Make the Most of Your Plan

GET YOUR SUMMARY OF BENEFITS AND COVERAGE

Thank you for applying for a PureCare One EPO 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 PureCare One EPO 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.

FLY047402EH00 (1/21)

Health Net Life Insurance Company (Health Net)

Individual & Family Plans PureCare One EPO

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 insurance, 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 a SSN or TIN for yourself or a 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 PureCare One EPO 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 (You must provide proof of residency[2] upon submission for your application to be complete.):			
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:	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 8, 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 premium payment ☐ Pay by check (Amount must match monthly premium.)

Mailing application	**Faxing application**	**Mailing your check**
Mail completed application and proof of permanent residency document to: Health Net Individual & Family Enrollment PO Box 1150 Rancho Cordova, CA 95741-1150	Fax completed application and proof of permanent residency document to 1-800-977-4161.	Complete the form on page 12 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 premiums

The policyholder is responsible for payment of premiums to Health Net. Except for family members of the policyholder or as required by law, Health Net does not accept payments of premiums on behalf of the policyholder directly or indirectly from a hospital, home health care agency, hospice, outpatient surgical center, physician, qualified autism provider, residential treatment center, skilled nursing facility, or other entities or persons which provide covered services and supplies. An insurance agent or broker may remit payment of premiums to Health Net on behalf of the insured using only funds received from the insured or the insured's family members. Health Net will not accept payment of premiums remitted by an agent or broker using funds from financially interested third parties that are not authorized by law to pay premiums on behalf of the insured. Upon discovery of any unacceptable payment described in this section, Health Net will return it and inform the policyholder that the payment is rejected and that the premium remains due. A 30-day Grace Period will be allowed for payment of the premium due, beginning on the date that Health Net notifies the policyholder that the payment was rejected. If Health Net does not receive payment on or before the last day of the Grace Period, Health Net will cancel coverage after the end of the Grace Period. Refer to the "Grace Periods" provision in the "Term of Policy and Premiums" section of the policy for further information.

B. CHOICE OF COVERAGE

Health Net Life Insurance Company EPO plans utilize Health Net's PureCare One EPO provider network.

- ☐ **Platinum 90 PureCare One EPO**
- ☐ **Gold 80 PureCare One EPO**
- ☐ **Silver 70 Off Exchange PureCare One EPO**
- ☐ **Bronze 60 PureCare One EPO**
- ☐ **Minimum Coverage PureCare One EPO** – Available to individuals who are under age 30. You may also be eligible for this plan if you are age 30 or older and are exempt from the federal requirement to maintain minimum essential coverage. Proof of exemption must be submitted with this application.

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

- ☐ **Dental**[3] **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.

[3]The Dental plan is an indemnity/scheduled reimbursement plan.

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. Out-of-network pediatric dental and vision coverage is not included on PureCare One EPO plans.

SERVICE AREA ELIGIBILITY REQUIREMENT

Applicants must reside in one of the following counties in the state of California: Contra Costa, Marin, Merced, Napa, Orange, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus and Tulare.

In addition, the service area consists of the following partial counties:

Kern: For ZIP codes 93203, 93205, 93206, 93215, 93216, 93220, 93222, 93224, 93225, 93226, 93238, 93240, 93241, 93243, 93249, 93250, 93251, 93252, 93255, 93263, 93268, 93276, 93280, 93283, 93285, 93287, 93301, 93302, 93303, 93304, 93305, 93306, 93307, 93308, 93309, 93311, 93312, 93313, 93314, 93380, 93383, 93384, 93385, 93386, 93387, 93388, 93389, 93390, 93501, 93502, 93504, 93505, 93516, 93518, 93519, 93523, 93524, 93531, 93560, 93561, 93581, 93596

Los Angeles: For ZIP codes starting with 906 to 912, inclusive, 915, 917, 918, and 935

Riverside: For ZIP codes 91752, 92201, 92202, 92203, 92210, 92211, 92220, 92223, 92230, 92234, 92235, 92236, 92240, 92241, 92247, 92248, 92253, 92254, 92255, 92258, 92260, 92261, 92262, 92263, 92264, 92270, 92274, 92276, 92282, 92320, 92501, 92502, 92503, 92504, 92505, 92506, 92507, 92508, 92509, 92513, 92514, 92516, 92517, 92518, 92519, 92521, 92522, 92530, 92531, 92532, 92536, 92539, 92543, 92544, 92545, 92546, 92548, 92549, 92551, 92552, 92553, 92554, 92555, 92556, 92557, 92561, 92562, 92563, 92564, 92567, 92570, 92571, 92572, 92581, 92582, 92583, 92584, 92585, 92586, 92587, 92589, 92590, 92591, 92592, 92593, 92595, 92596, 92599, 92860, 92877, 92878, 92879, 92880, 92881, 92882, 92883

San Bernardino: For ZIP codes 91701, 91708, 91709, 91710, 91729, 91730, 91737, 91739, 91743, 91758, 91759, 91761, 91762, 91763, 91764, 91784, 91785, 91786, 92252, 92256, 92268, 92277, 92278, 92284, 92285, 92286, 92301, 92305, 92307, 92308, 92309, 92310, 92311, 92312, 92313, 92314, 92315, 92316, 92317, 92318, 92321, 92322, 92324, 92325, 92327, 92329, 92331, 92333, 92334, 92335, 92336, 92337, 92339, 92340, 92341, 92342, 92344, 92345, 92346, 92347, 92350, 92352, 92354, 92356, 92357, 92358, 92359, 92365, 92368, 92369, 92371, 92372, 92373, 92374, 92375, 92376, 92377, 92378, 92382, 92385, 92386, 92391, 92392, 92393, 92394, 92395, 92397, 92398, 92399, 92401, 92402, 92403, 92404, 92405, 92406, 92407, 92408, 92410, 92411, 92413, 92415, 92418, 92423, 92427

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 insurance 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 policy 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.

You must select a primary care physician. You may choose the same or different 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.

RELATION		LAST NAME	FIRST NAME	MI
☐ Spouse ☐ Domestic partner	☐ Male ☐ Female			
SOCIAL SECURITY NUMBER		**DATE OF BIRTH**	**PURECARE ONE EPO PRIMARY CARE PHYSICIAN ID**	
– –		/ /		
RELATION: CHILD 1		**LAST NAME**	**FIRST NAME**	**MI**
☐ Son ☐ Daughter				
SOCIAL SECURITY NUMBER		**DATE OF BIRTH**	**PURECARE ONE EPO PRIMARY CARE PHYSICIAN ID**	
– –		/ /		
RELATION: CHILD 2		**LAST NAME**	**FIRST NAME**	**MI**
☐ Son ☐ Daughter				
SOCIAL SECURITY NUMBER		**DATE OF BIRTH**	**PURECARE ONE EPO PRIMARY CARE PHYSICIAN ID**	
– –		/ /		
RELATION: CHILD 3		**LAST NAME**	**FIRST NAME**	**MI**
☐ Son ☐ Daughter				
SOCIAL SECURITY NUMBER		**DATE OF BIRTH**	**PURECARE ONE EPO PRIMARY CARE PHYSICIAN ID**	
– –		/ /		

(continued)

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

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

ADDITION OF A DEPENDENT TO AN EXISTING POLICY (newborn, adopted/placed for adoption, stepchild, or assumption of a parent-child relationship, marriage or domestic partnership, and court-ordered coverage)

Dependent last name:	First name:	MI:
Dependent date of birth (mm/dd/yy): / /	Date of adoption/placement for adoption or other applicable qualifying event (mm/dd/yy):	☐ Male ☐ Female
Social Security number: – –	Primary subscriber's member ID:	

If you are adding an eligible newborn/adopted child to a PureCare One EPO plan, you must select a primary care physician from the PureCare One EPO 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: Health Net reserves the right to reject any application for enrollment not received within 60 days of the birth date, date of adoption or other applicable qualifying event. No other department, officer, agent, or employee of Health Net is authorized to grant enrollment. The primary insured's broker or agent cannot grant approval, change terms or waive requirements of this application. This application shall become a part of the Insurance Policy.

Please remit the first month's premium for the dependent 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 primary insured. The primary insured must personally sign the primary insured's name in ink and agree to comply with the Arbitration Clause and the terms, conditions and provisions of the application and the Insurance Policy 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.

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 (see pages 5–7). 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 a child support order or other court order, for which coverage which will be effective the date of the qualifying event or court order. Coverage as a result of marriage, domestic partnership or loss of coverage will be effective the first day of the month after the application receipt.** For applications submitted before loss of coverage, the effective date will be the first day of the month following the loss of coverage.

Applications must be received within 60 days of the qualifying event. Documentation 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

(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):	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. • Discharge records. • Court order documentation for adoption. • Certificate of divorce decree. • Legal separation agreement. • Death 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.	

(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. Please note that a move for the purpose of obtaining medical care (such as a move to an inpatient hospital or similar medical facility to receive medical treatment) is not a "permanent move" for the purposes of this Special Enrollment Period.	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 insured, 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, with respect to health benefit plans offered through the Exchange, or to the California Department of Insurance, with respect to health benefit plans offered outside 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. • Verification of the qualifying event from Covered California or the California Department of Insurance.
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.

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.

Please provide one (1) acceptable proof of permanent residency document, showing the home address that matches the one you listed on page 1 of this application. **If we do not receive your proof of permanent residency document upon submission of your application, your application will be denied.** Health Net reserves the right to investigate the information related to any proof of residency submitted by or on behalf of the applicant and 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 obtain the assistance 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: _____

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

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.

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 explained to the applicant, in easy to understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation.

If I willfully state as true any material fact I know to be false, I shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to ten thousand dollars ($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 Insurance Policy.

ANY FRAUDULENT OR INTENTIONAL MISREPRESENTATION OF MATERIAL FACTS in application materials is cause for disenrollment and rescission of the Insurance Policy during the 24-month period after the Insurance Policy is issued. Health Net may recoup from the policyholder (or from you or from the applicant) any amounts paid for covered services obtained as a result of such fraudulent or intentional misstatement of material fact.

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 the 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 or a notarized affidavit of assumption of parent-child relationship 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").

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 Insurance Policy. To obtain a copy of the Insurance Policy, call Health Net at 1-877-609-8711. I, the applicant, represent that I have read and understand the terms of this application, and my signature below indicates that, to the best of my knowledge and belief, 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, except disputes concerning adverse benefit determinations as defined in 45 CFR 147.136, arising from or relating to the Insurance Policy or my Health Net coverage, must be submitted to individual, final and binding arbitration instead of a jury or court trial, and that I am waiving all rights to class arbitration. This agreement to arbitrate 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, except disputes concerning adverse benefit determinations, 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 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 Insurance Policy. Mandatory Arbitration may not apply to certain disputes if the Insurance Policy 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, except disputes concerning adverse benefit determinations, to binding arbitration instead of a court of law.

(continued)

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

Part IX. Important provisions (continued)

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:

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 Insurance Policy 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. "Insurance Policy" refers to Health Net Life Insurance Company's Individual & Family Plan Policy PureCare One EPO Plan.

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

Part X. Instructions for submitting your enrollment application, proof of permanent residency document and check to Health Net

- **Mail your completed application and proof of permanent residency document to:**
  Health Net Individual and Family Enrollment
  PO BOX 1150
  Rancho Cordova, CA 95754
- **Or, FAX your completed application and proof of permanent residency document 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

Health Net Life Insurance Company (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) Covered Persons On Exchange/Covered California 1-888-926-4988 (TTY: 711)
Individual & Family Plan (IFP) Covered Persons Off Exchange 1-800-839-2172 (TTY: 711)
Individual & Family Plan (IFP) Applicants 1-877-609-8711 (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 Life Insurance Company Appeals & Grievances
PO Box 10348
Van Nuys, CA 91410-0348

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

You may submit a complaint by calling the California Department of Insurance at 1-800-927-4357 or online at https://www.insurance.ca.gov/01-consumers/101-help/index.cfm.

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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