

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
Application

Health Net Health Plan of Oregon, Inc.
Medicare Supplement Coverage

Please follow the application instructions

Complete your application, providing any supporting information requested, sign and date it where indicated.

If your spouse is applying to be insured, please complete a separate application.

If your application is approved, the contract will become effective on the first of the month following the date that Health Net of Oregon receives your completed application and premium payment.

Upon acceptance by Health Net of Oregon, this application becomes part of your contract.

Check the Health Net Medicare Supplement Plan for which you are applying

Plan A **Plan F** **Plan F with High Deductible** **Plan K** **Plan M**

Your Personal Information

Last Name	First Name	Initial	Birth Date	Sex	Social Security number
Residence address (Street, city, state, zip code)					Home phone number
PO Box (Street, city, state, zip code)					Work phone number
Email address					Requested start date

Do you have Medicare Part A and Part B?



Yes No

What is your Medicare Number?

Part A _____

Part B _____

What is the effective date for Medicare?

Effective date _____

Applicant please go to the next page ----- >

FOR OFFICE USE ONLY

Check #	Amount	Agent #	Group #	Premium amount
---------	--------	---------	---------	----------------

INSURANCE PRODUCER USE ONLY

I certify that the information supplied by the applicant has been truly and accurately recorded and that I have made no representation about benefits, conditions, or limitations of the contract except through written material furnished by Health Net. I have provided the applicant with a notice regarding replacement of Medicare supplement coverage if applicable.

Insurance Producer's Signature _____ Date _____

Insurance Producer's Name (please print) Rick Plata Insurance Producer's # AF136

Insurance Producer's Phone # 888-235-8060

Agency/GA _____ Agency/ GA # _____

Mail contract to Member

Existing Insurance Information

Note that you do not need more than one Medicare supplement policy.

If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated, if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB).

Terminating from Another Policy

Under certain circumstances, we cannot deny you enrollment under this policy. In general, this applies when you have recently terminated coverage under a prior policy. To qualify for Health Net of Oregon Medicare supplement policy, your prior coverage and manner of termination must meet certain requirements. You also must enroll under the Health Net of Oregon plan (and provide proof of termination of the previous plan) within 63 days of that termination.

To determine if you qualify, please answer the following questions to the best of your knowledge

Did you turn age 65 in the last six months? Yes No

Did you enroll in Medicare Part B in the last six months? Yes No

If yes, what was the effective date? _____

Terminating from Another Policy (cont.)

● Are you covered for medical assistance through the state Medicaid program? Yes No

Note to applicant: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.

If yes,

(a) Will Medicaid pay your premiums for this Medicare supplement policy? Yes No

(b) Do you receive any benefits from Medicaid **other than** payments toward your Medicare Part B premium? Yes No

● If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START	/ /
	Mo/Day/Yr
END	/ /
	Mo/Day/Yr

If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? Yes No

Was this your first time in this type of Medicare plan? Yes No

● Did you drop a Medicare supplement policy to enroll in the Medicare plan? Yes No

Do you have another Medicare supplement policy in force? Yes No

If so, with what company, and what plan do you have? _____

If so, do you intend to replace your current Medicare supplement policy with this policy? Yes No

● Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan.) Yes No

If so, with what company and what kind of policy? _____

What are your dates of coverage under the other policy? START / / Mo/Day/Yr

If you are still covered under the other policy, leave END blank. END / / Mo/Day/Yr

● Are you covered for medical assistance through the state Medicare program as (1) a Specified Low Income Medicare Beneficiary (SLMB), (2) a Qualified Medicare Beneficiary (QMB), or (3) for other Medicaid medical benefits? Yes No

Health Statement Requirement

Check either of the following statements if true for you

You were covered under another Medicare Advantage or Medicare Supplement plan within 63 days of your requested effective date under this plan and you lost your prior coverage through no fault of your own.

It is less than 6 months after your initial Medicare Part B enrollment. (NOTE: You must be enrolled in both Medicare Part A and Part B on your requested enrollment date under the Health Net of Oregon Medicare supplement plan.)

If you checked either of the boxes above, do not complete the health statement that follows. Go to the last page. Read, sign and date the "Conditional Authorization To Use and Disclose Protected Health Information" section.

If you have not checked either of these boxes, you must complete the "Current Health Statement" sections.

NOTE: If you are transferring from one Health Net of Oregon Medicare Supplement plan to another Health Net of Oregon Supplement plan, you must complete the health statement below and on the next two pages.

If you are unsure if you should complete the health statement, please call 1-800-709-4193 for help from a Health Net Medicare Sales Representative.

Current Health Statement**Genetic Information and Non-discrimination Act of 2008 (GINA) Compliance Statement**

This insurance application is not a request for genetic information. In answering these questions you should not include any genetic information. That is, please do not include family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic disease for which you believe you may be at risk.

Answer the following health questions to the best of your knowledge. If you need more space for additional information, please attach a separate sheet.

Current height**Current weight**

Medications: List all medications that you are currently taking.

Medication Name	Name/ address/ telephone of prescriber	Date Prescribed

Condition	Yes	No	Date of Last Treatment
Alcohol/ chemical/ drug abuse/ habit	<input type="checkbox"/>	<input type="checkbox"/>	
Liver condition/ hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Knee/ shoulder/ hip/ other joints	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes/ sugar in urine	<input type="checkbox"/>	<input type="checkbox"/>	
Stomach disorders/ ulcer/ acid reflux	<input type="checkbox"/>	<input type="checkbox"/>	
Bladder/ urinary tract	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney/ kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	
Reproductive system disorder/ infertility	<input type="checkbox"/>	<input type="checkbox"/>	
Prostate/ elevated PSA/ prostatitis	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Tumors	<input type="checkbox"/>	<input type="checkbox"/>	
AIDS/ ARC/ HIV positive	<input type="checkbox"/>	<input type="checkbox"/>	
Lupus/ chronic muscle pain/ muscle injury or disease, or fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological condition/ disease/ injury	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke/ paralysis/ seizures	<input type="checkbox"/>	<input type="checkbox"/>	
High blood pressure (if "Yes" please record last reading) _____	<input type="checkbox"/>	<input type="checkbox"/>	
Heart/ chest pain/ angina	<input type="checkbox"/>	<input type="checkbox"/>	
Endocrine/ gland/ hormone system	<input type="checkbox"/>	<input type="checkbox"/>	
Disease or injury of eye/ cataract/ glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic ear/ nose/ throat/ tonsil condition/ disease/ disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Emphysema/ asthma/ chronic lung disease (COPD)	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological condition/ disease/ injury	<input type="checkbox"/>	<input type="checkbox"/>	

Additional health questions

Have you had any medical advice, diagnosis, care or treatment - including prescribed medications - recommended or received from a licensed health care professional or had any illness, ailment, injury, health problem, symptoms, physical impairment, surgery or hospital confinement not listed above?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you had chronic cough, fatigue, diarrhea or enlarged glands?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you been advised to have or contemplated having an operation or medical procedure not yet performed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you been scheduled to see a health care provider?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you taken any prescription medication on a regular basis?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Payment Options

Initial Payment:

You will be billed for your initial premium upon acceptance.

Future Payment (check box):

- Mail-in premium payment.
- Simple Pay Option (Automatic Premium Withdrawal)

Health Net of Oregon may change or amend this policy upon prior approval from the Oregon Insurance Division by giving the subscriber thirty (30) days notice before the change is effective.

Certification of Completion and Correctness

I affirm that the answers given in this application are complete and correct. I have provided these answers as part of the application procedure required by this insurance carrier to enroll in its insurance coverage. I understand that if this application contains any material misstatements or omissions, the insurance carrier may, within the first two years of coverage, deny coverage, modify or cancel the contract, or take other legal action. I will promptly inform the insurance carrier in writing if anything happens before my coverage takes effect that makes this incomplete or incorrect. I understand and agree that no coverage shall be in force until approved by the insurance carrier. If approved, coverage will be in force as of the effective date determined by the carrier. The carrier may contact me to clarify answers on this application. As the applicant, I understand I have the right to inspect the information in my file.

Conditional Authorization To Use and Disclose Protected Health Information

Note: All applicants must sign and date the following authorization.

To any physician; health care provider, including OHSU; hospital, including OHSU; insurance or reinsurance company; the Medical Information Bureau, Inc. (MIB), or other insurance information exchange:

I authorize you to give Health Net Health Plan of Oregon, Inc. or its representatives any medical record information (including alcohol, chemical dependency, mental treatment, or HIV treatment) you have about me. Such information may be used for processing application for coverage, for prior authorizing services or processing claims for benefits, or for purposes of health care provider credentialing, quality assurance, utilization review, case management, peer review, and audit. A photocopy of this authorization is as valid as the original. I understand that I may receive a copy of this authorization upon request.

This authorization takes effect on the date signed and it remains in effect as follows:

- For information used to process this application – 30 months
- For information used for all the other reasons listed above – as long as coverage is in effect or until the completion of processing any claim, whichever is longer.

Applicant's Signature _____

Date _____



Health Net

Health Net Health Plan of Oregon, Inc.
13221 SW 68th Parkway, Suite 200
Tigard, Oregon 97223

888.802.7001

www.healthnet.com

Health Net® is a registered service mark of Health Net, Inc. All rights reserved. Health Net Health Plan of Oregon, Inc. is a subsidiary of Health Net, Inc.



Health Net®

Health Net Health Plan of Oregon, Inc. Simple Pay Option

Simple Pay Option helps guard against a missed payment or possible lapse in coverage. It also saves the expense of postage, check writing, or money orders. Each month, **Simple Pay Option** automatically deducts your health insurance premium amount directly from an account you select. The premium will be deducted on approximately the sixth day of each month. Your premium payments will be clearly identified on your monthly bank statement.

Automatic Payment Instructions for Individual Plans

1. Fill out and sign this form. Please use black ink.
2. Attach a **blank** check from your personal financial account and write "VOID" on it. We will use it as a record of your account number. Please do not submit a deposit slip instead of a voided check.
3. We will communicate with your bank regarding this authorization.
4. Send a personal check for the first month's premium.
5. If you are returning this authorization separately from your Individual Enrollment application, please mail or fax to:

**Health Net Health Plan of Oregon, Inc.
Medicare Enrollment Services
PO Box 10420
Van Nuys, CA 91410
Fax: 1-866-214-1992**

Applicant Name (please print)	Applicant's Subscriber ID or Social Security Number	
Account Holder Name – if different from above (please print)		
Account Number	Routing Number	
Bank Name		
Bank Street Address		
City	State	Zip

**Health Net Health Plan of Oregon, Inc. ● P.O. Box 10420, Van Nuys, CA 91410 ●
888.802.7001 www.healthnet.com**

As a convenience, I request and authorize Health Net Health Plan of Oregon, Inc. to pay and charge to the above account checks drawn on that account by and payable to the order of **"Health Net Health Plan of Oregon, Inc."** provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that Health Net's rights in respect to each such check shall be the same as if it were a check written to Health Net and signed personally by me. 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 check.

I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, Health Net shall be under no liability whatsoever even though such dishonor may result in the forfeiture of health coverage.

I further agree that I may terminate the plan Agreement with Health Net Health Plan of Oregon, Inc. upon 30 days written notice. In such event, termination will be effective on the first day of the month following expiration of the 30-day notice period. All returned bank items are subject to a \$15.00 fee. (Note: A 30-day notice is required to discontinue this service due to the time required to initiate this change with your bank.)

Signature of Account Holder

Date

PLEASE INCLUDE YOUR VOIDED CHECK.

Health Net Health Plan of Oregon, Inc. is a subsidiary of Health Net, Inc. Health Net is a registered service mark of Health Net, Inc. All rights reserved.

**Health Net Health Plan of Oregon, Inc. ● P.O. Box 10420, Van Nuys, CA 91410 ●
888.802.7001 www.healthnet.com**



HIV ANTIBODY TEST

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant or by exposure to infected blood (as in needle sharing during intravenous drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another male, intravenous drug users, hemophiliacs and persons who have had sexual contact with any of these persons. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. An infected person has a significant chance of developing AIDS over the next 10 years.

What you need to know:

Before you consent to testing, please read the following important information:

1. Purpose. This test is being run to determine whether you may have been infected with HIV. If you are infected, your options for obtaining life and health insurance may be limited. This test is not a test for AIDS; AIDS can only be diagnosed by medical evaluation.
2. Positive Test Results. If you test positive, you should seek medical follow-up with your personal physician because you may be infected with HIV.
3. Accuracy. An HIV test will be considered positive only after confirmation by a laboratory procedure that the state health officer has determined to be highly accurate. Nonetheless, the HIV antibody test is not 100% accurate. Possible errors include:
 - a. False positives: The test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high risk behavior. Retesting should be done to help confirm the validity of a positive test.
 - b. False negatives: The test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4 to 12 weeks for a positive test result to develop after a person is infected.
4. Possible Adverse Effects of Test. A positive test result may cause you significant anxiety. A positive test result may limit your ability to obtain life, health, or disability insurance coverage in the future. Although prohibited by law, discrimination in housing, employment, or public accommodations may result if your test results were to become known to others. A negative result may create a false sense of security.
5. Disclosure of Results. A positive test result will be disclosed to you or the physician or county health department that you designate.

6. Confidentiality. Like all medical information, HIV test results are confidential. An insurer, insurance agent, or insurance-support organization is required to maintain the confidentiality of HIV test results. Certain disclosures of your test results may occur, however, including those authorized by consent forms that you may have signed as part of your overall application. Your test results may be provided to affiliates, reinsurers, employees and contractors of the insurer in relation to the underwriting of the insurance application. In addition, a positive result from a blood, oral specimen or urine test may be reported to the Medical Information Bureau, a national insurance data bank, as a nonspecific abnormality determined by the testing of blood, oral specimen or urine.

7. Prevention. Persons who have a history of high risk behavior should change these behaviors to prevent getting or giving AIDS, regardless of whether they are tested. Specific important changes in behavior include safe sex practices (including condom use for sexual contact with someone other than a long-term monogamous partner) and not sharing needles.

8. Information. Further information about HIV testing and AIDS can be obtained by calling the Oregon AIDS hotline within the Portland area at 503-223-AIDS and outside the Portland area at 1-800-777-AIDS. Health insurance may be available through the Oregon Medical Insurance Pool for persons who are not otherwise able to obtain coverage. The telephone number for the Oregon Medical Insurance Pool is 1-800-542-3104 or 1-503-373-1692.

I have read the above information, or it has been read to me in my primary language. By signing I indicate that I understand the information about HIV/AIDS and the HIV test, and I have been given full opportunity to ask questions and received satisfactory answers to my questions.

A consent form signed by an applicant is valid for six months following the date that the consent form was signed. If after six months the test is not performed or retesting is needed, a new signed consent form must be obtained.

Signature of Applicant _____ Date _____

Signature of person explaining consent _____ Date _____

I authorize the following person(s), other than those permitted by Oregon law, to receive the test results. If none, specify "None".

Name: _____ Address: _____

Name: _____ Address: _____

Health Net Health Plan of Oregon, Inc. is a subsidiary of Health Net Inc. Health Net is a registered service mark of Health Net, Inc. All rights reserved.



Health Net Health Plan of Oregon, Inc.
 13221 SW 68th Parkway
 Tigard, Oregon 97223
 888.802.7001
 www.healthnet.com

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

SAVE A COPY OF THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to terminate existing Medicare supplement coverage and replace it with a policy to be issued by Health Net Health Plan of Oregon, Inc. Your new policy allows 30 days with which you may decide, without cost, whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement coverage because you intend to terminate your existing Medicare supplement coverage. The replacement policy is being purchased for the following reason or reasons:

- Additional benefits
- Fewer benefits and lower premiums
- No change in benefits, but lower premiums
- Other (please specify reason): _____

State law provides that your replacement policy may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy or coverage for similar benefits to the extent such a time period was spent or depleted under the original policy.

If you still wish to terminate your present policy and replace it with new coverage, be certain to answer truthfully and completely all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the 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.

Applicant's Signature Date _____

Signature of Insurance Producer or Representative _____ Date _____
 (Not required for direct response sales.)

Typed Name of Insurance Producer or Representative _____

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Health Net Health Plan of Oregon, Inc. is a subsidiary of Health Net Inc.
 Health Net is a registered service mark of Health Net, Inc. All rights reserved.