



SMALL BUSINESS GROUP ENROLLMENT AND CHANGE FORM

Medical and Life/AD&D plans are provided by Health Net of California, Inc. and/or Health Net Life Insurance Company (together, the “Health Net Entities”). Dental plans are provided by SafeGuard Health Plans, Inc. and/ or its affiliate, SafeHealth Life Insurance Company, (together “SafeGuard Entities”). Vision plans are provided by Fidelity Security Life Insurance Company and serviced by Eyemed Vision Care LLC (together the “Fidelity Entities”).

Neither the SafeGuard Entities nor The Fidelity Entities are affiliated with the Health Net Entities. Obligations under dental and vision plans are not obligations of, and are not guaranteed by, the Health Net Entities.

Welcome to Health Net

SIMPLE STEPS FOR COMPLETING THE FORM:

- 1) Review the materials enclosed in your enrollment packet. Be sure that you understand the coverage options that are available to you by your employer.
- 2) Carefully review and select the plan option(s) that are best for you and your covered family members.
- 3) If you choose to enroll in the HMO, HMO Silver Network, HMO Salud con Health Net, SELECT (POS), ELECT Open Access (EOA) or Dental HMO (DHMO), you must select your dental provider, physician group and primary care physician. Be sure to fill in the names and numbers as they appear in the HMO Health Net Directory of Providers, or call the Customer Contact Center from 8:00 a.m.- 6:00 p.m., Monday through Friday for assistance.

Small Business Group (English): 1-800-361-3366

Small Business Group (Spanish): 1-800-331-1777

Health Net Life: 1-800-865-6288

Health Net Dental: 1-800-880-8113

Health Net Vision: 1-866-392-6058

- 4) If you choose to select PPO or Flex Net, you are not required to select a primary care physician or physician group to enroll.

Post Office Box 9103

Van Nuys, California 91409-9103

www.healthnet.com

HEALTH NET ENROLLMENT AND CHANGE FORM FOR SMALL BUSINESS GROUP

EMPLOYER NAME

| | |
|------------------------|---------------------------------|
| | |
| EFFECTIVE DATE | EMPLOYER GROUP NUMBER (Medical) |
| | |
| SOCIAL SECURITY NUMBER | |
| | |

(Sections 1, 2, 3, 4 and 8 are required.)

IMPORTANT: PLEASE PRINT ALL SECTIONS IN BLACK INK.

| 1 SELECTED COVERAGE | | | | | | | |
|--|--|--|--|--|--|---|--|
| PPO | HSA | HMO | HMO SILVER NETWORK | EOA | H ^o OPTIONS | SALUD CON HEALTH NET | DENTAL |
| Standard | | Standard | Standard | Standard | <input type="checkbox"/> Options PPO 250 <input type="checkbox"/> Options PPO 500 <input type="checkbox"/> Options PPO 1500 <input type="checkbox"/> Options PPO 1750 <input type="checkbox"/> Options PPO 3000 (HSA compatible) <input type="checkbox"/> Options PPO 4000 (HSA compatible) <input type="checkbox"/> Options HMO 25 <input type="checkbox"/> Options HMO 35 <input type="checkbox"/> Options EOA 25 <input type="checkbox"/> Options EOA 35 | <input type="checkbox"/> Salud HMO y más (available in Los Angeles and Orange counties) <input type="checkbox"/> Salud PPO (available in Los Angeles, Orange and Ventura counties) <input type="checkbox"/> Salud Mexico (available in San Diego and Imperial counties) <input type="checkbox"/> Salud EPO (available in Los Angeles, Orange and Ventura counties) | DHMO <input type="checkbox"/> Advantage Plan _____ <input type="checkbox"/> HN SGX Plan _____ |
| <input type="checkbox"/> PPO 10 <input type="checkbox"/> PPO 20 <input type="checkbox"/> PPO 30 <input type="checkbox"/> PPO 40 | <input type="checkbox"/> HSA 10 (1500) <input type="checkbox"/> HSA 20 (2500) <input type="checkbox"/> HSA 30 (3500) <input type="checkbox"/> HSA 40 (4500) | <input type="checkbox"/> HMO 10 <input type="checkbox"/> HMO 20 <input type="checkbox"/> HMO 30 <input type="checkbox"/> HMO 40 | <input type="checkbox"/> HMO 10 <input type="checkbox"/> HMO 20 <input type="checkbox"/> HMO 30 <input type="checkbox"/> HMO 40 | <input type="checkbox"/> EOA 10 <input type="checkbox"/> EOA 20 <input type="checkbox"/> EOA 30 <input type="checkbox"/> EOA 40 | | <input type="checkbox"/> Flex Net <input type="checkbox"/> Indemnity (Out of service area only) | DPPO <input type="checkbox"/> HB Plan _____ <input type="checkbox"/> HC Plan _____ <input type="checkbox"/> HD Plan _____ |
| Value | POS | Value | Value | Value | | | VISION PPO <input type="checkbox"/> Preferred 1025-2 <input type="checkbox"/> Preferred 1025-3 <input type="checkbox"/> Value 10-2 |
| <input type="checkbox"/> PPO 10 <input type="checkbox"/> PPO 20 <input type="checkbox"/> PPO 30 <input type="checkbox"/> PPO 40 | <input type="checkbox"/> POS 10 <input type="checkbox"/> POS 20 | <input type="checkbox"/> HMO 10 <input type="checkbox"/> HMO 20 <input type="checkbox"/> HMO 30 <input type="checkbox"/> HMO 40 | <input type="checkbox"/> HMO 10 <input type="checkbox"/> HMO 20 <input type="checkbox"/> HMO 30 <input type="checkbox"/> HMO 40 | <input type="checkbox"/> EOA 10 <input type="checkbox"/> EOA 20 <input type="checkbox"/> EOA 30 <input type="checkbox"/> EOA 40 | | | |

| | |
|---|--|
| <p>REASON FOR CHANGE:</p> <input type="checkbox"/> Plan change <input type="checkbox"/> Change address/name <input type="checkbox"/> Delete dependent (list names below) <input type="checkbox"/> Other _____ | <p>REASON FOR APPLICATION:</p> <input type="checkbox"/> New hire <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Loss of prior coverage date _____ <input type="checkbox"/> COBRA ¹ effective date _____ <input type="checkbox"/> ADD DEPENDENT: Qualifying event _____ Qualifying event date _____ |
|---|--|

¹Employers who normally employed 20 or more employees during the previous calendar year are subject to federal COBRA. Employers who employed 2-19 employees on at least 50% of its working days the previous calendar year are subject to Cal-COBRA. Please consult your legal counsel if you need help determining which law applies to you.

| 2 PERSONAL INFORMATION | | | | | | | |
|--|-------|-----------|---------------|--|--|-------|--|
| Last Name | | | | First Name | | M.I. | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Street Address | | | | City | | State | Zip |
| Telephone no. () () | | Job Title | | | Work Phone no. () () | | |
| Date of Hire / / | Class | Dept. no. | Email Address | Employment Status <input type="checkbox"/> Salaried <input type="checkbox"/> Hourly | Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner | | |
| For Salud con Health Net Members: If available, I would prefer to receive communication or plan information in Spanish. <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |

| 3 EMPLOYEE & FAMILY INFORMATION Please list yourself and all eligible family members to be enrolled. (Attach additional sheets if necessary). | | | | | | | |
|---|--|------------------------------------|---|-------------------------------------|--|---|---------------------------------------|
| <input type="checkbox"/> Self | | Last Name, First Name, M.I. | | Residence address, City, State, ZIP | | Date of Birth Mo Day Yr | Social Security #/ Matricular ID # |
| Medicare | Overage Dependent Type | Participating Physician Group/PPG# | Health Net Primary Care Physician/PCP # | Physician Name (First, Last) | | Is this your current M.D.? | Dental HMO Provider ID # |
| <input type="checkbox"/> Part A <input type="checkbox"/> Part B | Not Applicable | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> M <input type="checkbox"/> F | | Last Name, First Name, M.I. | | Residence address, City, State, ZIP | | Date of Birth Mo Day Yr | Social Security #/ Matricular ID # |
| Medicare | Overage Dependent Type | Participating Physician Group/PPG# | Health Net Primary Care Physician/PCP # | Physician Name (First, Last) | | Is this your current M.D.? | Dental HMO Provider ID # |
| <input type="checkbox"/> Part A <input type="checkbox"/> Part B | Not Applicable | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| <input type="checkbox"/> Son <input type="checkbox"/> Daughter | | Last Name, First Name, M.I. | | Residence address, City, State, ZIP | | Date of Birth Mo Day Yr | Social Security #/ Matricular ID # |
| Medicare | Overage Dependent Type | Participating Physician Group/PPG# | Health Net Primary Care Physician/PCP # | Physician Name (First, Last) | | Is this your current M.D.? | Dental HMO Provider ID # |
| <input type="checkbox"/> Part A <input type="checkbox"/> Part B | <input type="checkbox"/> Disabled <input type="checkbox"/> Full-time Student <input type="checkbox"/> Over 50% support | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| <input type="checkbox"/> Son <input type="checkbox"/> Daughter | | Last Name, First Name, M.I. | | Residence address, City, State, ZIP | | Date of Birth Mo Day Yr | Social Security #/ Matricular ID # |
| Medicare | Overage Dependent Type | Participating Physician Group/PPG# | Health Net Primary Care Physician/PCP # | Physician Name (First, Last) | | Is this your current M.D.? | Dental HMO Provider ID # |
| <input type="checkbox"/> Part A <input type="checkbox"/> Part B | <input type="checkbox"/> Disabled <input type="checkbox"/> Full-time Student <input type="checkbox"/> Over 50% support | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

| |
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| |
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4 DO YOU OR YOUR DEPENDENTS HAVE OTHER HEALTH CARE COVERAGE? If yes, please complete this section including Medicare.

Please fill out the following information to receive proper credit for PREVIOUS COVERAGE, if immediately prior to becoming eligible for this plan, you or your dependents were covered under any public or private health care coverage (including MediCal or individual coverage). According to federal law, your employer or FORMER CARRIER must provide you with a certificate that shows evidence of your prior coverage. We reserve the right to request a copy of this certificate.

| | | | | | | |
|--|-----------------------------------|--|---|---|--|-------------------------------|
| <input type="checkbox"/> Self | Name | Name of Other Insurance Carrier | Prior Coverage Start Date | | | |
| | | | Mo | Day | Yr | |
| Prior Coverage End Date | Reason for Ending Coverage | Group #/ Policy ID # | Is this your dependent's primary coverage? | Does it cover? | Medicare | Medicare Claim/ HICN # |
| Mo Day Yr | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Part A <input type="checkbox"/> Part B | |
| | Name | Name of Other Insurance Carrier | Prior Coverage Start Date | | | |
| <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner | | | Mo | Day | Yr | |
| Prior Coverage End Date | Reason for Ending Coverage | Group #/ Policy ID # | Is this your dependent's primary coverage? | Does it cover? | Medicare | Medicare Claim/ HICN # |
| Mo Day Yr | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Part A <input type="checkbox"/> Part B | |
| | Name | Name of Other Insurance Carrier | Prior Coverage Start Date | | | |
| <input type="checkbox"/> Son <input type="checkbox"/> Daughter | | | Mo | Day | Yr | |
| Prior Coverage End Date | Reason for Ending Coverage | Group #/ Policy ID # | Is this your dependent's primary coverage? | Does it cover? | Medicare | Medicare Claim/ HICN # |
| Mo Day Yr | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Part A <input type="checkbox"/> Part B | |
| | Name | Name of Other Insurance Carrier | Prior Coverage Start Date | | | |
| <input type="checkbox"/> Son <input type="checkbox"/> Daughter | | | Mo | Day | Yr | |
| Prior Coverage End Date | Reason for Ending Coverage | Group #/ Policy ID # | Is this your dependent's primary coverage? | Does it cover? | Medicare | Medicare Claim/ HICN # |
| Mo Day Yr | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Part A <input type="checkbox"/> Part B | |

5 YOUR EMPLOYER COMPLETES THIS SECTION (if applying for Group Life AD&D.)

| | | | | |
|----------------|---------------|------------|------------|--------------------|
| Effective Date | Annual Salary | Occupation | Life Class | Life / AD&D Amount |
| | | | | |

6 GROUP TERM LIFE INSURANCE If applicable. (Attach separate sheet for additional or contingent beneficiaries.)

Life coverage Yes No If yes, I am applying for Basic Life/AD&D \$ _____ Dependent Life \$ _____

| | | |
|------------------------------|--------------|---|
| Life Beneficiary (Full Name) | Relationship | % |
| | | |
| Life Beneficiary (Full Name) | Relationship | % |
| | | |
| Life Beneficiary (Full Name) | Relationship | % |
| | | |
| Life Beneficiary (Full Name) | Relationship | % |
| | | |

7 DECLINATION OF COVERAGE (Complete this section if any coverage is to be declined by you or your eligible dependents.)

Declining Medical coverage for: Self Spouse Dependent(s) **Reason:** Other group coverage through this employer Individual Coverage Other _____
 _____ Domestic Partner Other group coverage by another group (*i.e. spouse's employer*)

Declining Dental coverage for: Self Spouse Dependent(s) **Reason:** Other group coverage through this employer Individual Coverage Other _____
 _____ Domestic Partner Other group coverage by another group (*i.e. spouse's employer*)

Declining Vision coverage for: Self Spouse Dependent(s) **Reason:** Other group coverage through this employer Individual Coverage Other _____
 _____ Domestic Partner Other group coverage by another group (*i.e. spouse's employer*)

The available coverages have been explained to me by my employer. I have been given the chance to apply for the available coverages. I have decided not to enroll myself and/or my dependent(s).

By declining coverage I acknowledge that my dependents and I may have to wait to be enrolled until the next Open Enrollment period or qualifying event. Additionally, by signing below I certify that the reason I am declining coverage is accurate as indicated by the check marks above.

| | |
|--|------------|
| Employee Signature _____ (SIGN ONLY IF DECLINING COVERAGE. If signed in error, please cross out and initial.) | Date _____ |
|--|------------|

8 ACCEPTANCE OF COVERAGE (signature required.)

THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: I acknowledge and understand that health care providers may disclose health information about me or my dependents to Health Net Entities, the SafeGuard Entities and/or Fidelity Entities. Health Net Entities, the SafeGuard Entities and/or Fidelity Entities use and may disclose this information for purposes of treatment, payment and health plan operations, including but not limited to, utilization management, quality improvement, disease or case management programs. Health Net's Notice of Privacy Practices is included in the evidence of coverage or certificate of insurance for coverage underwritten by Health Net Entities. I may also obtain a copy of this Notice on the website at www.healthnet.com or through the Health Net Customer Contact Center.

NOTICE: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

ACKNOWLEDGEMENT AND AGREEMENT: I understand and agree that by enrolling with or accepting services from the Health Net Entities, the SafeGuard Entities and/or the Fidelity Entities, I and any enrolled dependents are obligated to understand and abide by the terms, conditions and provisions of the Plan Contract or Insurance Policy. I have read and understand the terms of this Application and

my signature below indicates that the information entered in this Application is complete, true and correct, and I accept these terms.

BINDING ARBITRATION AGREEMENT: Subject to the terms of the Plan Contract or Insurance Policy (which may prohibit mandatory arbitration of certain disputes if the Plan Contract or Insurance Policy is subject to ERISA, 29 U.S.C. section 1001, et seq.), I, the Employee, understand and agree that any and all disputes or disagreements between me (including any of my enrolled family members or heirs or personal representatives) and the Health Net Entities, the Safeguard Entities and/or the Fidelity Entities, regarding the construction, interpretation, performance or breach of the Plan Contract or Insurance Policy, or regarding other matters relating to or arising out of my Health Net Entities, the Safeguard Entities and/or the Fidelity Entities membership, whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or employees, are also involved, must be submitted to final and binding arbitration in lieu of a jury or court trial. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties, including the Health Net Entities, the Safeguard Entities and/or the Fidelity Entities, are giving up their constitutional right to have their dispute decided in a court of law before a jury. I also understand that disputes that I may have with the Health Net Entities, the Safeguard Entities and/or the Fidelity Entities involving claims for medical malpractice are also subject to final and binding arbitration. A more detailed arbitration provision is included in the Plan Contract or Insurance Policy. My signature below indicates that I agree to submit any dispute to binding arbitration.

| | |
|--------------------------|------------|
| Employee Signature _____ | Date _____ |
|--------------------------|------------|

“Plan Contract” refers to the Health Net of California, Inc. and/or SafeGuard Health Plans, Inc. Group Service Agreement and Evidence of Coverage; “Insurance Policy” refers to Health Net Life Insurance Company, SafeHealth Life Insurance Company, and/or Fidelity Security Life Insurance Company Group Policy and Certificate of Insurance.



Please contact the Health Net Customer Contact Center at the toll free numbers below should you need assistance in completing this form or if you have questions about your coverage:

| | |
|------------|----------------|
| English | 1-800-361-3366 |
| Cantonese | 1-877-891-9050 |
| Korean | 1-877-339-8596 |
| Mandarin | 1-877-891-9053 |
| Spanish | 1-800-331-1777 |
| Tagalog | 1-877-891-9051 |
| Vietnamese | 1-877-339-8621 |

If you have questions about your dental or vision coverage, please call:

| | |
|--------|----------------|
| Dental | 1-800-880-8113 |
| Vision | 1-866-392-6058 |

If you have questions about your physician or physician group, call your physician group directly or contact Health Net Provider Services at 1-800-641-7761.

You can use your copy of the Health Net enrollment form as your temporary ID card until you receive your permanent ID card.

HMO, HMO Silver Network, Salud con Health Net HMO, SELECT, ELECT Open Access, EPO Dental HMO Enrollees:
Participating Physician Group (PPG), Primary Care Physician (PCP) and Dental Provider Selection.

Please note, if you do not select a participating physician group, Primary Care Physician, or Dental Provider for yourself and each of your eligible dependents, a physician group, Primary Care Physician, and Dental Provider will be selected for you.

Emergency and Urgently Needed Care

- **If your situation is life threatening or an emergency:**
Call **911** or go to the nearest Hospital.
- **If your situation is not so severe:** If you cannot call your Primary Care Physician or physician group, or you need medical care right away, go to the nearest hospital or medical center.
- **If you are outside your physician group's service area:**
Go to the nearest hospital, medical center or call **911**.
In all cases, contact your Primary Care Physician or physician group as soon as possible to inform them about your condition.

PPO, FLEX NET Enrollees:

Emergency and Urgently Needed Care

- **If your situation is life threatening or an emergency:**
Call **911** or go to the nearest hospital. Please call the appropriate number within 48 hours of being admitted, or as soon as possible.

PRE-CERTIFICATION

You the member are responsible for obtaining certification for certain services. Please check your plan certificate for a list of services requiring pre-certification.

For pre-certification, please call 1-800-977-7282

Pre-existing Conditions and Creditable Coverage

Your coverage under the PPO, EPO and Flex Net benefit plans may be subject to pre-existing condition limitations for a maximum period of six months from the effective date of your enrollment. In accordance with state and federal law, Health Net Life Insurance Company will credit any prior coverage that you document at the time you apply to enroll in PPO, EPO or FLEX NET, provided the prior coverage qualifies as "creditable coverage" as defined under federal and state law. Creditable coverage will be applied to offset (in part or whole) the pre-existing condition limitation, which may apply to your coverage under this policy. If you're unable to provide documentation of bona fide creditable coverage at enrollment time, Health Net Life Insurance Company may provide assistance in obtaining the necessary documentation upon request. Note: Prior coverage, which is interrupted by a period of 63 days (or 180 days if your previous employer terminated the coverage) or more, does not qualify as creditable coverage.

Disabling Conditions:

If you or your family member were disabled as of the date of termination of coverage with a prior health insurer and the loss of coverage was due to the termination of the employer's insurance policy, you may be entitled to an extension of health benefits according to California Insurance Code section 10128. Under this law, the prior insurer retains responsibility until whichever of the following occur first: (a) the member is no longer totally disabled; (b) the maximum benefits of the prior insurer's coverage are paid; or (c) a period of 12 consecutive months has passed since the date coverage ended with prior insurer.

Products/Entities:

Health Net of California, Inc. offers the following products: ELECT Open Access, HMO and SELECT POS.

Health Net Life Insurance Company offers the following products: EPO, Flex Net, PPO, Salud con Health Net EPO & PPO, Life and AD&D insurance.

SafeGuard Health Plans, Inc. offers the following products: Dental HMO (DHMO) and DHMO Ortho Rider.

SafeHealth Life Insurance Company offers the following products: PPO Dental, Indemnity Dental, Indemnity Ortho Rider.

Fidelity Security Life Insurance Company offers the following products serviced by EyeMed Vision Care, LLC: PPO Vision.

Declination of Coverage:

If you decline coverage for yourself or an eligible dependent because of coverage under other health insurance and you lose that coverage, or, if you acquire a new dependent due to marriage, birth, adoption, or placement for adoption, you and your dependent may be eligible for special enrollment rights. You must request special enrollment within 30 days of the loss of coverage or acquisition of a new dependent.

