

Application must be typed or completed in blue or black ink.
Please note that applicants under 1 year of age on the policy effective date cannot be enrolled as the primary subscriber.

THE APPLICATION MUST BE COMPLETED BY THE APPLICANT.

Please request your effective date (*cannot precede the postmark date of this application*).

Requested effective date: ____/____/____

Applicant's last name		First name		MI	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Applicant's birth date (mo/day/year) □□/□□/□□□□		
Home address			City		State	ZIP	Height	Weight
County	Home phone number ()	Work phone number ()	Email address		Applicant's Social Security Number □□□-□□-□□□□			

List all eligible dependents to be enrolled. Dependents must be at least 30 days old or less than 65 years of age on the policy's effective date in order to qualify as an eligible dependent. If the last name of the dependent is different from the subscriber, please explain on a separate sheet of paper. For Domestic Partner coverage, all requirements for eligibility, as required by the applicable laws of the State of California, must be met and a joint Declaration of Domestic Partnership must be filed with the California Secretary of State. All applicants must reside at the same address.

For additional dependents, please attach another sheet with the requested information.

Last name	First name	MI	Social Security Number	Sex	Date of birth	Height	Weight (lbs.)
Spouse/Domestic Partner				<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /		
Child 1				<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /		
Child 2				<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /		

PLAN CHOICE

Please designate your plan choice: \$750 deductible \$1,000 deductible \$2,000 deductible \$4,500 deductible

Please designate your plan type: Daily Plan¹ Monthly Plan

Note: If you have applied for both a short-term and a standard Individual & Family health plan and have been simultaneously approved for each, you will *automatically be enrolled in the standard Individual & Family health plan* and this application for Quick Net coverage will be cancelled. Should you wish to not be enrolled in the standard Individual & Family health plan, please check this box. **NO, do not enroll me in the standard health plan.**

¹Please complete the Daily Policy Only section.

DAILY POLICY ONLY² (Do not complete this section for the monthly plan)

Benefit Coverage Period: Please choose the number of days for your Benefit Period: _____ days (30 – 185 Days)

Once enrolled, there are no changes permitted and the policy cannot be renewed.

Calculate your total premium due:

\$_____ daily rate² (please see rates) x _____ # of coverage days = \$_____ Total Premium Due

Please remit a check payable to "Health Net" for the full amount owed for the Policy Benefit period.

²Daily Rate is based on the number of days selected.

MEDICAL QUESTIONS 1 – 13

- In the past 6 months, have you been a US resident? Yes No If no, are applicants U.S. citizens or permanent residents? Yes No
If no, applicant(s) is(are) not eligible for this policy.
- Are you, your spouse/domestic partner, female dependent or companion currently pregnant or have you, your spouse/domestic partner, female dependent or companion performed a home pregnancy test during the previous 90 days which has reacted positive? Yes No
- Are you in the process of adoption or surrogate pregnancy? Yes No
- During the past 12 months, have you or any applying family member experienced symptom(s) for which a health care practitioner has not been consulted? Yes No
- During the benefit coverage period, will you or any applying family member train for or participate in: 1) a team or individual sports activity as a professional; 2) national or international competition as an amateur or 3) a collegiate sports activity? Yes No

MEDICAL QUESTIONS 1 – 13 (continued)

6. Within the last 5 years, have you or any applying family member ever received any medical or surgical consultation, advice, or treatment including medication for: heart or circulatory system disorder including heart attack or chest pain; stroke; diabetes; cancer or tumor; alcoholism or alcohol abuse; drug abuse or chemical dependency; or liver, kidney disorder? Yes No
7. Have you or any person applying enrolled in training for or engaged in an occupation involving unusual hazards, and are not covered by Workers' Compensation Insurance? Yes No
8. In the past 12 months, have you or any applying family member consulted a health care practitioner and have been recommended to have or been scheduled for diagnostic testing, treatment or surgery that has not been completed? Yes No
9. In the last 30 days have you or any applying family member been confined to a hospital? Yes No
10. Have you or any applying family member been diagnosed as having or been treated for AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS-Related Complex)? Yes No
11. Do you or any applying family member have any hospital, major medical, group health or medical insurance coverage in force that will NOT terminate prior to the effective date of this policy? Yes No If yes, when will existing coverage expire? ____/____/____
12. If you answered "Yes" to questions 2 – 11, please complete the lines below. Please note, these persons are excluded from coverage.
 Question # _____ family member's name _____
 Question # _____ family member's name _____
13. During the previous 62 days, have you or any person applying for coverage been covered by other health insurance? **If yes, please complete the prior coverage information below for all periods in the last 12 months. For additional dependents, please attach additional sheets.**
 Yes No
 Insured's name _____ Current carrier _____
 Effective date _____ Expected termination date _____

WRITING AGENT INFORMATION

Health Net Broker ID:	Sub-Agent ID: (Must be completed only if Sub-Agent Agreement is approved)
Name (<i>print</i>):	Phone number:
Address:	Fax number:
	Email address:

Writing Agent Certification

Are you aware of any information not disclosed in this application that might have a bearing on the risk? Yes No If "Yes," please explain:

Did you personally see the applicant signing the Application (includes spouse/domestic partners, if applying)? Yes No

IMPORTANT INFORMATION (Please read carefully)

I UNDERSTAND THAT:

- The minimum coverage time under the Health Net Life Insurance Quick Net **Daily Policy is 30 Days** and for the **Monthly Policy it is one calendar month**. The maximum length of coverage time is **185 Days for the Daily Policy** and **6 months for the Monthly Policy**.
- There are no changes to this policy once it goes into force. Under no circumstances will I, or my dependents, be allowed to make changes or request a refund beyond the 10-day free look period. No exceptions will be made.
- No benefits are payable for any expenses incurred as a result of a pre-existing condition. Pre-existing condition means an illness, injury or condition which existed during the twelve-month period, when this Policy insures one or two Covered Persons, or six-month period when this Policy insures three or more Covered Persons, immediately prior to the Member's Effective Date. An illness, injury, or condition is considered to have existed when the Member: (1) sought or received professional advice for that illness, injury, or condition; or (2) received medical care or treatment for that illness, injury or condition.
- If I am approved under a Health Net permanent plan I must exhaust my coverage under Quick Net.
- My check will be held in trust while my application is reviewed by Health Net Life Insurance Company. Applications **submitted without payment** or with **partial payment** will be **pending** until payment is received. If my payment is not received within 2 weeks of the application signature date, my application will be withdrawn.

Additional information for Monthly Policies only:

- If my Monthly policy is terminated due to lack of payment, my policy will **not** be reinstated. I may terminate my policy at any time.

Primary Applicant's SSN
 — —

Any intentional or unintentional nondisclosure or misstatement of fact in application materials is cause for disenrollment and rescission of the Policy and Health Net may recoup from the Subscriber (or from you or from the applicant) any amounts paid for Covered Services obtained as a result of such nondisclosure or misstatement of fact. In addition, if a Subscriber makes a false statement or omission as to the Subscriber's or Family Member's health status or history on application materials, Health Net shall have no liability for the provision of coverage under the Policy.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: I acknowledge and understand that health care providers may disclose health information about me or my dependents, including information regarding substance abuse, mental/emotional conditions, AIDS (Acquired Immune Deficiency Syndrome), or ARC (AIDS-Related Complex) to Health Net. Health Net uses 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 Insurance Policy, and I may also obtain a copy of this Notice on the website at www.healthnet.com or through Health Net's Customer Contact Center. Authorization for use and disclosure of potential health information shall be valid for a period of 30 months from the date of my signature below.

IF SOLE APPLICANT IS A MINOR: If the sole Applicant under this application is under 18 years of age, the Applicant's parent or legal guardian must sign as such. By signing, he or she does hereby agree to be legally responsible for the accuracy of information in this Application and for payments of premiums. If such responsible party is not the natural parent of the Applicant, copies of the court papers authorizing guardianship must be submitted with this Application.

Important Provisions 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 care services plans or insurance companies as a condition of obtaining coverage.**

ACKNOWLEDGEMENT AND AGREEMENT: I, the applicant, understand and agree that by enrolling with or accepting services from Health Net, I and any enrolled dependents are obligated to understand and abide by the terms, conditions and provisions of the Insurance Policy. I, the applicant, 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.

Acceptance of a short-term policy will impact eligibility for individual guaranteed issue health insurance according to the requirements within the Health Insurance Portability and Accountability Act of 1996.

BINDING ARBITRATION:

I, the applicant, agree that any and all disputes or disagreements between me (including any of my enrolled family members or heirs or personal representatives) and Health Net regarding the construction, interpretation, performance or breach of the Health Net Plan Contract or Insurance Policy, or regarding other matters relating to or arising out of my Health Net 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 Health Net, are giving up their constitutional right to the extent permitted by law to have their dispute decided in a court of law before a jury. I also understand that disputes that I may have with Health Net involving claims or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) 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 understand the terms of this Binding Arbitration Clause and agree to submit disputes to binding arbitration.

Applicant or Parent or Legal Guardian's signature if Applicant is under 18 years old:	Date signed:
Spouse/Domestic partner's signature:	Date signed:
Signature of applicant's dependent (age 18 and older):	Date signed:
Signature of applicant's dependent (age 18 and older):	Date signed:

Applicants' signatures (the applicant must personally sign his/her name and agree to the Arbitration Clause in order for the application to be processed) REQUIRED IN INK.

Health Net reserves the right to cancel, rescind, or terminate any policy where this arbitration clause was signed by anyone other than the applicant. Neither Broker nor any other person may sign this Arbitration Agreement.

CREDIT CARD PAYMENT INFORMATION (Optional)

Premium charge can be charged directly to your credit card account. The premium will be charged to your credit card account approximately ten days in advance of the due date.

First payment (daily and monthly policies) **Monthly payment** (monthly policies)

First name (as appears on card):	Middle name (as appears on card):	Last name (as appears on card):	Card type: <input type="checkbox"/> Visa <input type="checkbox"/> Mastercard	
Account number:	Expiration date (mm/yyyy):	Signature panel code:¹	Cardholder's email address:	
Billing address:		City:	State:	ZIP code:²

¹Signature Panel Code can be found on the back of your credit card. This 3-digit code is usually the last three digits located in the signature panel. This information is required in order for the credit card to be processed.

²The zip code must match the Cardholder's address otherwise the credit card cannot be processed.

As a convenience, I request and authorize Health Net Life Insurance Company ("Health Net") to charge my credit card account identified above for the payment of my initial premium and/or my monthly premium. This authority is to remain in effect until revoked by me in writing and until Health Net actually receives such notice, I agree that Health Net shall be fully protected in honoring any such charge. *(Note: A 30-day notice is required to discontinue this service due to the time required to initiate this change with your credit card company.)*

SIGNATURE OF CREDIT CARD ACCOUNT HOLDER:	DATE:
---	--------------

Fax your completed application and payment to 1-800-977-4161 (toll free) or mail your completed application and payment to Health Net Individual & Family Enrollment, PO Box 1150, Rancho Cordova, CA 95741-1150