you receive your ID card, please use your pink copy of this enrollment form as your temporary ID card.

If you have any questions, please call our representatives:

- For Health Net Seniority Plus and Healthy Heart, call: 1-800-977-6738 (TDD/TTY 1-800-929-9955)
- For Health Net Options Plus, call: 1-800-579-9096 (TDD/TTY 1-800-929-9955)

Representatives are available from 8:00 a.m. to 8:00 p.m., 7 days a week.

Health Net Seniority Plus, Healthy Heart and Health Net Options Plus mailing address:

P. O. Box 10420
Van Nuys, CA 91410-0420

Material ID# M0004-07-5015A (H0562, H5439)
CMS Approval 8/07

1. TELL US ABOUT YOURSELF

Name as it appears on Medicare card: Last		First		MI
Permanent residence address		Apt#	City	County ZIP
Mailing address (if different from residential address)		Apt#	City	County ZIP
Have you recently moved into the service area for the plan you want to enroll in? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of move:				
(Area code) Telephone #	Email address	Sex	Birth date (MM/DD/YYYY)	Social Security # (optional)
Language preference <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Other:				
Please read the following statements and check the box to the left of the statement that applies to you.				
<input type="checkbox"/> I am new to Medicare.				
<input type="checkbox"/> I recently moved outside of the service area for my current plan. Date of move: _____				
<input type="checkbox"/> I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.				
<input type="checkbox"/> I received, or am no longer eligible for, extra help paying for Medicare prescription drug coverage.				
<input type="checkbox"/> I live in a long term care facility (for example, a nursing home or long term care facility). Please provide the following information: Your date of admission to institution _____ Name of institution _____ Address and phone number of institution (number and street) _____				
<input type="checkbox"/> I recently moved out of a long term care facility (for example, a nursing home or long term care facility).				
<input type="checkbox"/> I recently involuntarily lost my creditable prescription coverage (that is, coverage that is at least as good as Medicare's).				
<input type="checkbox"/> I am either losing coverage I had from an employer or leaving employer coverage.				
<input type="checkbox"/> I belong to a pharmacy assistance program provided by my state.				
<input type="checkbox"/> I recently returned to the United States after living permanently outside of the U.S.				

2. YOUR MEDICARE INFORMATION

Your Medicare # (from red, white & blue Medicare card)	Entitlement: Part A Hospital date: _____ Part B Medical date: _____
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3. YOUR PLAN PREMIUM OPTION

How do you want to pay your monthly premium? (See back of form "Your plan premium option" for more information.)

- Automatic Bank Draft (see Automatic bank draft billing information section of this form)
- Deduction from your Social Security check
- Bill me Send me a coupon book
- Link me with my spouse's plan (please provide spouse's name):

4. AUTOMATIC BANK DRAFT BILLING INFORMATION

See back of form "Automatic bank draft" for more information. Please include a voided bank check with your authorization. This will be used to verify bank information.

Billing name (if different)		Billing telephone # (if different)			
Billing address (if different)		Apt #	City	State	ZIP
Name of bank or financial institution		City		State	ZIP
Name(s) shown on account to be debited	Account number to be debited	<input type="checkbox"/> Savings <input type="checkbox"/> Checking			
Signature(s) shown on account to be debited	# shown between : & : at bottom of check				

5. CHOOSE YOUR PLAN – PLEASE CHOOSE ONLY ONE

Please refer to the Summary of Benefits for detailed information, service areas, benefits and costs associated with each plan. Some plans are not available in all service areas.

Are you currently a Health Net member? Yes No

Please check which plan you want to enroll in:

___ Health Net Healthy Heart I (includes prescription drug coverage)

___ Health Net Healthy Heart II (includes prescription drug coverage)

___ Health Net Seniority Plus Green (does not include prescription drug coverage)
(in San Diego County, please check Plan 1 Plan 2)

___ Health Net Seniority Plus Ruby (includes prescription drug coverage)
(in San Diego County, please check Plan 1 Plan 2)

___ Health Net Seniority Plus Amber (Congestive Heart Failure/Chronic Obstructive Pulmonary Disease)
(includes prescription drug coverage)

___ Health Net Seniority Plus Amber I (All Dual Eligible beneficiaries enrolled in Medicare and Medi-Cal) (includes prescription drug coverage)

___ Health Net Seniority Plus Amber II (Full Benefit Dual Eligible beneficiaries enrolled in Medicare and Medi-Cal) (includes prescription drug coverage)

___ Health Net Options Plus Violet (PPO) (includes prescription drug coverage)

___ Optional Supplemental Benefits Package Plan # _____ for an additional monthly plan premium of \$ _____

Monthly Plan Premium Amount \$ _____ Requested Effective Date _____

6. FOR SENIORITY PLUS AND HEALTHY HEART PLANS ONLY

Provider Selection from a Health Net Medicare Programs provider directory Existing patient Yes No

Selected Health Net Participating Provider Group (PPG) Name	PPG ID #
Selected Primary Care Physician (PCP) Name	PCP ID #
Dental provider selection from a Health Net Dental provider directory (See back of form "Dental provider selection" for more information.)	
Provider Name	Provider ID #

7. PLEASE READ AND ANSWER THESE QUESTIONS

1. Do you currently have end-stage renal disease (ESRD)? ESRD is permanent kidney failure and requires regular kidney dialysis or a transplant to maintain life. Yes No
Note: If you answered "yes" to this question and you do not need regular dialysis anymore, or have had a successful kidney transplant, please attach a note or records from your doctor showing you do not need dialysis or have had a successful kidney transplant.
2. Do you receive Medi-Cal (Medicaid) benefits? Yes No
 If yes, Medi-Cal (Medicaid) # _____
3. Do you, on your own or through your spouse, have any health insurance and/or prescription drug coverage other than Medicare, such as private insurance, workers compensation, VA benefits, TRICARE, federal employee health benefits coverage, or state pharmaceutical assistance programs? Yes No
 If yes, what kind of insurance do you have? _____
 Name of insurance _____ ID # and/or Group # for this coverage _____
4. Do you or your spouse work? Yes No
5. Have you had Medicare prescription drug coverage or other drug coverage that was at least as good as standard Medicare prescription drug coverage since you became eligible to join a Medicare drug plan?
 Yes No
If no, you may have to pay a penalty. Health Net may ask you to provide evidence that some or all of your previous prescription drug coverage was at least as good as Medicare drug coverage. If you have questions about the late enrollment penalty, call Health Net at the phone number listed on the cover of this enrollment form.

8. PLEASE READ THIS IMPORTANT INFORMATION AND SIGN

I understand that my signature on this enrollment form certifies that I have read and understand the information contained on **both sides** of this form. I agree to abide by Health Net Medicare Programs membership rules as outlined in the Evidence of Coverage (**please read your Evidence of Coverage document to know what rules you must follow in order to receive coverage with Health Net Medicare Programs**).

X _____
 Signature of Enrollee² Date Health Net Medicare Programs Representative's signature

²If the individual cannot sign, a court-appointed Legal Guardian or person with Durable Power of Attorney for Health Care (DPAHC) or designated in a written advance directive, if authorized by state law, must sign the following line. Attach a copy of proof of Legal Guardian, DPAHC, written advance directive, or proof of authorization by state law.

X _____
 Signature of legal representative Date Address (number and street)

X _____
 Signature of individual who assisted in completing this form Date Address (number and street)

Relationship to Enrollee: _____

Authorized Agent Use Only:

Broker or Agency Name: Steve Shorr Broker or Agency HN ID# L 981
 Broker or Agency Phone #: 310.519.1335 GA/FMO Name: _____ GA/FMO HN ID# _____
 Health Net Rep Name: _____ Health Net Rep ID#: _____ Health Net Rep Phone#: _____

HN ENROLLMENT SERVICES ONLY		Group #	Effective date of coverage	Processor ID
Correction of Member information (PPG, PCR, etc.)			Election type	
ICEP/IEP:	OEP:	AEP:	SEP (type):	Not Eligible:



Please read this important section

If you currently have health coverage from an employer or union, joining Health Net Medicare Programs could affect your employer or union health benefits. If you have health coverage from an employer or union, joining Health Net Medicare Programs may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Paying your plan premium

You can pay your monthly plan premium by mail or Electronic Funds Transfer (EFT) each month or quarterly. You can also choose to pay your premium by automatic deduction from your Social Security Check each month. If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover. If you don't select a payment option, you will receive a bill each month.

Dental provider selection

After you have completed your enrollment through a Health Net Seniority Plus or Healthy Heart plan and the Optional Supplemental Benefits Package Plan #1, you must select a Health Net Dental Participating Dental Provider. Please refer to the Health Net Dental Provider Directory, which will be included in your upcoming welcome kit for additional instructions in making your selection. You can also call 1-800-880-8113 (TDD/TTY 1-800-880-3165) Monday–Friday, 6:00 a.m. to 6:00 p.m. or visit Health Net at the following web sites: members: www.healthnet.com, prospective members: www.abetterdecision.com. Services must be provided by your Primary Care Dentist in order to be covered under this dental plan.

Automatic bank draft

I hereby authorize Health Net of California, Inc. or Health Net Life Insurance Company (HNL) to debit the account shown on the front of this form for my (the subscriber's) Health Net of California or HNL coverage when my premium payment comes due. I authorize the bank or financial institution shown on the front of this form to accept such debits without responsibility for their correctness.

I may terminate this Automatic Bank Draft Authorization at any time by giving Health Net of California or HNL written notification of termination or by calling 1-800-275-4737 for Seniority Plus Green and Ruby or Healthy Heart I; 1-800-431-9007 for Seniority Plus Amber, Amber I, Amber II or Healthy Heart II; 1-800-960-4638 for Options Plus (TDD/TTY 1-800-929-9955), 8:00 a.m.–8:00 p.m., 7 days a week, to request termination. I understand that such notification will become effective after Health Net of California or HNL has received the termination request and has had a reasonable amount of time to act on it (at least sixty (60) days).

If the amount of my Health Net of California or HNL premium should change for any reason, such as when switching Health Net plans or upon annual renewal described in the Annual Notice of Change, I will be notified in writing by Health Net of California or HNL at least thirty (30) calendar days prior to my account being debited.

Automatic Bank Draft (ABD) transmissions are submitted to the bank approximately the 5th of every month, for the following month's premium. Therefore, your premium should be submitted with your request for ABD, and/or manual payment should continue to be submitted to Health Net of California or HNL by the 1st of the month for each month, until such time that you receive confirmation of ABD commencement in writing from Health Net of California or HNL.

In the interim, if a manual payment is received after the bank transmission has occurred (the 5th of the month), it may not be captured on the ABD transmit to the bank. Consequently, based upon the outstanding balance due at the time of transmission, your account may be drafted for more than one month's premium payment. If this occurs, your Health Net of California or HNL account will reflect the collected manual and automatic

withdrawal premiums on the following billing statement/period. Conversely, if you manually pay your premium due, before the 5th of the month, your payment may be processed, whereby there will be no outstanding balance for the ABD to draft/process. Once any outstanding balance is collected (if applicable), only your monthly premium will be deducted from your account, on, or about, the 6th of the month for which payment is due.

Please read below

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

Health Net of California, Inc. and Health Net Life Insurance Company (HNL) are Medicare Advantage plans. I will need to keep my Parts A and B and maintain Medi-Cal coverage (for Dual Eligible Plans only). I can only be in one Medicare Advantage plan at a time. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I do not have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to Health Net of California or HNL, or by calling 1-800-MEDICARE. TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week.

Health Net of California and HNL serve specific service areas. If I move out of an area that Health Net of California or HNL serve, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Health Net of California or HNL, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Health Net of California or HNL when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan.

For Health Net Seniority Plus and Healthy Heart plans only:

I understand that beginning on the date Health Net Seniority Plus or Healthy Heart coverage begins, I must get all of my health care from Health Net Seniority Plus or Healthy Heart, with the exception of emergency or urgently needed services (worldwide) or out-of-area dialysis services (in U.S.). Services authorized by Health Net Seniority Plus or Healthy Heart and other services contained in my Health Net Seniority Plus or Healthy Heart Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. ***WITHOUT AUTHORIZATION, NEITHER MEDICARE NOR HEALTH NET SENIORITY PLUS NOR HEALTH NET HEALTHY HEART WILL PAY FOR THE SERVICES.***

For Health Net Options Plus plan only:

Beginning on the date my Health Net Options Plus coverage begins, I can use any provider who is part of the Health Net Options Plus network. The network providers can change at any time. It is my responsibility to check the current status of a provider prior to obtaining covered services. I can go to doctors, specialists, or hospitals in or out-of-network. I may have to pay more for out-of-network services, and I must follow special rules in order for Health Net Options Plus to pay for these services. ***OTHERWISE, NEITHER ORIGINAL MEDICARE NOR HEALTH NET OPTIONS PLUS WILL PAY FOR THESE SERVICES.***

Release of information

By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Health Net Medicare Programs will release my information, including my prescription drug event data if applicable, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on the reverse side of this form means that I have read and understand the contents of this form. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Health Net Medicare Programs or by Medicare.

Note: This document is available in alternative formats.