MEMBER ENROLLMENT AND CHANGE FORM

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

IMPORTANT: PLEASE PRINT ALL SECTIONS IN BLACK INK.

EMPLOYER NAME: **MPIPHP**

COVERAGE EFFECTIVE DATE:

EMPLOYER GROUP NUMBER *(Medical)*: **61880-**

SOCIAL SECURITY NUMBER:

1 SELECTED COVERAGE

1a: CHECK THE DESIRED PLAN AS OFFERED BY YOUR EMPLOYER:

MEDICAL PLAN (write the plan number next to the product, if known)

- ☒ HMO _____
- ☐ HMO HRA _____
- ☐ HMO Silver Network _____
- ☐ HMO Variable Copay _____
- ☐ HMO y Más _____
- ☐ ELECT℠ Open Access (EOA) _____
- ☐ ELECT (POS) _____
- ☐ EPO _____
- ☐ FLEX NET (Indemnity) _____
- ☐ PPO _____
- ☐ PPO HSA _____
- ☐ Out-Of-State PPO (OOS PPO) _____
- ☐ SALUD con Health Net _____
- ☐ SELECT (POS) _____
- ☐ SELECT 3-tier POS _____
- ☐ Other _____

Complete sections 1b /1c only if Health Net will be your dental and/or vision provider.

1b: DENTAL PLAN (choose one)
(write the plan number next to the product)

- ☐ HMO _____
- ☐ PPO _____
- ☐ INDEMNITY _____

1c: VISION PLAN
(write the plan number next to the product)

- ☐ PPO _____

REASON FOR APPLICATION:

- ☐ New hire
- ☐ Open Enrollment
- ☐ Loss of prior coverage date _____
- ☐ COBRA effective date _____
- Qualifying event _____
- Qualifying event date _____
- ☐ Add dependent
- Qualifying event _____
- Qualifying event date _____

REASON FOR CHANGE:

- ☐ Plan change
- ☐ Change address/name
- ☐ Delete dependent(s) (list names in Section 3)
- ☐ Other _____

2 EMPLOYEE PERSONAL INFORMATION

Last Name	**First Name**	**M.I.**	☐ **Male** ☐ **Female**

Residence Address	**City**	**State**	**Zip**

Date of Birth Mo/Day/Yr	**Social Security #/Matricula ID#**	Job Title

Telephone No. ( )	Work Telephone No. ( )	Email Address

Date of Hire / /	Job Class	Dept. no.	Employment Status ☐ Salaried ☐ Hourly	Marital Status ☐ Single ☐ Married ☐ Domestic Partner

NOTE: If you are choosing to decline coverage, skip to Section 5.

Coverage Type ☐ Medical ☐ Dental ☐ Vision	**Medicare** ☐ Part A ☐ Part B ☐ Part D	**Medicare Claim/HICN #**	**Participating Physician Group/PPG#**	**Primary Care Physician/PCP#**

Physician Name (First, Last)	**Is this your current M.D.?** ☐ Yes ☐ No	**Dental HMO Provider ID # (complete only if electing Health Net Dental)**

For HMO y más or Salud con Health Net Members: If available, I would prefer to receive communication and plan information in Spanish.
☐ Yes ☐ No

SOCIAL SECURITY NUMBER

3 FAMILY INFORMATION Please list all eligible family members to be enrolled. (Attach additional sheets if necessary)

☐ Spouse ☐ M ☐ Domestic Partner ☐ F	Last Name	First Name	M.I.
Residence Address ❏ Check here if same as employee	City	State	Zip
Date of Birth Mo/Day/Yr	**Social Security #/Matricula ID #**		
Coverage Type ☐ Medical ☐ Dental ☐ Vision **Medicare** ☐ Part A ☐ Part B ☐ Part D	**Medicare Claim/HICN#**	**Participating Physician Group/PPG#**	**Primary Care Physician/PCP#**
Physician Name (First, Last)	**Is this your current M.D.?** ☐ Yes ☐ No	**Dental HMO Provider ID #** **(complete only if electing Health Net Dental)**	

☐ Son ☐ Daughter	Last Name	First Name	M.I.
Residence Address ❏ Check here if same as employee	City	State	Zip
Date of Birth Mo/Day/Yr	**Social Security #/Matricula ID #**		
Coverage Type ☐ Medical ☐ Dental ☐ Vision **Medicare** ☐ Part A ☐ Part B ☐ Part D	**Medicare Claim/HICN#**	**Overage Dependent Type** ☐ Disabled ☐ Full-time Student ☐ Over 50% support	**Participating Physician Group/PPG#** **Primary Care Physician/PCP#**
Physician Name (First, Last)	**Is this your current M.D.?** ☐ Yes ☐ No	**Dental HMO Provider ID #** **(complete only if electing Health Net Dental)**	

☐ Son ☐ Daughter	Last Name	First Name	M.I.
Residence Address ❏ Check here if same as employee	City	State	Zip
Date of Birth Mo/Day/Yr	**Social Security #/Matricula ID #**		
Coverage Type ☐ Medical ☐ Dental ☐ Vision **Medicare** ☐ Part A ☐ Part B ☐ Part D	**Medicare Claim/HICN#**	**Overage Dependent Type** ☐ Disabled ☐ Full-time Student ☐ Over 50% support	**Participating Physician Group/PPG#** **Primary Care Physician/PCP#**
Physician Name (First, Last)	**Is this your current M.D.?** ☐ Yes ☐ No	**Dental HMO Provider ID #** **(complete only if electing Health Net Dental)**	

☐ Son ☐ Daughter	Last Name	First Name	M.I.
Residence Address ❏ Check here if same as employee	City	State	Zip
Date of Birth Mo/Day/Yr	**Social Security #/Matricula ID #**		
Coverage Type ☐ Medical ☐ Dental ☐ Vision **Medicare** ☐ Part A ☐ Part B ☐ Part D	**Medicare Claim/HICN#**	**Overage Dependent Type** ☐ Disabled ☐ Full-time Student ☐ Over 50% support	**Participating Physician Group/PPG#** **Primary Care Physician/PCP#**
Physician Name (First, Last)	**Is this your current M.D.?** ☐ Yes ☐ No	**Dental HMO Provider ID #** **(complete only if electing Health Net Dental)**	

SOCIAL SECURITY NUMBER

☐ Son ☐ Daughter	Last Name	First Name	M.I.
Residence Address ❏ Check here if same as employee	City	State	Zip
Date of Birth Mo/Day/Yr	**Social Security #/Matricula ID #**		

Coverage Type ☐ Medical ☐ Dental ☐ Vision **Medicare** ☐ Part A ☐ Part B ☐ Part D	**Medicare Claim/HICN#**	**Overage Dependent Type** ☐ Disabled ☐ Full-time Student ☐ Over 50% support	**Participating Physician Group/PPG#** **Primary Care Physician/PCP#**
Physician Name (First, Last)	**Is this your current M.D.?** ☐ Yes ☐ No	**Dental HMO Provider ID #** **(complete only if electing Health Net Dental)**	

4 DO YOU OR YOUR DEPENDENTS HAVE OTHER HEALTH CARE COVERAGE? IF YES, PLEASE COMPLETE THIS SECTION, INCLUDING MEDICARE (if applicable).

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.

☐ Self	**Name**	**Name of Other Insurance Carrier**	**Prior Coverage Start Date** Mo | Day | Yr

Prior Coverage End Date Mo | Day | Yr	**Reason for Ending Coverage**	**Group #/Policy ID #**	**Does it cover?** Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	**Medicare** ☐ Part A ☐ Part B ☐ Part D	**Medicare Claim/ HICN #**

☐ Spouse ☐ Domestic Partner	**Name**	**Name of Other Insurance Carrier**	**Prior Coverage Start Date** Mo | Day | Yr

Prior Coverage End Date Mo | Day | Yr	**Reason for Ending Coverage**	**Group #/ Policy ID #**	**Is this your dependent's primary coverage?** ☐ Yes ☐ No	**Does it cover?** Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	**Medicare** ☐ Part A ☐ Part B ☐ Part D	**Medicare Claim/ HICN #**

☐ Son ☐ Daughter	**Name**	**Name of Other Insurance Carrier**	**Prior Coverage Start Date** Mo | Day | Yr

Prior Coverage End Date Mo | Day | Yr	**Reason for Ending Coverage**	**Group #/ Policy ID #**	**Is this your dependent's primary coverage?** ☐ Yes ☐ No	**Does it cover?** Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	**Medicare** ☐ Part A ☐ Part B ☐ Part D	**Medicare Claim/ HICN #**

☐ Son ☐ Daughter	**Name**	**Name of Other Insurance Carrier**	**Prior Coverage Start Date** Mo | Day | Yr

Prior Coverage End Date Mo | Day | Yr	**Reason for Ending Coverage**	**Group #/ Policy ID #**	**Is this your dependent's primary coverage?** ☐ Yes ☐ No	**Does it cover?** Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	**Medicare** ☐ Part A ☐ Part B ☐ Part D	**Medicare Claim/ HICN #**

☐ Son ☐ Daughter	**Name**	**Name of Other Insurance Carrier**	**Prior Coverage Start Date** Mo | Day | Yr

Prior Coverage End Date Mo | Day | Yr	**Reason for Ending Coverage**	**Group #/ Policy ID #**	**Is this your dependent's primary coverage?** ☐ Yes ☐ No	**Does it cover?** Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	**Medicare** ☐ Part A ☐ Part B ☐ Part D	**Medicare Claim/ HICN #**

☐ Son ☐ Daughter	**Name**	**Name of Other Insurance Carrier**	**Prior Coverage Start Date** Mo | Day | Yr

Prior Coverage End Date Mo | Day | Yr	**Reason for Ending Coverage**	**Group #/ Policy ID #**	**Is this your dependent's primary coverage?** ☐ Yes ☐ No	**Does it cover?** Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	**Medicare** ☐ Part A ☐ Part B ☐ Part D	**Medicare Claim/ HICN #**

SOCIAL SECURITY NUMBER

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

☐ **Declining Medical coverage for:**
Name: _____
☐ Self ☐ Spouse ☐ Domestic Partner ☐ Dependent(s)

Reason: ☐ Other group coverage through this employer ☐ Individual Coverage
☐ Other group coverage by another group *(i.e. spouse's employer)* ☐ Other_____

❑ **Declining Dental coverage for:**
Name: _____
☐ Self ☐ Spouse ☐ Domestic Partner ☐ Dependent(s)

Reason: ☐ Other group coverage through this employer ☐ Individual Coverage
☐ Other group coverage by another group *(i.e. spouse's employer)* ☐ Other_____

❑ **Declining Vision coverage for:**
Name: _____
☐ Self ☐ Spouse ☐ Domestic Partner ☐ Dependent(s)

Reason: ☐ Other group coverage through this employer ☐ Individual Coverage
☐ Other group coverage by another group *(i.e. spouse's employer)* ☐ Other_____

STOP AND READ CAREFULLY.

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 _____ **Date** _____

(SIGN ONLY IF DECLINING COVERAGE. IF SIGNED IN ERROR, PLEASE CROSS OUT AND INITIAL.)

6 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 DBP Entities and/or Fidelity Entities. Health Net Entities, the DBP 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 DBP 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 DBP 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 DBP 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 DBP 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 DBP 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 Dental Benefit Providers of California, Inc. Group Service Agreement and Evidence of Coverage; "Insurance Policy" refers to Health Net Life Insurance Company, Unimerica Insurance Company, and/or Fidelity Security Life Insurance Company Group Policy and Certificate of Insurance.