

Please mail your completed form to:

Medicare Options

Attention: Rick Plata
23331 Via Sausalito
Moreno Valley, CA 92557

Or

Fax to: (888) 391- 0562

Enrollment questions, please call Rick Plata at (888) 235-8060.



Health Net®

LIFE INSURANCE COMPANY

HEALTH NET LIFE INSURANCE COMPANY APPLICATION FOR A MEDICARE SUPPLEMENT POLICY

Office use only: Approval date: ___/___/___ Effective date: ___/___/___ Plan/group ID: _____ Guarantee issue: _____ ABD included: Yes No

Please follow these application instructions:

- 1. Complete your application, provide any supporting information requested, sign and date it where indicated. 2. Mail your application in the prepaid envelope provided. 3. Please include your first payment. Your payment will be returned if your application is denied. 4. NOTE: If you do not choose an effective date and your policy is approved, your coverage will begin on the first day of the month following receipt of your application by Health Net Life. If you have any questions regarding your enrollment, please call 1-800-944-7287 or TTY/TDD 1-800-929-9955.

Conditions of membership in Health Net Life Insurance Company (Health Net Life)

Medicare Supplement:

- 1. This application and the Statement of Health, together with the Health Net Life Policy and any endorsements, appendices and attachments thereto, will collectively constitute the entire agreement for coverage. 2. I will not receive coverage from Health Net Life unless they approve this application. Health Net Life is not liable for bills incurred before the effective date of coverage. 3. Only Health Net Life can approve this application. I understand that any insurance agent, broker or sales representative cannot grant approval, change terms or waive requirements. 4. I acknowledge receipt of the Outline of Coverage, the "Guide to Health Insurance for People with Medicare" and a copy of this application. I have read the Outline of Coverage and the terms, conditions and authorizations set forth herein. I certify that I meet the eligibility requirements set forth in the Outline of Coverage. I alone am responsible for the accuracy and completeness of this application and have answered all questions to the best of my knowledge and belief. I understand that I will not be eligible for coverage if any information is false or incomplete, and that coverage may be revoked based on such finding.

Print name: _____

Signature: _____ Date: (___/___/___) M M / D D / Y Y Y Y

Your Personal Information:

First name: _____ Middle initial: _____ Last name: _____

Home address: _____

City: _____ State: _____ ZIP: _____

Mailing address (if different from above): _____

Home telephone: () - E-mail address: _____ Gender: Male Female

Date of birth: (___/___/___) M M / D D / Y Y Y Y Preferred language: English Other: _____

Please indicate the type of Medicare plan you currently have? Medicare Advantage HMO Medicare Advantage PDP Medicare Advantage PPO Medicare Advantage Private Fee-For-Service Medicare

4. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO	a. Do you have another Medicare Supplement policy in force? b. If so, with what company and what plan do you have? _____ c. If so, do you intend to replace your current Medicare Supplement policy with this policy? If "Yes," have you received and completed the Notice to Applicant Regarding Replacement of Medicare Supplement Coverage or Medicare Advantage form?
5. <input type="checkbox"/> YES <input type="checkbox"/> NO	a. Have you had coverage under any other health insurance coverage within the past 63 days (For example, an employer, union, or individual plan)? b. If so with what companies and what kind of policy? _____ c. What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "End date" blank.) <div style="text-align: center;"> (____ / ____ / ____) (____ / ____ / ____) Start date: M M / D D / Y Y Y Y End date: M M / D D / Y Y Y Y </div>

Guaranteed Acceptance Statement

If you think you qualify for guaranteed acceptance, please write the number of the qualifying criterion as described in the accompanying Guarantee Issue Guide on the line below. Please attach any supporting documents as outlined in the Guarantee Issue Guide. **PLEASE NOTE:** If you are applying for coverage during an open enrollment or guaranteed issue period as specified in the accompanying Guarantee Issue Guide, you do **NOT** need to complete the **Current Health Statement** portion of this application or to sign a form required by the federal Health Insurance Portability and Accountability Act of 1996.

I qualify for guaranteed acceptance through an open enrollment or guaranteed issue period based on criterion number _____

Current Health Statement

Genetic Information Non-discrimination Act of 2008 (GINA) Compliance Statement: This Current Health Statement is not a request for genetic information. In answering these questions, you should not include any genetic information. That is, please do not include any family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which you believe you may be at risk. **If you qualify for Guaranteed Acceptance, you do not need to complete this section.**

To the best of your knowledge, please answer "YES", "NO" or "NOT SURE" to each question in this section.

1. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT SURE	Are you currently hospitalized, confined to a nursing facility, or have you been hospitalized one or more times in the past two years? If you answered "Yes," please list the date(s) and diagnosis below.
2. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT SURE	Within the past year, have you had or been treated for internal cancer?
3. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT SURE	Within the past year have you been advised to have joint replacement surgery that has not yet been performed?
4. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT SURE	Within the past two years have you had an amputation caused by a disease, heart surgery, a cerebral vascular accident (stroke), liver disease, or kidney dialysis?
5. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT SURE <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT SURE	Do you have diabetes? Do you take insulin or oral medications for treatment of diabetes?
6. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT SURE	Are you presently receiving dialysis or have you ever had a kidney transplant?
7. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT SURE	Are you currently taking medication? If you answered "Yes," please list at the end of this section all medications you are currently taking and the condition for which the medication is prescribed.

Signature Section**AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION**

I authorize the United States Department of Health and Human Services, the Centers for Medicare & Medicaid services, any health care provider, hospital or medical facility to furnish to any agent, designee, employee or representative of Health Net Life any and all records pertaining to claims payment or rejections, medical history, services rendered, or treatment given to myself for purposes of review, investigation or evaluation of this application (**except to those applicants eligible for Guaranteed Issue, including applicants who are applying for coverage during an open enrollment period**) or a claim. I also authorize Health Net Life and its employees, participating providers, agents and representatives to disclose to any health care provider, health care service plan, insurer or self-insurer any such medical information obtained if such disclosure is necessary to allow the processing of a claim or if requested pursuant to legal process. This authorization shall become effective immediately and shall remain in effect for the term of coverage under the Policy.

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 this application means that I have read and understand the contents of this application. If signed by an individual (as described previously), the signature certifies that:

1. The person is authorized under State law to complete this enrollment form on behalf of the named applicant and,
2. Documentation of the authority is available upon request by Health Net Life Insurance Company or other authorized regulatory agency.

Note: Health Net Life requests that a copy of the authorization form, Durable Power of Attorney for Health Care or similar document, be included with this application.

BINDING ARBITRATION

I, the applicant, understand and agree that any and all disputes or disagreements between me (including any of my heirs or personal representatives) and Health Net Life regarding the construction, interpretation, performance or breach of the Health Net Life Medicare Supplement Policy, but not as to professional negligence (medical malpractice), 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 Life, 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. A more detailed arbitration provision is included in the Policy. My signature below indicates that I understand the terms of this Binding Arbitration Clause and agree to submit disputes to binding arbitration.

Print name: _____

Signature: _____	Date: (____/____/____) M M / D D / Y Y Y Y
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If you are the authorized representative, you must provide the following information:

First name:	Middle initial:	Last name:
Address:		
City:	State:	ZIP:
Relationship to applicant:		Phone number: (____)____-_____

Preferred Payment Information

Please include your first payment along with your application. Please note that your check accompanying this application will be processed by Health Net Life electronically and will be shown as an ACH Debit on your bank statement. By signing this enrollment application you agree to permit Health Net Life to process your check electronically. The payment will take 5–7 days to reflect in your Health Net Life account. To determine the monthly payment amount, refer to Health Net Medicare Supplement Plans Outline of Coverage. If you are not approved, Health Net Life will refund your payment amount. If your application is approved, you will receive a bill indicating the amount and the date your next payment is due. Health Net Life will also send you an approval letter, policy and member identification card as proof of approval.

Health Net Life has two options for you to pay for this policy if you are approved. You may pay monthly by check or you have the option of monthly Automatic Bank Draft (ABD) (a form is included in the information packet for your convenience or you may contact Health Net Life and request one).

I will pay monthly by check. I have completed the ABD form and attached a voided check.

I understand that in using Health Net Life's ABD, that my bank account will be automatically debited on or about the sixth (6th) of each month. Returned checks or insufficient funds on Automatic Bank Drafts are subject to a \$15.00 return fee.

Sales Rep / Producer Information – This section must be completed by Licensed Seller

The following items have been included with the application. Check all that apply:

- Proof of Guarantee Issue Broker Attestation
 Notice to Applicant Regarding Replacement of Coverage Form (RMSC)

Note: Applications received without the required supporting documentation are pended for up to 30 days. If missing documentation is not received within 30 days, the application will be returned to the applicant.

Sales rep name:	Sales rep phone: (____) _____-_____	Sales rep ID#: _____
FMO/GA/MA agency name:	FMO/GA/MA agency ID number:	
Producer name:	Producer ID number:	
Producer phone number: (____) _____-_____	Producer fax number: (____) _____-_____	
Producer mailing address:	Date received stamp:	
Producer email address:		
Producer signature:		



NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT COVERAGE OR MEDICARE ADVANTAGE

Save this notice! It may be important in the future.

If you intend to cancel or terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with coverage issued by Health Net Life Insurance Company, please review the new coverage carefully and replace the existing coverage ONLY if the new coverage materially improves your position. DO NOT CANCEL YOUR PRESENT COVERAGE UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.

If you decide to purchase the new coverage you will have 30 days after you receive the policy to return it to Health Net Life Insurance Company, for any reason, and receive a refund of your money.

If you want to discuss buying Medicare Supplement or Medicare Advantage coverage with a trained insurance counselor, call the California Department of Insurance’s toll-free telephone number, 1-800-927-HELP and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

STATEMENT TO APPLICANT FROM THE INSURER AND AGENT:

I have reviewed your current health insurance coverage. To the best of my knowledge, the replacement of insurance involved in this transaction does not duplicate coverage or if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. In addition, the replacement coverage contains benefits that are clearly and substantially greater than your current benefits for the following reasons:

- Additional benefits that are: _____
- No change in benefits, but lower premiums
- Plan has outpatient prescription drug coverage and applicant is enrolled in Medicare Part D
- Disenrollment from a Medicare Advantage Plan. Reasons for disenrollment:

- Fewer benefits and lower premiums
- Other reasons specified here: _____

Complete Answers Are Very Important

You do not need to answer questions about your medical and health history if you are applying for coverage during an open enrollment or guarantee issue period.

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer any and all questions on the application concerning your medical and health history. Failure to include all material medical information on an application requesting that information may provide a basis for Health Net Life Insurance Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

DO NOT CANCEL YOUR PRESENT POLICY UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.

(Signature of Agent, Broker or Other Representative)

(Name and Address of Agent, Broker or Other Representative)

(Applicant's Signature)

(Date)

Health Net Life Medicare Supplement Plan
P.O. Box 10420
Van Nuys, CA 91410-0420

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White – Medicare Files

Yellow – Health Net

Pink – Member



HEALTH NET MEDICARE SUPPLEMENT AUTOMATIC BANK DRAFT AUTHORIZATION

Subscriber / Reference ID #		Group #		Sex	
Subscriber name Last			First		MI
Subscriber street address					Apt #
City		State	Zip	Home telephone # ()	
BILLING 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		Monthly premium charge can be withdrawn directly from your personal checking or savings account. Please select your account type: <input type="checkbox"/> Checking <input type="checkbox"/> Savings			
Account number to be debited		Signature(s) shown on account to be debited			

I hereby authorize Health Net Life Insurance Company to debit the account shown above for my (the subscriber's) Health Net Life Insurance Company coverage when my premium payment comes due. I authorize the bank or financial institution shown above to accept such debits without responsibility for their correctness.

I may terminate this Automatic Bank Draft Authorization at any time by giving Health Net Life Insurance Company written notification of termination or by calling 1-800-926-4178 (or 1-800-929-9955 TDD/TTY for hearing and speech impaired) Monday-Friday 8:00 a.m. to 8:00 p.m., except holidays, to request termination. I understand that such notification will become effective after Health Net Life Insurance Company 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 Life Insurance Company premium should change for any reason, I will be notified in writing by Health Net Life Insurance Company at least thirty (30) calendar days prior to my account being debited.

Please mail this form to:

Health Net Life Insurance Company
P.O. Box 10420
Van Nuys, CA 91410-0420

Automatic Bank Draft (ABD) transmissions are submitted to the bank approximately the 6th of every month, for that 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 Life Insurance Company by the first of the month for each month, until such time that you receive confirmation of ABD commencement in writing from Health Net Life Insurance Company.

In the interim, if a manual payment is received after the bank transmission has occurred (the 6th 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 Life Insurance Company account will reflect the collected manual and automatic withdrawal premiums on the current billing statement/period. Conversely, if you manually pay your premium due, before the 6th 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. Insufficient funds on Automatic Bank Drafts are subject to a \$15.00 return fee.

Subscriber signature <input checked="" type="checkbox"/>	Additional signature (if any) <input checked="" type="checkbox"/>	Date
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***PLEASE INCLUDE A VOIDED BANK CHECK WITH YOUR AUTHORIZATION.
THIS WILL BE USED TO VERIFY BANK INFORMATION.***