

**MEDICAL, DENTAL, VISION, CHIROPRACTIC & ACUPUNCTURE  
ENROLLMENT APPLICATION AND DECLINATION**

Please print in blue or black ink

Page 1 of 4

Enrollment reason:

<input type="checkbox"/> New Hire	<input type="checkbox"/> New Firm Enrolling	<input type="checkbox"/> Other Qualifying Event: _____
<input type="checkbox"/> Loss of Coverage (Date of loss): _____ (HIPAA Certificate of Creditable Coverage is required)	<input type="checkbox"/> New Enrollment (Open Enrollment)	Event Date: _____
	<input type="checkbox"/> Add a Line of Coverage (Open Enrollment)	<input type="checkbox"/> Rehire/Re-Enroll (90 day limit)

**SECTION 1: EMPLOYEE INFORMATION**

<b>Requested Effective Date:</b> ____ / ____ / ____ (1st of the month following waiting period)				Full-Time Date of Hire (required) (If owner, enter company start date)	
Name of Company				Employee Job Title	
Employee Last Name	Employee First Name	M. I.	<input type="checkbox"/> Male <input type="checkbox"/> Female	Home Phone ( )	
Employee Social Security Number	Date of Birth (mm/dd/yy)	E-mail		Are you disabled? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Residence Address (Physical address required, no PO boxes)		Apt#	City	State	Zip Code
Mailing Address (If different)		Apt#	City	State	Zip Code
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partner (Affidavit required)			Are you currently enrolled in Medicare? <input type="checkbox"/> No <input type="checkbox"/> Yes Effective Date:		

**SECTION 2: MEDICAL BENEFITS** Please contact your Employer to determine which benefits your Company offers.  
(select one plan ONLY)

KAISER PERMANENTE	HEALTH NET		
<input type="checkbox"/> Copay Plan 15 <input type="checkbox"/> HSA Plan 0/1500 <input type="checkbox"/> Copay Plan 20 <input type="checkbox"/> HSA Plan 0/2200 <input type="checkbox"/> Copay Plan 30 <input type="checkbox"/> HSA Plan 0/2700 <input type="checkbox"/> Copay Plan 50 <input type="checkbox"/> HRA Plan 30/1500 <input type="checkbox"/> HD Plan 30/1000 <input type="checkbox"/> HRA Plan 30/2500	<input type="checkbox"/> Value HMO 20 <input type="checkbox"/> Standard HMO 30 <input type="checkbox"/> Value HMO 30 <input type="checkbox"/> Value HMO 40	<input type="checkbox"/> Standard PPO 40 <input type="checkbox"/> Value PPO 40 <input type="checkbox"/> Value HSA 1500 <input type="checkbox"/> Standard HSA 2000 <input type="checkbox"/> Value HSA 3500	<input type="checkbox"/> Options HMO 35 <input type="checkbox"/> Options PPO 500 <input type="checkbox"/> Options PPO 1750 <input type="checkbox"/> Options HSA 3000 <input type="checkbox"/> Options HSA 4000
If enrolling in Kaiser, have you had Kaiser coverage in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, what is your Medical Record #:	If enrolling in a Health Net HMO Plan, please complete the Physician information below		
	Health Net Primary Care Physician (PCP)*:	Physician ID # and City:	Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

**SECTION 3: ADDITIONAL BENEFIT SECTION** (Participation requirements DO APPLY)

Please contact your Employer to determine if your company offers any of the additional benefits listed below.  
If so, employees who check yes below will be enrolled in the **plan offered by your employer.**

<b>Dental Plan</b> *: Either MetLife or Premier Access Plan <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Vision Plan</b> **: Either VSP (group) or Blue View (group) or Voluntary Blue View <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Chiropractic or Chiro/Acupuncture</b> **: Offered by American Specialty Health (ASH) <input type="checkbox"/> Yes <input type="checkbox"/> No
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\* Employees who are enrolling with Premier Access are required to submit proof of prior group dental coverage to have the one-year wait on major services waived.  
\*\*Vision and Chiro/Acu enrollment must match medical enrollment for all enrollees. If vision is a stand alone plan then 100% participation is required.

**SECTION 4: DEPENDENT ENROLLMENT INFORMATION** Do you have any legal dependents?  No  Yes

If yes, are you enrolling any dependents in any combination of plans:  No - Please cross out the dependent grid (page 2) and complete the declination on page 4  
 Yes - Please complete the dependent grid (page 2) for those to be enrolled.

Internal Use Only	Tier	Plan	Group #
<input type="checkbox"/> Health Net	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5		
<input type="checkbox"/> Kaiser	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5		
<input type="checkbox"/> MetLife or Premier	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> PO <input type="checkbox"/> P <input type="checkbox"/> Std <input type="checkbox"/> Sav	
<input type="checkbox"/> ASH	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> EO <input type="checkbox"/> E <input type="checkbox"/> 1500 <input type="checkbox"/> 1000	
<input type="checkbox"/> VSP or BV or BVV	<b>BX</b>	<input type="checkbox"/> Chiro <input type="checkbox"/> Chiro/Acu	<b>Checked by:</b>
		<b>Waiting Period</b>	

**MEDICAL, DENTAL, VISION, CHIROPRACTIC & ACUPUNCTURE ENROLLMENT APPLICATION**

This page MUST be submitted or application will be considered incomplete.

**SECTION 4 (continued): DEPENDENT ENROLLMENT GRID**

Complete this section ONLY for those family members who are enrolling in one or more plans. Please cross section out if NOT enrolling any dependents.

	SPOUSE/DOMESTIC PARTNER	CHILD # 1	CHILD # 2	CHILD # 3
LAST NAME:				
FIRST NAME:				
SOCIAL SECURITY NUMBER:	- -	- -	- -	- -
DATE OF BIRTH:	/ /	/ /	/ /	/ /
GENDER:	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
RELATIONSHIP TO EMPLOYEE:	<input type="checkbox"/> SP <input type="checkbox"/> DP			
ENROLLED IN MEDICARE:	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	Effective Date:			
DISABLED <sup>¶</sup>		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
FULL-TIME STUDENT <sup>¶</sup>		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
DEPENDENT ENROLLING IN:** (Only check plans that are offered)	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Chiro/A	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Chiro/A	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Chiro/A	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Chiro/A

If you are declining yourself or any dependents for coverage being offered, you must complete the Declination Section on page 4.

IF HEALTH NET: PRIMARY CARE PHYSICIAN (PCP)* NAME, PHYSICIAN ID # & CITY:				
CURRENT PATIENT OF PCP?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
IF KAISER, DO YOU HAVE A MEDICAL RECORD #?	<input type="checkbox"/> Yes <input type="checkbox"/> No #	<input type="checkbox"/> Yes <input type="checkbox"/> No #	<input type="checkbox"/> Yes <input type="checkbox"/> No #	<input type="checkbox"/> Yes <input type="checkbox"/> No #

<sup>¶</sup>For full-time students (age 19 - 24) or disabled dependents, please submit an Over Age Dependent Certification or Disabled Dependent Certification in addition to this form.

If **Last Name** of spouse or dependent is different from Employee's Last Name, please explain:

If **Address** of spouse/domestic partner or dependent is different from Employee's Address, please list here:

\* For Health Net Primary Care Physician (PCP), please know that if you have not selected a PCP above or your PCP is not contracted with Health Net, a PCP will be assigned to you.

For Kaiser enrollees no PCP selection is required: instead please use your medical record number.

\*\* Vision and chiro/Acu enrollment must match medical enrollment for all enrollees. If vision is a stand alone plan then 100% participation is required.

**SECTION 5: OTHER HEALTH INSURANCE** (This section is required)

Are you or have you and/or any of your eligible family members been covered by other medical coverage within the last 6 months?

If Yes, complete the section below to receive pre-existing condition credit. Please list all current or prior medical coverage.

Attach additional sheets if necessary.

COVERED PERSON'S NAME	POLICY HOLDER NAME(S) (i.e. Company Name)	INSURANCE COMPANY NAME	TYPE OF COVERAGE	POLICY/ GROUP #	EFFECTIVE DATE	TERMINATION DATE
			<input type="checkbox"/> Health <input type="checkbox"/> Other:			
			<input type="checkbox"/> Health <input type="checkbox"/> Other:			
			<input type="checkbox"/> Health <input type="checkbox"/> Other:			

**SECTION 6: WOMEN’S HEALTH AND CANCER RIGHTS ACT ENROLLMENT NOTICE**

Your plan, as required by the Women’s Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Please see the Group Health Plans Benefit Booklet for deductibles and coinsurance for the plan you are enrolling in. If you would like more information on WHCRA benefits, call your Plan Administrator.

**SECTION 7: YOUR LEGAL ACKNOWLEDGEMENT (Please Read, Sign and Date Below)**

**American Specialty Health Plan Enrollees:**

I understand that American Specialty Health Plans (“ASHP”) uses binding arbitration to settle disputes, including to settle any claim of medical malpractice against ASHP. In addition, I understand that any claims I might have against an ASHP participating provider, including a claim for medical malpractice, will not be subject to ASHP’s arbitration procedures, except to the extent I and the participating provider agree to follow and/or be bound by those procedures.

**I also understand** that California Health and Safety Code Section 1363.1 requires ASHP to include the statements set forth above in this Application Form as well as the following statement, which is substantially the wording provided by Section 1295(a) of the California Code of Civil Procedure: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under the ASHP agreement under which I receive chiropractic and/or acupuncture services were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, and any dispute as to the delivery of services under that agreement will, to the extent described above, be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provided for judicial review of arbitration proceedings. I understand that, by signing this Application Form or otherwise becoming a member under that agreement, ASHP and I are giving up any constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting use of arbitration.

**MetLife Dental, Blue View Vision, & Vision Service Plan Enrollees:**

**Employee Statement** - I request coverage under my employer’s group insurance plan as noted and also verify the accuracy of the employee section. Furthermore, I authorize my employer to deduct from my earnings any payment, if applicable for this coverage.

**Premier Access Plan Enrollees:**

As more fully set out in the Policy and Certificate, I agree that binding arbitration is the final process for the resolution of any dispute arising out of or relating to the Policy. If a face-to-face hearing is involved in the arbitration, the hearing shall be conducted in Sacramento, CA. By enrolling in this plan, Employer and Covered Persons waive their constitutional right to a trial before a jury or judge. Any dispute alleging the malpractice, negligence and/or wrongful act of a provider, shall not include Premier and shall include only the provider subject to the allegation.

**Health Net Plan Enrollees:**

**Explanation of Authorization to Obtain or Release Medical Information:** The authorization below to obtain and release medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act, effective January 1, 1980, Section 56 et seq. of the California Civil Code. Your cooperation is requested.

**Authorization to Obtain or Release Medical Information:** I hereby authorize my physician, health care practitioner, hospital, clinic or other medically related facility to furnish an agent, designees or representatives of Health Net or Health Net Life, any and all records pertaining to medical history, services rendered or treatment given to anyone enrolled hereunder, or added hereunder for purpose of review, investigation, or evaluation of an application or a claim. I authorize Health Net, Health Net Life, or its agents designees or representatives to disclose to a hospital or health care service plan, self-insurer, and such medical information obtained if such disclosure if necessary to allow the processing of any claim. This authorization shall become effective immediately and shall remain in effect as long as is necessary to enable Health Net or Health Net Life to process claims and benefits.

**Arbitration Agreement:** I understand that any dispute or controversy, except medical malpractice, that may arise regarding the performance, interpretation or breach of the agreement between myself (and/or any enrolled family member) and Health Net. Health Net Life Insurance Company or any Participating Medical Group/Independent Physicians Association, whether arising in contract, tort or otherwise, must be submitted to arbitration in lieu of a jury or court trial.

**California Law prohibits** an HIV test from being required or used by Health Companies as a condition of obtaining insurance coverage.

**Any person who with intent to defraud** or knowing he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Please sign and date this application below. Your signature indicates** that you have completed all requested information as accurately as possible and that you read the Plan information and understand all agreements, including your agreement to submit disputes to binding arbitration.

**Preexisting Conditions and Creditable Coverage** -Your coverage under this plan may be subject to preexisting condition limitations for a maximum period of six months from the effective date of your enrollment. In accordance with state and federal law, Health Net will credit any prior coverage that you document at the time you apply to enroll in PPO or Flex Net, provided the prior coverage qualifies as “creditable coverage” as defined under federal and state law. Creditable coverage will be applied to offset (in part or whole) the preexisting condition limitation, which may apply to your coverage under this policy. If you’re unable to provide documentation of bona fide creditable coverage at enrollment time, Health Net may provide assistance in obtaining the necessary documentation upon request. Note: Prior coverage which is interrupted by a period of 63 days (or 181 days if your previous employer terminated the coverage) or more does not qualify as creditable coverage.

**Kaiser Permanente Plan Enrollees:**

**Kaiser Foundation Health Plan Arbitration Agreement:** I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with Employee Retirement Income Security Act (ERISA) regarding certain benefit related disputes) and dispute between myself, or my heirs, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the full Arbitration provision is contained in the Evidence of Coverage.

**Employee Signature to Enroll in Coverage**

X

**Date**

**Print Name**

# INSURANCE COVERAGE DECLINATION FORM

Please complete this form **ONLY** if you **do not want coverage for yourself and/or your dependents**.

Please note that Chiropractic and Vision coverage, if offered by your Employer, cannot be waived when enrolling for Medical coverage.

## SECTION A: PERSONAL INFORMATION (to be completed by Employee)

Name of Company		Employer Phone Number (    )	
Employee Last Name	First Name	Middle Initial	
Date of Hire		Employee Social Security Number	

## SECTION B: TYPE OF DECLINATION (check all that apply and include names of dependents which is required)

I am declining coverage for:	Medical	Dental	Vision	Chiro / Acup
<input type="checkbox"/> Myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Spouse or <input type="checkbox"/> Domestic Partner Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Child(ren) Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## SECTION C: REASON FOR DECLINING COVERAGE (must be filled out completely)

<input type="checkbox"/> <b>Other Group Coverage through a Spouse/Domestic Partner:</b> Medical Carrier Name: _____ Dental Carrier Name: _____ Vision Carrier Name: _____ Chiropractic Carrier Name: _____	(list and attach proof of coverage) Group #: _____ Group #: _____ Group #: _____ Group #: _____	Company Sponsor _____ _____ _____ _____
<input type="checkbox"/> <b>Individual Coverage:</b> (please choose one) <input type="checkbox"/> <b>Medicare</b> <input type="checkbox"/> <b>Medi-Cal</b> <input type="checkbox"/> <b>Individual Policy</b> _____		
<input type="checkbox"/> <b>Other Reasons:</b> _____		

## SECTION D: SPECIAL ENROLLMENT RIGHTS

In certain circumstances, you and your eligible dependents may have rights to enroll outside the Open Enrollment period. To take advantage of special enrollment rights, you must request enrollment with the Contract Administrator (via your Employer) within 30 days of the event triggering special enrollment. Special enrollment rights may be triggered by any of the following events:

- If you or any of your dependents declined enrollment under this Plan because of other health insurance coverage, other than COBRA coverage, but afterwards lost eligibility for that coverage for any of the following reasons other than the failure to pay timely premiums or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other plan):
  - Loss of eligibility for coverage as result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of the employee, termination of employment, and reduction in the number of hours of employment;
  - In the case of coverage through an individual HMO, a loss of eligibility for coverage under your individual HMO because you no longer reside, live or work in the HMO's service area;
  - In the case of coverage through a group HMO, a loss of eligibility for coverage under the group HMO because you no longer reside, live or work in the HMO's service area and no other benefit package is available to you;
  - If you incur a claim under the other plan that would meet or exceed a lifetime limit on all benefits under the other plan; or
  - The other plan ceases to offer any benefits to the class of similarly situated individuals that includes you or your dependent (e.g., your dependent is a part-time employee with employer A and employer A discontinues coverage for part-time employees);
- If you are covered under another plan for which an employer makes a contribution towards your premium and that contribution is terminated (such contributions must be completely terminated; a reduction in the value of the benefit or an increase in cost to the participant does not trigger a special enrollment right); or
- You exhaust COBRA coverage; or
- If you acquire a new dependent(s) as a result of marriage or domestic partnership, birth, adoption or placement for adoption, you may be able to add the new spouse or domestic partner or child(ren), or enroll yourself and your dependents.

If you are covered by a medical plan or HMO offered under the Plan and you enroll yourself and/or a new dependent(s) in accordance with the Plan's special enrollment procedures, you have the right to enroll in any other medical plan or HMO option for which you and your dependents are eligible.

**SECTION E: YOUR LEGAL ACKNOWLEDGEMENT** By signing, I understand that by failing to elect coverage now, I will not be able to enroll until the next Open Enrollment period or a Qualifying Event occurs as stated above. This declination provision will not apply if a Court orders coverage of a spouse or child and the request for enrollment follows the Special Enrollment Rights guidelines as stated above.

<b>Employee Signature to Decline Coverage</b> X	<b>Date</b> _____
<b>Print Name</b> _____	