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.

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): 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.

_____ 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 ☐ 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