Health Net of California, Inc. (Health Net)

Make the Most of Your Plan

GET YOUR SUMMARY OF BENEFITS AND COVERAGE

Thank you for applying for a CommunityCare HMO plan. Please read your ***Summary of Benefits and Coverage* (SBC)**. The SBC gives you some of the basics about your plan and how to get care when you need it, including:

- How your health plan works.
- A list of common medical services that are covered and what they cost on your health plan.
- Your rights to file grievances and appeals. This is the process you use to make a complaint to your plan or request regulator assistance.
- A list of other services that are covered or excluded from your health plan.
- Examples of how your plan might cover medical care for certain medical conditions.
- How to get help in your main language.
- Common questions and answers (Q&A).

Understanding your SBC is the key *to making the most of your health coverage.*

To view, download or print a copy of the SBC for your 2021 plan:

1. Go to **www.myhealthnetca.com/sbc**.
2. Select *2021 Summary of Benefits and Coverage (Directly through Health Net)*.
3. Under CommunityCare HMO Plans, find the SBC for the plan you are applying for.

If you prefer, you can call our Customer Contact Center at **1-800-839-2172 (TTY: 711)** for a copy.

FLY047401EH00 (1/21)

Health Net of California, Inc. (Health Net)

Individual & Family Plans CommunityCare HMO

Enrollment Application

Health Net®

Requested effective date

☐☐ / ☐☐ / ☐☐☐☐

APPLICATION MUST BE TYPED OR COMPLETED IN BLUE OR BLACK INK.

Effective date of coverage: Coverage is only available for enrollment during the annual open enrollment period, which is November 1, 2020, through January 31, 2021, or during a special enrollment period. Applications must be received within 60 days of a qualifying event. Generally, for applications received between the 1st and 15th, coverage will be effective the first day of the month following submission of the application. For applications received between the 16th and month's end, coverage will be effective the first day of the second month following submission of the application.

If you are currently enrolled in a Medicare plan, you are ineligible to apply for an Individual & Family Plan.

Health Net requests a **Social Security number (SSN)** for everyone enrolling for health coverage, including spouses and dependent children, or a **Tax Identification Number (TIN)** for the primary applicant. This is requested so that we can provide you with verification of coverage for your tax return, as required by the Affordable Care Act and Senate Bill 78. You may still apply for coverage, and coverage will not be denied, if you cannot provide an SSN or TIN for yourself or an SSN for other family members. Health Net will not use your SSN or TIN for other purposes or share it with anyone other than as required by law. For newborns, you have six months to provide the newborn's SSN.

THE AGENT/BROKER MAY NOT SIGN THIS APPLICATION AND AGREEMENT ON BEHALF OF THE APPLICANT.

IMPORTANT: Please see Part VI if the applicant does not read/write English. The Individual & Family Plan CommunityCare HMO Enrollment Application is available in Spanish, Chinese, Korean, and Vietnamese language versions. You can also have someone help you read it. For free help, please call 1-877-609-8711.

If you need assistance in completing this application, an agent/broker may assist you. An agent/broker who helped you read and complete this application must sign the application (see Part VII).

I (and my dependents if applicable) am applying during: ☐ **Annual open enrollment period** ☐ **Special enrollment period (see Part IV)**

Part I. Applicant information

☐ **New application (Check family type below)**
☐ Self ☐ Self and spouse ☐ Self and domestic partner ☐ Self and child ☐ Self and children
☐ Self, spouse and child(ren) ☐ Self, domestic partner and child(ren) ☐ Child only[1] ☐ **Change request**

☐ **Adding dependent (Fill in the primary subscriber's information below, then complete dependent information in Part III.)**

Primary applicant's last name:	First name:	MI:	☐ Male ☐ Female
Permanent home street address:[2]			
City:	State:	ZIP:	County applicant resides in:
Billing / Mailing address:			
Cell phone number: ( )	Additional phone number: ☐ Home ☐ Work ( )		Email address:
Primary applicant's birth date (mm/dd/yy): / /	Primary applicant's Social Security number: – –		Primary applicant's Tax Identification Number:
Are you currently a Health Net member? ☐ Yes ☐ No If "Yes," please provide the primary subscriber's member ID:			
Primary care physician ID:	Primary group ID:		Current patient: ☐ Yes ☐ No
Please select your language preference (optional): ☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Vietnamese			

[1]Applicants on child-only plans must be under age 18 as of the requested coverage effective date. Each child age 18 and older must submit a separate individual enrollment application.

[2]See page 9, Part V. "Proof of permanent residency requirement."

Last 4 digits of primary applicant's Social Security # or TIN: __ __ __ __

Part II. Payment information and choice of coverage

A. PAYMENT INFORMATION (First full monthly premium payment is required for your application to be considered.)

First premium payment ☐ Pay by check (Amount must match monthly premium.)

Mailing application	**Faxing application**	**Mailing your check**
Mail completed application to: Health Net Individual & Family Enrollment PO Box 1150 Rancho Cordova, CA 95741-1150	Fax completed application to: 1-800-977-4161	Complete the form on page 15 and send it with your check to: Health Net CA Individual PO Box 748705 Los Angeles, CA 90074-8705

Current members can log in to **www.myhealthnetca.com** and select *Pay My Bill* in the "For Members" section.

Payment of subscription charges
The Subscriber is responsible for payment of Subscription Charges to Health Net.

B. CHOICE OF COVERAGE

Health Net of California, Inc. CommunityCare HMO plans utilize the CommunityCare HMO provider network.

☐ **Platinum 90 CommunityCare HMO**

☐ **Gold 80 CommunityCare HMO**

☐ **Silver 70 Off Exchange CommunityCare HMO**

Optional coverage: Dental/Vision plan for adults (ages 19 and over).

☐ **Dental and Vision Plus** – If Dental and Vision Plus is purchased for the primary applicant, all family members ages 19 and over will also be enrolled in the Dental and Vision Plus plan. Dental and Vision Plus can only be purchased with, or added to, medical coverage during the open enrollment or special enrollment periods.

Note: All medical plans include pediatric dental and pediatric vision coverage. Individuals will receive pediatric dental and vision coverage under the medical plans until the last day of the month in which the individual turns 19.

Last 4 digits of primary applicant's Social Security # or TIN: __ __ __ __

Part III. Family member(s) to be enrolled

List all eligible family members to be enrolled other than yourself. If a listed family member's last name is different from yours, please explain on a separate sheet of paper. For additional dependents, please attach another sheet with the requested information.

☐ Check here if a supplemental page is attached. Please write the primary applicant's Social Security number or Tax Identification Number on the upper right-hand corner of the supplemental page.

Note: If a family member is requesting a different health plan than the primary subscriber, a separate application for each family member requesting a different plan should be filled out and submitted. Being on a different plan means that each person will be subject to the individual deductible and out-of-pocket maximum of the plan selected and that the family cannot collectively contribute to a family deductible and/or out-of-pocket maximum.

For domestic partner coverage, all requirements for eligibility, as required by the applicable laws of the State of California, must be met, and a joint Declaration of Domestic Partnership must be filed with the California Secretary of State.

Selecting providers:
You must select a physician group and primary care physician. You may choose the same or a different physician group and primary care physician for each family member you are enrolling. If you do not select a primary care physician, one will be selected for you within your regional area.

To find the most up-to-date list of Health Net-contracted physicians, visit www.myhealthnetca.com, then go to *Find a Doctor*. You'll find a complete listing of our Individual & Family Plan network physicians, and you can search by specialty, city, county, or doctor's name. You can also call 1-877-609-8711 to request provider information or contact your Health Net authorized agent/broker.

If you are purchasing optional Dental and Vision Plus coverage, please provide the dentist number for the HMO dentist you've chosen. You may choose a different dentist for each family member. If you do not select a dental office, one will be selected for you in your area. For names, addresses, primary dentist number, and telephone numbers of participating dental providers, or for help in selecting a provider, call Health Net at 1-866-249-2382 or visit www.yourdentalplan.com/healthnet.

RELATION		LAST NAME	FIRST NAME	MI
☐ Spouse ☐ Domestic partner	☐ Male ☐ Female			
SOCIAL SECURITY NUMBER			**DATE OF BIRTH**	
– –			/ /	
COMMUNITYCARE HMO PRIMARY CARE PHYSICIAN ID ***(REQUIRED FOR COMMUNITYCARE PLANS)***			**COMMUNITYCARE HMO PHYSICIAN GROUP ID**	
IF ADULT DENTAL AND VISION PLUS IS PURCHASED, PLEASE NOTE HMO PRIMARY DENTIST #				

RELATION: CHILD 1	LAST NAME	FIRST NAME	MI
☐ Son ☐ Daughter			
SOCIAL SECURITY NUMBER		**DATE OF BIRTH**	
– –		/ /	
COMMUNITYCARE HMO PRIMARY CARE PHYSICIAN ID ***(REQUIRED FOR COMMUNITYCARE PLANS)***		**COMMUNITYCARE HMO PHYSICIAN GROUP ID**	
IF ADULT DENTAL AND VISION PLUS IS PURCHASED, PLEASE NOTE HMO PRIMARY DENTIST #			

(continued)

Last 4 digits of primary applicant's Social Security # or TIN: _ _ _ _

Part III. Family member(s) to be enrolled (continued)

RELATION: CHILD 2	LAST NAME	FIRST NAME	MI
☐ Son ☐ Daughter			

SOCIAL SECURITY NUMBER	DATE OF BIRTH
– –	/ /

COMMUNITYCARE HMO PRIMARY CARE PHYSICIAN ID *(REQUIRED FOR COMMUNITYCARE PLANS)*	COMMUNITYCARE HMO PHYSICIAN GROUP ID

IF ADULT DENTAL AND VISION PLUS IS PURCHASED, PLEASE NOTE HMO PRIMARY DENTIST #

RELATION: CHILD 3	LAST NAME	FIRST NAME	MI
☐ Son ☐ Daughter			

SOCIAL SECURITY NUMBER	DATE OF BIRTH
– –	/ /

COMMUNITYCARE HMO PRIMARY CARE PHYSICIAN ID *(REQUIRED FOR COMMUNITYCARE PLANS)*	COMMUNITYCARE HMO PHYSICIAN GROUP ID

IF ADULT DENTAL AND VISION PLUS IS PURCHASED, PLEASE NOTE HMO PRIMARY DENTIST #

ADDITION OF A NEWBORN OR ADOPTED CHILD TO AN EXISTING POLICY

Newborn/Adopted child's last name:	First name:	MI:

Effective date:[3] (mm/dd/yy): / /	Newborn/Adopted child's date of birth (mm/dd/yy): / /	Date of adoption/placement for adoption (mm/dd/yy): / /	☐ Male ☐ Female

Social Security number: – –	Primary subscriber's member ID:

If you are adding an eligible newborn/adopted child to a CommunityCare HMO plan, you must select a primary care physician from the CommunityCare Network. If you do not select a primary care physician, one will be selected for you within your regional area.

Primary care physician ID:	Current patient: ☐ Yes ☐ No

GENERAL CONDITIONS: If your application is not received within 60 days of the birth date or date of adoption, Health Net of California, Inc. (Health Net) will require that a standard application be completed. No other department, officer, agent, or employee of Health Net is authorized to grant enrollment. The subscriber's broker or agent cannot grant approval, change terms or waive requirements of this application. This application shall become a part of the Plan Contract.

Please remit the first month's premium for a newborn or adopted child. **Please note:** If the child's coverage effective date is other than the first of the month, you will be required to pay additional prorated premiums, which will be added to your next regular premium billing.

The application and Arbitration Clause must be signed by the subscriber. The subscriber must personally sign his or her name in ink and agree to comply with the Arbitration Clause and the terms, conditions and provisions of the application and the Plan Contract in order for this application to be processed. For this application to be considered, neither broker nor any other person may sign this application and Arbitration Clause.

[3]Effective date will be the date of birth or date of adoption (or placement for the purpose of adoption if earlier) if the application is received within 60 days of the birth date or date of adoption.

Last 4 digits of primary applicant's Social Security # or TIN: __ __ __ __

Part IV. Special enrollment period

In addition to the open enrollment period, you and your dependents are eligible to enroll or change plans during a special enrollment period, which is within 60 days of certain qualifying events. Generally, for applications received between the 1st and 15th, coverage will be effective the first day of the month following submission of application. For applications received between the 16th and month's end, coverage will be effective the first day of the second month following submission of application. **Exceptions to these effective dates include birth, adoption, placement for adoption, or through a child support order or other court order, which will be effective the date of the qualifying event or court order. Marriage will be effective the first day of the month after the application receipt.** The application must be received within 60 days[4] of the qualifying event. Proof of the qualifying event is required. Please write in the applicable qualifying event below and the name of the person to whom it applies. For additional dependents, please attach a separate sheet of paper.

QUALIFYING EVENT # (SEE CHART ON NEXT PAGE)	DATE OF EVENT	PRIMARY APPLICANT	SPOUSE/DOMESTIC PARTNER	DEPENDENT 1	DEPENDENT 2	DEPENDENT 3

[4]If your application is received before the loss of coverage, your effective date will be the first day of the month following the loss of coverage. If the application is received during the 60-day period after the loss of coverage, the effective date will be the first day of the month after the application receipt.

(continued)

Last 4 digits of primary applicant's Social Security # or TIN: __ __ __ __

Part IV. Special enrollment period (continued)

QUALIFYING EVENT		EXAMPLES OF CALIFORNIA DOCUMENTATION
1)	The qualified individual or the qualified individual's dependent loses minimum essential coverage which could be due to one of the following reasons (not including voluntary termination of your previous coverage or termination due to failure to pay premium). For these events, you may be eligible to enroll 60 days before or after the qualifying event:	Copy of one of the following: • Front and back of previous insurance carrier's ID card. • Letter from previous carrier documenting loss of coverage. • Termination or hour reduction confirmation from employer (must be on employer letterhead and signed by employer management).
	A. The death of the covered employee.	
	B. The termination or reduction of hours of the covered employee's employment.	
	C. The divorce or legal separation of the covered employee from the employee's spouse.	
	D. The covered employee becoming entitled to benefits under Medicare.	
	E. A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan.	
	F. A proceeding in a case under Title 11 bankruptcy, commencing on or after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time. In this case, a loss of coverage includes a substantial elimination of coverage with respect to a qualified beneficiary (spouse/domestic partner, dependent child, or surviving spouse/domestic partner) within one year before or after the date of commencement of the proceeding.	
	G. Is enrolled in any non-calendar year group health plan or individual health insurance coverage, even if the qualified individual or the qualified individual's dependent has the option to renew such coverage. The date of the loss of coverage is the last day of the plan or policy year.	
	H. Loss of minimum essential coverage for any reason other than failure to pay premiums or situations allowing for a rescission for fraud or intentional misrepresentation of material fact.	• Letter from applicant supporting qualifying event. • Letter from previous carrier documenting loss of coverage.
	I. Termination of employer contributions.	Notice from employer of contributions termination.
	J. Exhaustion of COBRA continuation coverage.	COBRA paperwork reflecting exhaustion of coverage.
	K. The qualified individual loses medically needy coverage under Medi-Cal or Medicaid (not including voluntary termination of your previous coverage or termination due to failure to pay premium).	Medi-Cal or Medicaid documentation.
	L. The qualified individual loses pregnancy-related coverage under Medi-Cal or Medicaid (not including voluntary termination of your previous coverage or termination due to failure to pay premium).	Medi-Cal or Medicaid documentation.
2)	A. The qualified individual gains a dependent or becomes a dependent through marriage, domestic partnership, birth, adoption, placement for adoption, or assumption of a parent-child relationship.	• Marriage certificate. • Declaration of domestic partnership. • Certificate of registered domestic partnership. • Notarized affidavit of assumption of parent-child relationship. • Birth certificate.
	B. The enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by State law in the State in which the divorce or legal separation occurs, or if the enrollee, or the enrollee's dependent dies.	• Discharge records. • Court order documentation for adoption. • Certificate of divorce decree. • Legal separation agreement. • Death certificate.

(continued)

Last 4 digits of primary applicant's Social Security # or TIN: __ __ __ __

Part IV. Special enrollment period (continued)

	QUALIFYING EVENT	EXAMPLES OF CALIFORNIA DOCUMENTATION
3)	The qualified individual's or the qualified individual's dependent's enrollment or non-enrollment in a health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct, or inaction of an officer, employee, a non-Exchange entity providing enrollment assistance or conducting enrollment activities, or agent of the Exchange or the Department of Health and Human Services, or its instrumentalities as evaluated and determined by the Exchange.	• Front and back of previous carrier ID card. • Letter from Exchange or HHS documenting qualifying event.
4)	The health plan in which the enrollee or the enrollee's dependent is enrolled substantially violated a material provision of its contract.	Resolution document from the Exchange or other plan.
5)	The qualified individual or enrollee, or the qualified individual's or enrollee's dependent, gains access to a new health plan as a result of a permanent move.	Copy of acceptable proof of residency documents: • Current driver's license or identification card. • Current and valid state vehicle registration form in the applicant's name. • Evidence the applicant is employed. • Evidence the applicant has registered with a public or private employment agency. • Evidence that the applicant has enrolled the applicant's children in a school. • Evidence that the applicant is receiving public assistance. • Voter registration form of receipt, voter notification card or an abstract of voter registration. • Current utility bill in the applicant's name. • Current rent or mortgage payment receipt in the applicant's name. Rent receipts provided by a relative shall not be accepted. • Mortgage deed showing primary residency. • Lease agreement in the applicant's name. • Government mail in the applicant's name (SSA statement, DMV notice, etc.). • Cell phone bill. • Credit card statement. • Bank statement or canceled check with printed name and address. • U.S. Postal Service change of address confirmation letter. • Moving company contract or receipt showing your address. • If you're living in the home of another person, like a family member, friend, or roommate, you may send a letter/statement from that person stating that you live with them and aren't just temporarily visiting. This person must prove their own residency by including one of the documents listed above. • If you're homeless or in transitional housing, you may submit a letter or statement from another resident of the same state, stating that they know where you live and can verify that you live in the area and aren't just temporarily visiting. This person must prove their own residency by including one of the documents listed above. • Letter from a local non-profit social services provider (excluding non-profit health care providers) or government entity (including a shelter) that can verify that you live in the area and aren't just visiting.
6)	The qualified individual is mandated to be covered as a dependent pursuant to a valid state or federal court order.	Court documentation.
7)	The qualified individual has been released from incarceration.	Probation or parole release paperwork showing date of event.

(continued)

Last 4 digits of primary applicant's Social Security # or TIN: __ __ __ __

Part IV. Special enrollment period (continued)

	QUALIFYING EVENT	EXAMPLES OF CALIFORNIA DOCUMENTATION
8)	The qualified individual was receiving services under another health benefit plan from a contracting provider who is no longer participating in that health plan's network for any of the following conditions: (a) an acute condition (a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration); (b) a serious chronic condition (a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration); (c) a terminal illness (an incurable or irreversible condition that has a high probability of causing death within one year or less); (d) a pregnancy; (e) care of a newborn between birth and 36 months; or (f) a surgery or other procedure that has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered member, and that provider is no longer participating in the health plan.	• Letter from health plan that documents the provider's termination from the network. AND • Letter from provider that documents the condition of the enrollee.
9)	The qualified individual demonstrates to the Exchange that the qualified individual did not enroll in a health benefit plan during the immediately preceding enrollment period available to the individual because the qualified individual was misinformed that the qualified individual was covered under minimum essential coverage.	• Letter from applicant supporting the qualifying event. • Copy of the plan renewal letter.
10)	The qualified individual is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code.	Active duty discharge documentation.
11)	Newly eligible or ineligible for advance payments of the premium tax credit or have a change in eligibility for cost-sharing reductions.	Advanced Premium Tax Credit (APTC) paperwork that shows the premium assistance you are eligible for.
12)	A qualified individual or enrollee is a victim of domestic abuse or spousal abandonment, including a dependent or unmarried victim within a household, is enrolled in minimum essential coverage and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment; or is a dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim.	A signed written statement under penalty of perjury stating your name and names of the victims of domestic abuse who enrolled in coverage.
13)	The individual or dependent applies for coverage through Covered California during the annual open enrollment period or due to a qualifying event, is assessed by Covered California as potentially eligible for Medi-Cal, and is determined ineligible for Medi-Cal either after open enrollment has ended or more than 60 days after the qualifying event; or applies for coverage with Medi-Cal during the annual open enrollment period, and is determined ineligible after open enrollment has ended.	Denial of eligibility letter from Covered California or Medi-Cal.
14)	The qualified individual adequately demonstrates to Covered California that a material error related to plan benefits, service area or premium influenced the qualified individual's decision to purchase coverage through Covered California.	A signed written statement under penalty of perjury stating your name, name of the health plan, what error occurred, and the date on which the error occurred.

Last 4 digits of primary applicant's Social Security # or TIN: __ __ __ __

Part V. Proof of permanent residency requirement

Health Net requires that, as an applicant, you must currently be a permanent California resident and that your initial premium be paid prior to considering your enrollment application.

Upon review of your application, Health Net reserves the right to request additional information in order to establish the applicant's residency.

Please note that a permanent residence does not include a move to a medical facility to receive medical treatment or visiting within a service area for the purpose of obtaining medical care.

Acceptable proof documents include:

- Current California driver's license or identification card.
- Current and valid California vehicle registration form in the applicant's name.
- Evidence the applicant is employed in California.
- Evidence the applicant has registered with a public or private employment agency in California.
- Evidence that the applicant has enrolled the applicant's children in a California school.
- Evidence that the applicant is receiving public assistance in California.
- Voter registration form of receipt, voter notification card or an abstract of a voter registration.
- Current California utility bill in the applicant's name.
- Current California rent or mortgage payment receipt in the applicant's name. Rent receipts provided by a relative shall not be accepted.
- Mortgage deed showing primary residency.
- Lease agreement in the applicant's name.
- Government mail in the applicant's name (SSA statement, DMV notice, etc.).
- Cell phone bill.
- Credit card statement.
- Bank statement or canceled check with printed name and address.
- US Postal Service change of address confirmation letter.
- Moving company contract or receipt showing your address.
- If you're living in the home of another person, like a family member, friend or roommate, you may send a letter/statement from that person stating that you live with them and aren't just temporarily visiting. This person must prove their own residency by including one of the documents listed above.
- If you're homeless or in transitional housing, you may submit a letter or statement from another resident of the same state, stating that they know where you live and can verify that you live in the area and aren't just temporarily visiting. This person must prove their own residency by including one of the documents listed above.
- Letter from a local nonprofit social services provider (excluding nonprofit health care providers) or government entity (including a shelter) that can verify that you live in the area and aren't just visiting.

If the application is for a child-only policy, proof of residency for where the child resides is required from a parent or legal guardian.

Last 4 digits of primary applicant's Social Security # or TIN: __ __ __ __

Part VI. Individual & Family Plans Exception to Standard Enrollment – Statement of Accountability regarding language assistance

Instructions for Part VI: The following process is to be used when the applicant cannot complete the application because the applicant cannot read, write and/or speak the language of the application. Health Net requires that if you need assistance in completing this application, you must employ the services of a qualified interpreter. Please contact Health Net at 1-877-609-8711 for information about qualified interpreter services and how to obtain them. This form must be submitted with the Individual & Family Plan enrollment application when applicable.

Health Net qualified interpreter – Please complete the following when assisted by a Health Net qualified interpreter.

I, _____, was assisted in the completion of this application by a qualified interpreter authorized by Health Net because I:

☐ Do not read the language of this application. ☐ Do not speak the language of this application.

☐ Do not write the language of this application. ☐ Other (explain): _____

A qualified interpreter assisted me with the completion of: ☐ The entire application.

☐ Other (explain): _____

A qualified interpreter read this application to me in the following language: _____

SIGNATURES AND DATE (required in ink)

Signature of applicant:	Today's date: / /
Date application was interpreted: / /	Time application was interpreted:
Qualified interpreter number: ( )	

Qualified interpreter other than a Health Net qualified interpreter – Please complete the following when assisted by a qualified interpreter other than a Health Net qualified interpreter.

If a qualified interpreter, other than a qualified interpreter provided by Health Net, assisted you in completing this application, the interpreter must complete the following:

I, _____, understand that a qualified interpreter should: (a) have the vocabulary equivalent of a native speaker that has received an advanced education (college or university equivalent) in the non-English language; (b) be able to demonstrate cultural sensitivity in their communication, taking into consideration that every language encompasses a wide range of variation; (c) have native speaker language skills (native speaker language skills are developed by growing up or functioning in a language community); and (d) have corresponding reading and writing skills in the non-English language (the reading and writing skills would be demonstrated by advanced education in the native language).

As a qualified interpreter, I personally read and completed the application for the applicant named above because:

☐ Applicant does not read the language of this application. ☐ Applicant does not speak the language of this application.

☐ Applicant does not write the language of this application. ☐ Other (explain): _____

Under the penalty of perjury, I declare that I read to the applicant:

☐ The entire application. ☐ Other (explain): _____

I read this application to the applicant in the following language: _____

Please provide the following information regarding the qualified interpreter who assisted the applicant and who is not a Health Net qualified interpreter:

Last name:		First name:	
Address of qualified interpreter:			
City:	State:	ZIP:	Phone: ( )
Qualified interpreter signature:		Date: / /	

Last 4 digits of primary applicant's Social Security # or TIN: _ _ _ _

Part VII. Applicant's agent/broker information

Complete agent/broker name and address are necessary for correspondence to be sent to the agent/broker.

National Producer Number (NPN) of Health Net-contracted agency or broker:	**Health Net direct sales agent ID:**
Name (print): Jorge Jiron	Phone number: (760-942-7684
Address: 1103 Quail Gardens Ct	
Email address: jorge@bestquoteinsurance.net	
Applicant's agent/broker signature/number (required):	**Date signed (required):** / /

Agent/broker certification

I, _____ (name of agent/broker),

(NOTE: You must select the appropriate box. You may only select one box.)

(_____) did not assist the applicant(s) in any way in completing or submitting this application. All information was completed by the applicant(s) with no assistance or advice of any kind from me. I understand that if any portion of this statement by me is false, I may be subject to civil penalties, including but not limited to a fine of up to $10,000.

OR

(_____) assisted the applicant(s) in submitting this application. I advised the applicant(s) that the applicant should answer all questions completely and truthfully and that no information requested on the application should be withheld. I explained that withholding information could result in rescission or cancellation of coverage in the future. The applicant(s) indicated to me that the applicant understood these instructions and warnings. To the best of my knowledge, the information on the application is complete and accurate. I understand that if any portion of this statement by me is false, I may be subject to civil penalties, including but not limited to a fine of up to $10,000.

Please answer all questions 1 through 3.

1. **Who filled out and completed the application form? (print full name)**

_____

2. Did you personally witness the applicant(s) sign the application? ☐ Yes ☐ No

3. Did you review the application after the applicant(s) signed it? ☐ Yes ☐ No

Last 4 digits of primary applicant's Social Security # or TIN: __ __ __ __

Part VIII. Conditions of enrollment

GENERAL CONDITIONS: Health Net reserves the right to reject any application for enrollment if the applicant is not eligible for coverage due to not meeting eligibility conditions. There is no coverage unless this application is accepted by Health Net's Membership Department and a Notice of Acceptance is issued to the applicant even though you paid money to Health Net for the first month's premium. No other department, officer, agent, or employee of Health Net is authorized to grant enrollment. The applicant's agent or broker cannot grant approval, change terms or waive requirements of this application. This application shall become a part of the Plan Contract.

WHEN HEALTH NET CAN RESCIND A PLAN CONTRACT

Within the first 24 months of coverage, Health Net may rescind a Plan Contract for any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact in the written information submitted by you, or on your behalf, on or with your enrollment application.

A material fact is information which, if known to Health Net, would have caused Health Net to decline to issue coverage.

If the Plan Contract is rescinded, Health Net shall have no liability for the provision of coverage under the Plan Contract.

By signing this application, you represent that all responses are true, complete and accurate and that the application will become part of the Plan Contract between Health Net and you. By signing this application, you further agree to comply with the terms of the Plan Contract.

If, after enrollment, Health Net investigates your application information, Health Net must notify you of this investigation, the basis of the investigation, and offer you an opportunity to respond.

If Health Net makes a decision to rescind your coverage, such decision will be first sent for review to an independent third-party auditor contracted by Health Net.

If the Plan Contract is rescinded, Health Net will provide a 30-day written notice prior to the effective date of the rescission that will:

1. explain the basis of the decision;
2. provide the effective date of the rescission;
3. clarify that all members covered under your coverage other than the individual whose coverage is rescinded may continue to remain covered;
4. explain that your monthly premium will be modified to reflect the number of members that remain under the Plan Contract;
5. explain your right and the options you have of going to both Health Net and/or the Department of Managed Health Care if you do not agree with Health Net's decision; and
6. include a Right to Request Review form. You have 180 days from the date of the Notice of Cancellation, Rescission or Nonrenewal to submit the Right to Request form to Health Net and/or the Department of Managed Health Care.

If the Plan Contract is rescinded:

1. Health Net may revoke your coverage as if it never existed, and you will lose health benefits including coverage for treatment already received;
2. Health Net will refund all premium amounts paid by you, less any medical expenses paid by Health Net on behalf of you and may recover from you any amounts paid under the Plan Contract from the original date of coverage; and
3. Health Net reserves its right to obtain any other legal remedies arising from the rescission that are consistent with California law.

If Health Net denies your appeal, you have the right to seek assistance from the California Department of Managed Health Care.

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. Health Net uses and may disclose this information for purposes of treatment, payment and health plan operations, including but not limited to, utilization management, quality improvement, and disease or case management programs. Health Net's Notice of Privacy Practices is included in the Plan Contract, and I may also obtain a copy of this Notice on the website at www.myhealthnetca.com or through the Health Net Customer Contact Center. Authorization for use and disclosure of protected health information shall be valid for a period of 24 months from the date of my signature on the next page.

IF SOLE APPLICANT IS A MINOR: If the sole applicant under this application is under 18 years of age, the applicant's parent or legal guardian must sign as such. By signing, the applicant does hereby agree to be legally responsible for the accuracy of information in this application and for payments of premiums. If such responsible party is not the natural parent of the applicant, copies of the court papers authorizing guardianship must be submitted with this application.

IF APPLICANT CANNOT READ THE LANGUAGE OF THIS APPLICATION: If an applicant does not read the language of this application and an interpreter assisted with the completion of the application, the applicant must sign and submit the Statement of Accountability (see Part VI of this application, "Individual & Family Plans Exception to Standard Enrollment – Statement of Accountability regarding language assistance").

Last 4 digits of primary applicant's Social Security # or TIN: __ __ __ __

Part IX. Important provisions

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.

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health care services, plans or insurance companies as a condition of obtaining coverage.

ACKNOWLEDGEMENT AND AGREEMENT: I, the applicant, understand and agree that by enrolling with or accepting services from Health Net, I and any enrolled dependents shall comply with the terms, conditions and provisions of the Plan Contract. To obtain a copy of the Plan Contract, call Health Net at 1-877-609-8711. **I, the applicant, 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: I, the applicant, understand and agree that any and all disputes between me (including any of my enrolled family members or heirs or personal representatives) and Health Net must be submitted to final and binding arbitration instead of a jury or court trial. This Agreement to arbitrate includes any disputes arising from or relating to the Plan Contract or my Health Net coverage, stated under any legal theory. This agreement to arbitrate any disputes applies even if other parties, such as health care providers or their agents or employees, are involved in the dispute. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties including Health Net are giving up their constitutional right to have their dispute decided in a court of law by a jury. I also hereby waive all rights to participate in any class action or class arbitration. I also understand that disputes that I may have with Health Net involving claims for medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) are also subject to final and binding arbitration. I understand that a more detailed arbitration provision is included in the Plan Contract. Mandatory Arbitration may not apply to certain disputes if the Plan Contract is subject to ERISA, 29 U.S.C. §§ 1001-1461. My signature below indicates that I understand and agree with the terms of this Binding Arbitration Agreement and agree to submit any disputes to binding arbitration instead of a court of law.

Applicant, or parent or legal guardian if applicant is under age 18: Print name: _____ Signature: _____	Date signed:	Signature of applicant's dependent (age 18 or older):	Date signed:
Signature of spouse/domestic partner or applicant's dependent (age 18 or older):	Date signed:	Signature of applicant's dependent (age 18 or older):	Date signed:
Signature of applicant's dependent (age 18 or older):	Date signed:	Signature of applicant's dependent (age 18 or older):	Date signed:

(continued)

Last 4 digits of primary applicant's Social Security # or TIN: _ _ _ _

The application and this Arbitration Clause must be signed by the applicant(s). The applicant(s) must personally sign the applicant's name in ink and agree to comply with the Arbitration Clause and the terms, conditions and provisions of the application and the Plan Contract in order for this application to be processed. For this application to be considered, neither agent/broker nor any other person may sign this application and Arbitration Clause.

You may submit a photocopy or facsimile of the application and authorizations. Health Net recommends that you retain a copy of this application and authorizations for your records.

All references to "Health Net" herein include the affiliates and subsidiaries of Health Net which underwrite or administer the coverage to which this enrollment application applies. "Plan Contract" refers to the Health Net of California, Inc. combined Plan Contract and Evidence of Coverage.

Last 4 digits of primary applicant's Social Security # or TIN: __ __ __ __

Part X. Instructions for submitting your enrollment application and check to Health Net.

- **Mail your completed application to:**
  Health Net Individual and Family Enrollment
  PO BOX 1150
  Rancho Cordova, CA 95754
- **Or, FAX your completed application to 1-800-977-4161.**
- **And, mail your check and the completed form below to:**
  Health Net CA Individual
  PO BOX 748705
  Los Angeles, CA 90074-8705

Cut here

To help ensure your payment is applied to your application, mail your check with this completed form to:

Health Net CA Individual
PO BOX 748705
Los Angeles, CA 90074-8705

Applicant information

Applicant's name:	
Applicant's address	
Applicant's birth date (mm/dd/yy): / /	Applicant's Social Security number: – –

Cut here

Nondiscrimination Notice

In addition to the State of California nondiscrimination requirements (as described in benefit coverage documents), Health Net of California, Inc. (Health Net) complies with applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, sexual orientation, age, disability, or sex.

HEALTH NET:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at:
Individual & Family Plan (IFP) Members On Exchange/Covered California 1-888-926-4988 (TTY: 711)
Individual & Family Plan (IFP) Members Off Exchange 1-800-839-2172 (TTY: 711)
Individual & Family Plan (IFP) Applicants 1-877-609-8711 (TTY: 711)
Group Plans through Health Net 1-800-522-0088 (TTY: 711)

If you believe that Health Net has failed to provide these services or discriminated in another way based on one of the characteristics listed above, you can file a grievance by calling Health Net's Customer Contact Center at the number above and telling them you need help filing a grievance. Health Net's Customer Contact Center is available to help you file a grievance. You can also file a grievance by mail, fax or email at:

Health Net of California, Inc. Appeals & Grievances
PO Box 10348
Van Nuys, CA 91410-0348

Fax: 1-877-831-6019
Email: Member.Discrimination.Complaints@healthnet.com (Members) or
Non-Member.Discrimination.Complaints@healthnet.com (Applicants)

If your health problem is urgent, if you already filed a complaint with Health Net of California, Inc. and are not satisfied with the decision or it has been more than 30 days since you filed a complaint with Health Net of California, Inc., you may submit an Independent Medical Review/Complaint Form with the Department of Managed Health Care (DMHC). You may submit a complaint form by calling the DMHC Help Desk at 1-888-466-2219 (TDD: 1-877-688-9891) or online at www.dmhc.ca.gov/FileaComplaint.

If you believe you have been discriminated against because of race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights (OCR), electronically through the OCR Complaint Portal, at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

English
No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, if you have an ID card, please call the Customer Contact Center number. Employer group applicants please call Health Netôs Commercial Contact Center at 1-800-522-0088 (TTY: 711). Individual & Family Plan (IFP) applicants please call 1-877-609-8711 (TTY: 711).

Arabic
خدمات لغوية مجانية. يمكننا أن نوفر لك مترجم فوري. ويمكننا أن نقرأ لك الوثائق بلغتك. للحصول على المساعدة، يرجى الاتصال برقم مركز خدمة العملاء المبين على بطاقتك. فيما يتعلق بمقدمي طلبات مجموعة صاحب العمل، يرجى التواصل مع مركز الاتصال التجاري في Health Net عبر الرقم: 1-800-522-0088 (TTY: 711). فيما يتعلق بمقدمي طلبات خطة الأفراد والعائلة، يرجى الاتصال بالرقم 1-877-609-8711 (TTY: 711).

Armenian
Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեր լեզվով: Եթե ID քարտ ունեք, օգնության համար խնդրում ենք զանգահարել Հաճախորդների սպասարկման կենտրոնի հեռախոսահամարով: Գործատուի խմբի դիմորդներին խնդրում ենք զանգահարել Health Net-ի Կոմերցիոն սպասարկման կենտրոն՝ 1-800-522-0088 հեռախոսահամարով (TTY՝ 711): Individual & Family Plan (IFP) դիմորդներին խնդրում ենք զանգահարել 1-877-609-8711 հեռախոսահամարով (TTY՝ 711):

Chinese
免費語言服務。您可使用口譯員服務。您可請人將文件唸給您聽並請我們將某些文件翻譯成您的語言寄給您。如需協助且如果您有會員卡，請撥打客戶聯絡中心電話號碼。雇主團保計畫的申請人請撥打 1-800-522-0088（聽障專線：711）與 Health Net 私人保險聯絡中心聯絡。Individual & Family Plan (IFP) 的申請人請撥打 1-877-609-8711（聽障專線：711）。

Hindi
बिना शुल्क भाषा सेवाएं। आप एक दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेजों को अपनी भाषा में पढ़वा सकते हैं। मदद के लिए, यदि आपके पास आईडी कार्ड है तो कृपया ग्राहक संपर्क केंद्र के नंबर पर कॉल करें। नियोक्ता सामूहिक आवेदक कृपया हेल्थ नेट के कमर्शियल संपर्क केंद्र को 1-800-522-0088 (TTY: 711) पर कॉल करें। व्यक्तिगत और फैमिली प्लान (आईएफपी) आवेदक कृपया 1-877-609-8711 (TTY: 711) पर कॉल करें।

Hmong
Tsis Muaj Tus Nqi Pab Txhais Lus. Koj tuaj yeem tau txais ib tus kws pab txhais lus. Koj tuaj yeem muaj ib tus neeg nyeem cov ntaub ntawv rau koj ua koj hom lus hais. Txhawm rau pab cuam, yog tias koj muaj daim npav ID, thov hu rau Neeg Qhua Lub Chaw Tiv Toj tus npawb. Tus tswv ntiav neeg ua haujlwm pab pawg sau ntawv thov ua haujlwm thov hu rau Health Net Qhov Chaw Tiv Toj Kev Lag Luam ntawm 1-800-522-0088 (TTY: 711). Tus Neeg thiab Tsev Neeg Qhov Kev Npaj (IFP) cov neeg thov ua haujlwm thov hu rau 1-877-609-8711 (TTY: 711).

Japanese
無料の言語サービスを提供しております。通訳者もご利用いただけます。日本語で文書をお読みすることも可能です。ヘルプについては、IDカードをお持ちの場合は顧客連絡センターまでお電話ください。雇用主を通じた団体保険の申込者の方は、Health Netの顧客連絡センター（1-800-522-0088、TTY: 711）までお電話ください。個人・家族向けプラン（IFP）の申込者の方は、1-877-609-8711（TTY: 711）までお電話ください。

Khmer

សេវាភាសាដោយឥតគិតថ្លៃ។ លោកអ្នកអាចទទួលបានអ្នកបកប្រែផ្ដាល់មាត់។ លោកអ្នកអាចស្ដាប់គេអានឯកសារឱ្យ លោកអ្នកជាភាសារបស់លោកអ្នក។ សម្រាប់ជំនួយ ប្រសិនបើលោកអ្នកមានប័ណ្ណសម្គាល់ខ្លួន សូមហៅទូរស័ព្ទទៅកាន់លេខរបស់មជ្ឈមណ្ឌលទំនាក់ទំនងអតិថិជន។ អ្នកដាក់ពាក្យសុំគម្រោងជាក្រុមដែលជាបុគ្គលិក សូមហៅទូរស័ព្ទទៅកាន់មជ្ឈមណ្ឌលទំនាក់ទំនងរបស់ Health Net តាមរយៈលេខ 1-800-522-0088 (TTY: 711)។ អ្នកដាក់ពាក្យសុំគម្រោងជាលក្ខណៈបុគ្គល និងក្រុមគ្រួសារ (IFP) សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-877-609-8711 (TTY: 711)។

Korean

무료 언어 서비스입니다. 통역 서비스를 받으실 수 있습니다. 문서 낭독 서비스를 받으실 수 있으며 일부 서비스는 귀하가 구사하는 언어로 제공됩니다. 도움이 필요하시면 ID 카드에 수록된 번호로 고객서비스 센터에 연락하십시오. 고용주 그룹 신청인의 경우 Health Net의 상업 고객서비스 센터에 1-800-522-0088(TTY: 711)번으로 전화해 주십시오. 개인 및 가족 플랜(IFP) 신청인의 경우 1-877-609-8711(TTY: 711)번으로 전화해 주십시오.

Navajo

Doo bą́ą́h íllínígóó saad bee háká ada'iiyeed. Ata' halne'ígíí da ła' ná hádídóot'įįł. Naaltsoos da t'áá shí shizaad k'ehjí shichį' yídooltah nínízingo t'áá ná ákódoolníłł. Ákót'éego shíká a'doowoł nínízingo Customer Contact Center hoolyéhíjį' hodíílnih ninaaltsoos nanitingo bee néého'dolzinígíí hodoonihjį' bikáá'. Naaltsoos nehiltsóosgo naanish bá dahikahígíí éí kojį' hodíílnih Health Net's Commercial Contact Center 1-800-522-0088 (TTY: 711). T'áá hó dóó ha'áłchíní (IFP) báhígíí éí kojį' hojilnih 1-877-609-8711 (TTY: 711).

Persian (Farsi)

خدمات زبان بدون هزینه. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید اسناد به زبان شما برایتان خوانده شوند. برای دریافت کمک، اگر کارت شناسایی دارید، لطفاً با شماره مرکز تماس مشتریان تماس بگیرید. متقاضیان گروه کارفرما لطفاً با مرکز تماس تجاری Health Net به شماره 1-800-522-0088 (TTY:711) تماس بگیرند. متقاضیان طرح فردی و خانوادگی (IFP)* لطفاً با شماره 1-877-609-8711 (TTY:711) تماس بگیرید.

Panjabi (Punjabi)

ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਦੀ ਸੇਵਾ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਜੇ ਤੁਹਾਡੇ ਕੋਲ ਇੱਕ ਆਈਡੀ ਕਾਰਡ ਹੈ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। ਮਾਲਕ ਦਾ ਗਰੁੱਪ ਬਿਨੈਕਾਰ, ਕਿਰਪਾ ਕਰਕੇ ਹੈਲਥ ਨੈੱਟ ਦੇ ਵਪਾਰਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ 1-800-522-0088 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਯੋਜਨਾ (IFP) ਬਿਨੈਕਾਰਾਂ ਨੂੰ ਕਿਰਪਾ ਕਰਕੇ 1-877-609-8711 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Russian

Бесплатная помощь переводчиков. Вы можете получить помощь переводчика. Вам могут прочитать документы на Вашем родном языке. Если Вам нужна помощь и у Васпри себе есть карточка участника плана, звоните по телефону Центра помощи клиентам. Участники коллективных планов, предоставляемых работодателем: звоните в коммерческий центр помощи Health Net по телефону 1-800-522-0088 (TTY: 711). Участники планов для частных лиц и семей (IFP): звонитепо телефону 1-877-609-8711 (TTY: 711).

Spanish
Servicios de idiomas sin costo. Puede solicitar un intérprete, obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, si tiene una tarjeta de identificación, llame al número del Centro de Comunicación con el Cliente. Los solicitantes del grupo del empleador deben llamar al Centro de Comunicación Comercial de Health Net, al 1-800-522-0088 (TTY: 711). Los solicitantes de planes individuales y familiares deben llamar al 1-877-609-8711 (TTY: 711).

Tagalog
Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo sa inyong wika. Para sa tulong, kung mayroon kayong ID card, mangyaring tumawag sa numero ng Customer Contact Center. Para sa mga grupo ng mga aplikante ng tagapag-empleyo, mangyaring tumawag sa Commercial Contact Center ng Health Net sa 1-800-522-0088 (TTY: 711). Para sa mga aplikante ng Planong Pang-indibiduwal at Pampamilya (Individual & Family Plan, IFP), mangyaring tumawag sa 1-877-609-8711 (TTY: 711).

Thai
ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังเป็นภาษาของคุณได้ หากต้องการความช่วยเหลือ และคุณมีบัตรประจำตัว โปรดโทรหมายเลขศูนย์ลูกค้าสัมพันธ์ ผู้สมัครกลุ่มนายจ้าง โปรดโทรหาศูนย์ลูกค้าสัมพันธ์เชิงพาณิชย์ของ Health Net ที่หมายเลข 1-800-522-0088 (โหมด TTY: 711) ผู้สมัครแผนบุคคลและครอบครัว (Individual & Family Plan: IFP) โปรดโทร 1-877-609-8711 (โหมด TTY: 711)

Vietnamese
Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu cầu được đọc cho nghe tài liệu bằng ngôn ngữ của quý vị. Để được giúp đỡ, nế u quý vị có thẻ ID, vui lòng gọi đến số điện thoại của Trung Tâm Liên Lạc Khách Hàng. Những người nộp đơn xin bảo hiểm nhóm qua hãng sở vui lòng gọi Trung Tâm Liên Lạc Thương Mại của Health Net theo số 1-800-522-0088 (TTY: 711). Người nộp đơn thuộc Chương Trình Cá Nhân & Gia Đình (IFP), vui lòng gọi số 1-877-609-8711 (TTY: 711).

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