Health Net®
A BETTER DECISION

INDIVIDUAL & FAMILY HEALTH PLANS ENROLLMENT APPLICATION

IMPORTANT ENROLLMENT INSTRUCTIONS

Read all sections carefully. Answer all questions thoroughly. Omissions or incomplete responses could result in a request for medical records and a delay in processing of this Enrollment Application.

- **Print clearly in ink** and **return within 30 calendar days** from the date of signature.
- Primary applicants **must be residents of Arizona**, and all applicants must be **under age 64 ½** to be eligible to apply.
- Persons who are eligible for Medicare coverage are **NOT** eligible for coverage under Health Net of Arizona, Inc. (HNAZ) or Health Net Life Insurance Company (together "Health Net") individual plans.
- If you need assistance to complete this form, please contact your broker or call Health Net toll-free at **1-888-463-4875**
- If you are applying for the HIPAA Portability Coverage described in Section 6, please attach the Certificate of Prior Creditable Coverage form issued to you by your former insurance carrier.
- The Enrollment Application **must be completed and signed by the applicant** and not by insurance brokers.

Return the **completed Enrollment Application and first month's premium for all applicants** in the enclosed return address envelope.
The Enrollment Application must be sent with the first month's premium payable by check or credit card. Make check payable to HNAZ.
Do not send cash. Your health plan and your life insurance premiums will be billed separately.

SECTION 1. TYPE OF APPLICATION

- O New Enrollment Application. Requested effective date:
  - O 1st of month: _____ O 15th of month: _____ O First available: _____
- O Plan change (From and to a current Health Net plan): Subscriber ID #: _____
- O Adding dependent(s). Dependent(s) may only be added to your current plan/deductible option. Subscriber ID #: _____
- O Adding newborn child within 31 days from date of birth. No underwriting required. (Complete Section 3, Name/SSN/Birth date and sign page 8 where applicable.)
- O Adding newborn child over 31 days from date of birth. Complete entire Enrollment Application.
- O HIPAA Portability Coverage

SECTION 2. TYPE OF COVERAGE

MEDICAL (Select one)

VALUE PPO PLANS – DEDUCTIBLE/COINSURANCE OPTIONS	**ADVANTAGE PPO PLANS – DEDUCTIBLE/COINSURANCE OPTIONS**	**HMO PLANS – DEDUCTIBLE/COINSURANCE OPTIONS**	**HIGH DEDUCTIBLE PPO PLANS — HSA-COMPATIBLE**
O $3,500 / 100%	O $500 / 80%	O $3,500 / 70%	O $2,000 / 100%
O $6,000 / 100%	O $1,000 / 80%		O $3,000 / 100%
O $7,500 / 100%	O $2,500 / 80%		O $5,000 / 100%
O $10,000 / 100%	O $5,000 / 80%		

DENTAL / VISION PLAN (Optional)

O Primary applicant O Spouse O Child #1 O Child #2 O Child #3

INDIVIDUAL TERM LIFE INSURANCE (Optional) Underwritten by Health Net Life Insurance Company.
Available only to primary applicants and spouse who are 19 years of age and older upon approval and acceptance for health coverage.

O Primary applicant	O $15,000 Policy	O $30,000 Policy	O $50,000 Policy
O Spouse	O $15,000 Policy	O $30,000 Policy	O $50,000 Policy

SECTION 3. ENROLLMENT INFORMATION

Eligible dependents include your spouse and/or children under 26. List all individuals for whom you are requesting coverage. Please provide Social Security Numbers for yourself and all dependents over one year of age. **Please print**.

NAME (Last, First, Middle Initial)	**SSN**	**SEX** (M/F)	**BIRTH DATE** (Mo/Day/Yr)	**RELATIONSHIP**	**HT** (Ft./In.)	**WT** #LBS	**PRIMARY CARE PROVIDER** (HMO ONLY)
			/ /	Primary applicant			
			/ /	Spouse			
			/ /	Child			
			/ /	Child			
			/ /	Child			
			/ /	Child			

Home address (List street address; PO Box will not be accepted.):	City:	State/ZIP:	County:
Mailing address (if different than home address):	City:	State/ZIP:	County:

Daytime phone #:	Email address:	Alternate phone #:

SECTION 4. PAYMENT INFORMATION

You must select one of the following payment options:

- ○ Send me a monthly bill.
- ○ Send me a monthly bill, but charge my credit card for the first month's premium ONLY. Complete credit card information below.
- ○ Automatically charge my credit card for all monthly premiums. Complete credit card information below.
- ○ Automatically withdraw from my bank account for all monthly premiums. Please complete the Quick Pay Authorization Agreement.

CREDIT CARD INFORMATION

Credit card type: ○ MasterCard ○ Visa

Name (as it appears on the card):	Card number:	Expires (Mo/Yr): /
Cardholder's billing address:	City:	State/ZIP:
Cardholder's daytime phone #:	Bank or card issuer name:	

For credit card charges only:
I authorize Health Net to charge my credit card account for the **first month's premium or the applicable monthly premium**, as selected above, if Health Net approves the Enrollment Application for me or any of my listed dependents. If I selected the automatic credit card payment option above, I also authorize Health Net to charge my credit card on a monthly basis for all future premium amounts, and understand that I will not receive a monthly bill for premiums.

Signature:	Date:

SECTION 5. BENEFICIARY SELECTION FOR INDIVIDUAL TERM LIFE INSURANCE

Please note that life insurance is issued at an additional premium. This amount will reflect on your bill.

Applicant's beneficiary:		Relationship:	
Beneficiary's address:	City:	State:	ZIP:
Spouse's beneficiary:		Relationship:	
Beneficiary's address:	City:	State:	ZIP:

SECTION 6. ELIGIBILITY FOR INDIVIDUAL PORTABILITY COVERAGE (Lost group or COBRA coverage)

If your group health care coverage provided by your employer or your COBRA continuation coverage has terminated within the past 63 days, you may be eligible for HIPAA Portability Coverage. This coverage does not require medical underwriting and there is no pre-existing waiting period. In order to qualify for this coverage, you must meet specific criteria. If you think you may qualify for this coverage, please contact your broker or our Individual Sales Department for further information. They will also provide an Individual Portability Questionnaire for you to complete. **NOTE: Not all benefit plans are available for HIPAA Portability Coverage.**

SECTION 7. HEALTH QUESTIONNAIRE

Within the specified period of time, have you or any persons listed on this Enrollment Application been aware of, diagnosed or treated (including maintenance therapy), been injured, experienced pain or other symptoms, had a history of, had tests or X-rays/CT scans/MRIs, taken medications, been evaluated or advised by any type of health care professional regarding any of the following conditions in any of the listed categories? The categories below serve as examples only, are not all-inclusive and do not limit the extent of the information requested.

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

Fill in "Yes" or "No" for each line. Please circle the specific condition. DO NOT leave any items blank, fill in with N/A or draw a line through an entire column.

Within the past 3 years, have you consulted with a health care provider(s) or practitioner(s) for or been diagnosed with, or been treated for any of the following:

Please check each item either Yes or No	Yes	No
1. Bone/Joint Muscle Conditions		
a. Back or neck pain/strain	○	○
b. Arthritis	○	○
c. Tendonitis/bursitis	○	○
d. Foot disorders	○	○
e. Fractures	○	○
f. Joint disorders – knee, hip, shoulder, ankle	○	○
2. Ear/Nose/Throat/Eye		
a. Ear infections (# _____ past 12 mos.)	○	○
b. Tubes Currently in ears? Y / N (circle one) Removed (date) ___/___/___ (mo/day/yr)	○	○
c. Hearing problems	○	○
d. Deviated septum/malformation	○	○
e. Nasal polyps/sinusitis/tonsillitis	○	○
f. Strabismus	○	○
3. Glandular or Hormonal Disorders		
a. Thyroid: hyper or hypo	○	○
4. Mental Health/Behavioral Disorders		
a. Psychiatric/psychological counseling	○	○
5. Respiratory Conditions		
a. Allergies/asthma/bronchitis/pneumonia	○	○
b. RSV/RSD/Valley fever	○	○
c. Sleep apnea	○	○
6. Skin Conditions		
a. Psoriasis/acne/ulcers	○	○

Within the past 5 years, have you consulted with a health care provider(s) or practitioner(s) for or been diagnosed with, or been treated for any of the following:

Please check each item either Yes or No	Yes	No
7. Bleeding/Blood/Circulatory Disorders		
a. Anemia/bleeding/hyper coagulation	○	○
b. Elevated cholesterol/triglycerides *(If "Yes," complete table in #44, page 6.)*	○	○
c. Hypertension *(If "Yes," complete table in #44, page 6.)*	○	○
d. Phlebitis/clots/Raynaud's/PVD/varicose veins	○	○
8. Bone/Joint/Muscle Conditions		
a. Carpal tunnel	○	○
9. Ear/Nose/Throat/Eye		
a. Retina/macular; detach/degeneration	○	○
b. Cataract(s)/lens implants/glaucoma	○	○
10. Gastrointestinal Conditions		
a. Swallowing problems/GERD/reflux	○	○
b. Ulcers/chronic abdominal pain/gallbladder	○	○
c. Diverticulitis/diverticulosis/hemorrhoids/IBS	○	○
d. Hernia	○	○
11. Glandular or Hormonal Disorders		
a. Goiter/nodule present	○	○
12. Kidney/Bladder Conditions		
a. Incontinence/urinary tract infections	○	○
b. Kidney infections/kidney stones	○	○
13. Mental Health/Behavioral Disorders		
a. Depression/anxiety	○	○
b. Attention deficient hyperactivity disorder	○	○
c. Attention deficient disorder	○	○
d. Psychiatric/psychological counseling	○	○
e. Psychiatric inpatient confinements	○	○
14. Neurological Conditions		
a. Brain injury/concussion/seizure	○	○
b. Headaches (vascular or migraine)	○	○
c. Meningitis (viral or non-viral)	○	○
d. Developmental/speech delay	○	○

(Continued)
Within the past **5 years**, have you consulted with a health care provider(s) or practitioner(s) for or been diagnosed with, or been treated for any of the following:

Please check each item either "Yes" or "No"	Yes	No
15. Organ		
a. Cyst/tumor/growths/mass/polyps	○	○
16. Sexually Transmitted Diseases		
a. Genital herpes, HPV, chlamydia/gonorrhea	○	○

17. Reproductive System Conditions		
a. Menstrual irregularity	○	○
b. Breast disorders/fibrocystic nodules/lumps/ abnormal mammogram	○	○
c. Abnormal Pap smear/Dysplasia	○	○
d. Endometrial/uterine/cervical disorders	○	○
e. Fibroids/ovarian cyst/mass	○	○
f. Testicular/prostate problems; mass/lump	○	○

○ Yes ○ No	**18.** Is any person named on this Enrollment Application pregnant?
○ Yes ○ No	**19.** Is any person **not** named on this Enrollment Application currently pregnant by any person to be insured?
○ Yes ○ No	**20.** During the past 12 months, have you seen a health care provider(s) or practitioner(s), had a physical exam, laboratory test(s), EDG, X-ray(s), MRI, CT scan, PET, EEG, CAT scan, sonogram, ultrasound, mammogram, biopsy, colonoscopy, endoscopy, upper GI tests or series, urine test or blood test(s)?
○ Yes ○ No	**21.** Has any applicant seen a mental health care professional (psychologist, psychiatrist, therapist or counselor) in the past 12 months? If "Yes," please indicate number of visits: _____.
○ Yes ○ No	**22.** Has any applicant received any abnormal lab or test results in the past 12 months?
○ Yes ○ No	**23.** Has any applicant seen a medical care professional (physician, nurse practitioner, therapist or chiropractor) in the past 24 months?
○ Yes ○ No	**24.** Has any applicant been hospitalized or visited an emergency room or urgent care center in the past 24 months?
○ Yes ○ No	**25.** Has surgery (major or minor, cosmetic or non-cosmetic, inpatient or outpatient) been performed on any applicant in the past 10 years?
○ Yes ○ No	**26.** Has surgery (major or minor, cosmetic or non-cosmetic, inpatient or outpatient) been advised, but not yet performed, for any applicant in the past 10 years?
○ Yes ○ No	**27.** Has any type of therapy (physical, occupational or speech) been advised, but not yet received, for any applicant in the past 10 years?

Have you **EVER** consulted with a health care provider(s) or practitioner(s), for, or been diagnosed with, or been treated for any of the following:

○ Yes ○ No	**28.** Manic depression, bipolar disorder, schizophrenia, obsessive compulsive disorder, suicide attempt or eating disorder?
○ Yes ○ No	**29.** Cancer, melanoma, leukemia, bone marrow transplant, Kaposi's sarcoma, Hodgkin's disease, enlarged lymph nodes or any other malignancy?
○ Yes ○ No	**30.** Cerebral palsy, Alzheimer's disease, Parkinson's disease, stroke or brain or nervous system disorder(s)?
○ Yes ○ No	**31.** Heart attack, angina, heart mumur, heart valve replacement, irregular heart beat, palpitations, peripheral vascular disease, blood clot, poor circulation, pacemaker, shunt, heart disease, heart valve disorder or heart, cardiovascular or circulatory disorder(s)?
○ Yes ○ No	**32.** Emphysema, chronic obstructive pulmonary disease (COPD), pneumocystis carinii pneumonia, cystic fibrosis, tuberculosis or coughing up blood?
○ Yes ○ No	**33.** Colitis, ulcerative colitis, Crohn's disease, cirrhosis, liver disease, hepatitis or gastric bypass surgery?
○ Yes ○ No	**34.** Infertility (infertility is defined as either (1) the presence of a demonstrated condition recognized by a licensed physician and surgeon as a cause of infertility, or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception)?
○ Yes ○ No	**35.** Ankylosing spondylitis, spondylosis, herniated, ruptured or bulging disc, rheumatoid arthritis, sclerodoma, joint replacement or fixation device(s) (pins, plate, rods), fibromyalgia or chronic fatigue syndrome?
○ Yes ○ No	**36.** Amyotrophic lateral sclerosis (ALS), Lou Gehrig's disease, multiple sclerosis, muscular dystrophy, Down syndrome or any congenital disorder?
○ Yes ○ No	**37.** Diabetes, adrenal disorder, lupus, endocrine or metabolic disorder?
○ Yes ○ No	**38.** Alcohol or substance abuse/dependency?
○ Yes ○ No	**39.** Reconstructive surgery, breast implants or any other prosthesis or implant?
○ Yes ○ No	**40.** Hemophelia or blood or bleeding disorder(s)?
○ Yes ○ No	**41.** Organ transplant?

42. If you answered "Yes" to any of the questions, please explain below, providing full details. Attach additional pages if needed.

APPLICANT'S NAME:	**QUESTION #:** _______________
A. DURATION: From mo/yr: __________ To mo/yr: __________	**B. DIAGNOSIS, CONDITION, ILLNESS:**
C. CONDITION STILL PRESENT? ○ Resolved on mo/yr: __________ ○ Ongoing symptoms/treatment *(Please provide details in Box D.)*	**D. DESCRIBE TREATMENTS, TESTING, PROGNOSIS:**
E. FOLLOW UP NEEDED? ○ No, resolved ○ Yes, continuing treatment *(Please provide details in Box D.)*	**F. NAMES/ADDRESSES OF PAST AND PRESENT PHYSICIANS AND HOSPITALS:**

APPLICANT'S NAME:	**QUESTION #:** _______________
A. DURATION: From mo/yr: __________ To mo/yr: __________	**B. DIAGNOSIS, CONDITION, ILLNESS:**
C. CONDITION STILL PRESENT? ○ Resolved on mo/yr: __________ ○ Ongoing symptoms/treatment *(Please provide details in Box D.)*	**D. DESCRIBE TREATMENTS, TESTING, PROGNOSIS:**
E. FOLLOW UP NEEDED? ○ No, resolved ○ Yes, continuing treatment *(Please provide details in Box D.)*	**F. NAMES/ADDRESSES OF PAST AND PRESENT PHYSICIANS AND HOSPITALS:**

APPLICANT'S NAME:	**QUESTION #:** _______________
A. DURATION: From mo/yr: __________ To mo/yr: __________	**B. DIAGNOSIS, CONDITION, ILLNESS:**
C. CONDITION STILL PRESENT? ○ Resolved on mo/yr: __________ ○ Ongoing symptoms/treatment *(Please provide details in Box D.)*	**D. DESCRIBE TREATMENTS, TESTING, PROGNOSIS:**
E. FOLLOW UP NEEDED? ○ No, resolved ○ Yes, continuing treatment *(Please provide details in Box D.)*	**F. NAMES/ADDRESSES OF PAST AND PRESENT PHYSICIANS AND HOSPITALS:**

APPLICANT'S NAME:	**QUESTION #:** _______________
A. DURATION: From mo/yr: __________ To mo/yr: __________	**B. DIAGNOSIS, CONDITION, ILLNESS:**
C. CONDITION STILL PRESENT? ○ Resolved on mo/yr: __________ ○ Ongoing symptoms/treatment *(Please provide details in Box D.)*	**D. DESCRIBE TREATMENTS, TESTING, PROGNOSIS:**
E. FOLLOW UP NEEDED? ○ No, resolved ○ Yes, continuing treatment *(Please provide details in Box D.)*	**F. NAMES/ADDRESSES OF PAST AND PRESENT PHYSICIANS AND HOSPITALS:**

SECTION 7. HEALTH QUESTIONNAIRE (CONTINUED)

43. ○ Yes ○ No **Is any applicant currently taking OR has ANY applicant taken ANY medication in the past 12 months? If you answered "Yes," please complete the following table. Be sure to indicate any changes in dosage. Attach additional pages if needed.**

APPLICANT'S NAME	MEDICATION, DOSAGE, DOSAGE CHANGES & FREQUENCY	DURATION	DIAGNOSIS	PRESCRIBING PHYSICIAN
		From mo/yr: _____ To mo/yr: _____		
		From mo/yr: _____ To mo/yr: _____		
		From mo/yr: _____ To mo/yr: _____		
		From mo/yr: _____ To mo/yr: _____		
		From mo/yr: _____ To mo/yr: _____		
		From mo/yr: _____ To mo/yr: _____		

44. If any applicant answered "Yes" to #7.b. (Elevated cholesterol, triglycerides) or 7.c. (Hypertension) on page 3, please complete the following table with appropriate readings. Use extra pages for each additional applicant with the condition(s).

APPLICANT'S NAME: _____	DATE	CHOLESTEROL	TRIGLYCERIDES	HDL	LDL	DATE	BLOOD PRESSURE READINGS
Readings within 3 months							/
Readings within 6 months							/
Readings within 12 months							/

45. ○ Yes ○ No **Has any applicant experienced a weight change greater than 10 pounds in the past 12 months? If you answered "Yes," please complete the following table. Add additional pages if needed.**

APPLICANT'S NAME	WEIGHT CHANGE DURING PAST 12 MONTHS	CAUSE OF WEIGHT CHANGE	
	○ Gained _____ pounds ○ Lost _____ pounds	○ Diet ○ Medication	○ Pregnancy ○ Unknown
	○ Gained _____ pounds ○ Lost _____ pounds	○ Diet ○ Medication	○ Pregnancy ○ Unknown

46. ○ Yes ○ No **Has any applicant ever used tobacco products? If "Yes," please complete the following table.**

APPLICANT'S NAME	PACKS A DAY / FREQUENCY	# OF YEARS	LAST USED

47. FEMALE APPLICANTS, please complete the following table.

APPLICANT'S NAME	DATE OF YOUR LAST PERIOD	IF YOU HAVE NOT MENSTRUATED IN THE LAST 30 DAYS, PLEASE EXPLAIN	LAST PAP SMEAR	RESULTS
	/ /		/ /	○ Normal ○ Abnormal
	/ /		/ /	○ Normal ○ Abnormal

SECTION 8. CONDITIONS OF ENROLLMENT

GENERAL CONDITIONS: To determine whether or not you will be offered enrollment in an individual plan, Health Net will review your medical history based on the information you provide in this application, including the Health Questionnaire and any supplemental health questionnaires requested by Health Net during its review of your medical history. This process is called medical underwriting. Should you have questions or need assistance completing this application, especially the Health Questionnaire, you can call Health Net at 1-888-463-4875 for assistance. If any health information changes after you submit the application to Health Net, but before enrollment is offered, you should contact Health Net prior to any possible effective date of coverage at [1-888-463-4875] to provide that new health information.

WHEN HEALTH NET CAN RESCIND COVERAGE: Health Net may rescind coverage for any fraudulent or intentional omission or misrepresentation of material facts 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 Evidence of Coverage is rescinded, Health Net shall have no liability for the provision of coverage under the Evidence of Coverage. By signing this Application, you represent that all responses to the Health Questionnaire are true, complete and accurate, to the best of your knowledge, and that should Health Net accept your Application, the Application will become part of the Evidence of Coverage between Health Net and you. By signing this Application you further agree to comply with the terms of the Evidence of Coverage. 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 Evidence of Coverage is rescinded, Health Net will provide a written notice that will:

1. explain the basis of the decision, and your appeal rights;
2. clarify that all members covered under your coverage other than the individual whose coverage is rescinded may continue to remain covered without medical underwriting; and
3. explain that your monthly premium will be modified to reflect the number of members that remain under the Evidence of Coverage.

If the Evidence of Coverage 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 Evidence of Coverage 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 Arizona law.

If your coverage is rescinded, you have the right to appeal Health Net's decision to rescind such coverage.

NOTICE OF INSURANCE INFORMATION PRACTICES: Pursuant to Arizona law, Health Net may collect personal information about you from sources other than you during the underwriting process. The information collected by Health Net about you may, in certain circumstances, be disclosed to third parties without your authorization. You have the right to review information collected by Health Net and correct erroneous information. A full description of your rights regarding the information collected by Health Net is available from Health Net upon request.

USE AND DISCLOSURE OF INFORMATION: I acknowledge that health care providers may disclose to Health Net health information about me or my dependents, including information regarding substance abuse or mental/emotional conditions. Health Net will use and disclose this information for purposes of treatment, payment and health plan operations, including but not limited to utilization management, quality improvement, disease or case management programs, as permitted by law.

PREMIUM PAYMENT ACKNOWLEDGEMENT: I understand and agree that in order to process my Enrollment Application, Health Net requires that I submit a payment of one month's premium but that Health Net will not cash my check or charge my credit card unless coverage is approved by the Underwriting Department. I understand that by collecting the first month's premium, Health Net will not issue coverage and is not assuming any risk for health coverage for me or any member of my family. I understand that my insurance broker(s) has no authority to approve or bind coverage or to assign effective dates for coverage. I understand that coverage does not become effective immediately and that I may be denied coverage as a result of underwriting. I understand that coverage is not effective until it is approved by Health Net in writing, regardless of whether Health Net has cashed my check or charged my credit card. I understand that if my Enrollment Application is approved, I will receive a refund for any applicant or dependent of applicant on this Enrollment Application who chooses not to enroll in the plan, or if I, or any one of my family members, is not approved for coverage by Health Net. I understand that if I select a 15th of the month effective date and my coverage is approved, I will be billed for half of a monthly premium.

To authorize another individual, including my insurance broker, to have access to my personal information, I must complete a separate Authorization to Release Confidential Medical Information form. Neither payment, enrollment or eligibility for coverage will be conditioned on my providing or refusing to provide this authorization.

ACKNOWLEDGMENT AND AGREEMENT: I understand and agree that by enrolling or accepting services under a health plan with HNAZ or Health Net Life Insurance Company, I am, and any enrolled dependents are, obligated to understand and abide by all terms, conditions and provisions of the Agreement.

I have read and understand the terms of this Enrollment Application, and my signature on the signature page indicates my acceptance of these terms and acknowledge that the information entered in this Enrollment Application is complete, true and correct. A photocopy of this is as valid as the original.

In addition, I understand and agree to the following:

- There is no coverage unless an Enrollment Application is approved by Health Net's Underwriting Department and a Notice of Acceptance is issued to you. No other department, officer, agent or employee of Health Net is authorized to grant enrollment.
- Health Net is not liable for bills incurred before the effective date of coverage.
- Health Net will notify me if my Enrollment Application is accepted. My effective date will also be subject to the receipt of my premium by HNAZ.
- The broker selling Health Net health coverage does not have the authority to approve my Enrollment Application and cannot change any terms of the Agreement or waive any requirements.
- I am responsible for reporting to Health Net any changes in health status that occur before the effective date of the Agreement or before receipt of premium, whichever is later. I understand any changes in health status may result in a change of the underwriting decision. This applies to every person listed on the Enrollment Application. I understand that my coverage may be rescinded if I fail to report a change.
- Applicant is responsible for obtaining medical records and any associated costs for obtaining those records.

X _____ _____

APPLICANT'S SIGNATURE (in ink) Date signed

X _____ _____

SPOUSE'S SIGNATURE (in ink) Date signed

X _____ _____

APPLICANT'S SIGNATURE (in ink) Date signed

X _____ _____

APPLICANT'S SIGNATURE (in ink) Date signed

ALL APPLICANTS 18 YEARS AND OLDER MUST SIGN APPLICATION.
PLEASE BE SURE ALL QUESTIONS ARE ANSWERED AND APPLICATION IS SIGNED AND DATED TO PREVENT APPLICATION FROM BEING RETURNED.

SECTION 9. BROKER INFORMATION

Broker's name:	
Insurance agency name:	**HEALTH NET BROKER NUMBER:**
GENERAL AGENT INFORMATION	
GA name (If applicable):	GA number:

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION FOR ENROLLMENT

This authorization for use or disclosure of personal health information is being requested by Health Net to comply with the terms of federal HIPAA regulations, 45 C.F.R. § 164.508. A copy of this form is as valid as the original.

THIS AUTHORIZATION FORM MUST BE COMPLETED IN ORDER TO ENABLE HEALTH NET TO UNDERWRITE YOUR COVERAGE. THE ENROLLMENT PROCESS CANNOT BE COMPLETED WITHOUT YOUR EXPRESS AUTHORIZATION WHICH IS MORE FULLY DESCRIBED BELOW. THIS FORM MUST BE SIGNED BY THE APPLICANT AND EACH ADULT FAMILY MEMBER APPLYING FOR COVERAGE (including dependents age 18 and over).

APPLICANT AND FAMILY MEMBERS REQUESTING ENROLLMENT:

Applicant Name	Social Security Number
Spouse Name	Social Security Number
Dependent (age 18 or older)	Social Security Number
Dependent (age 18 or older)	Social Security Number

I, _____, _____
applicant (print name) spouse (print name)

_____, _____
adult dependent (print name) adult dependent (print name)

hereby authorize the use or disclosure of personal health information as described below.

All references to "Health Net" herein include the affiliates and subsidiaries of Health Net, Inc. which underwrite or administer the coverage to which the Enrollment Application applies.

Additional adult dependents may be listed below.

As the (applicant) parent, I, (print name) _____, authorize the use or disclosure of personal health information about my minor dependent(s), age 17 and under, as described below:

_____, _____, _____
(print dependent[s'] name[s])

_____, _____, _____

1. Person(s) or group of persons authorized to disclose the information to Health Net include:
   - Any medical professional, hospital, or other health care facility, clinic, pharmacy, insurer or health benefit plan administrator, Medicare or Medicaid, or any other health care provider or health plan that has medical information about me or my dependent(s);
   - Health care providers or health plans indicated in my application for coverage or on my dependents' applications for coverage, or identified by me during a health history interview in regard to myself or my dependent(s), or identified by me or my dependent(s) to my agent, or any other healthcare provider or health plan referred to in my medical records or my dependent's(s') medical records.
2. I authorize the following person(s) or group of persons to receive the information disclosed by one of the persons or organizations listed in paragraph 1 above, and to use that information and the information included on my application for coverage to underwrite and rate the health plan coverage for which I have applied:
   - Health Net and its affiliates including, but not limited to, its agents, underwriting operations, including independent contractors who have executed Business Associates contracts to conduct underwriting activities on behalf of Health Net or do post enrollment review of any information for determination of whether policy should be rescinded for misrepresentation, who have agreed to safeguard protected health information from unauthorized disclosure, claims operations, legal representatives, its Medical Director or his/her designees, and its sales and marketing operations. I understand that Health Net may condition my or my dependent's(s') enrollment in the health plan on my signing this Authorization and initialing this paragraph 2.

Applicant _____ Spouse _____ Dependent _____ Dependent _____

3. Description of the information that may be used or disclosed includes: All health information pertaining to me or my minor dependent(s), if applicable, related to the diagnosis, treatment or prognosis with respect to any physical, accident, illness, medical or mental condition, including but not limited to, alcohol abuse, substance abuse, mental or emotional disorders, AIDS (Acquired Immune Deficiency Syndrome), or ARC (AIDS-Related Complex), except psychotherapy notes, including but not limited to, the information provided on my application.
4. I understand that if this Authorization is for disclosures to someone other than Health Net, personal health information disclosed may be subject to re-disclosure by the recipient, in which case it would no longer be protected by federal Privacy Rules. However, Health Net is subject to federal Privacy Rules and any information Health Net receives is protected by these Rules.
5. I understand that my enrollment in Health Net's health plan may be conditioned on my signing this Authorization and initialing paragraph 2. I understand that I may refuse to initial paragraph 2 of this Authorization, and that such refusal could affect my enrollment in the health plan or eligibility for benefits under the health plan.
6. If the person completing this Authorization is the personal representative of the applicant or dependent, describe your authority to act on this person's behalf.

_____

_____

_____

7. As described in the "Notice of Privacy Practices," I understand that I may revoke this Authorization in writing at any time, except to the extent that action has been taken by Health Net and its subsidiaries and affiliates in reliance on this Authorization. I may send a written and dated revocation to Health Net to: Health Net Privacy Office, 21650 Oxnard Street, Ste. 2211, Woodland Hills, CA 91367. Health Net's "Notice of Privacy Practices" is available on the Health Net website at www.healthnet.com or will be provided to me in writing upon request.
8. I understand that either I am, or my personal representative is, entitled to receive a copy of my signed Authorization and by my signature below, I acknowledge that I have been provided with a copy.
9. This authorization will become effective immediately and shall remain valid for thirty (30) months from the date the authorization form is signed as to Health Net's determination on enrollment.

SIGNATURES (REQUIRED IN INK)

Applicant's Signature	Date Signed
Spouse's Signature	Date Signed
Signature of Applicant's Dependent (age 18 or older)	Date Signed
Signature of Applicant's Dependent (age 18 or older)	Date Signed
Personal Representative's Name, if applicable (Print)	Date Signed
Personal Representative's Signature	Date Signed

Please return this form with the Enrollment Application in the enclosed return address envelope.

Health Net®
A BETTER DECISION

AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL INFORMATION

Please complete this Authorization to Release Confidential Medical Information form to authorize Health Net to disclose your confidential personal information with the individual or organization you identify on this form. This Authorization is voluntary. We will not condition payment, enrollment in our health plan, or eligibility for benefits on you giving this Authorization.

INFORMATION TO BE DISCLOSED

I authorize Health Net of Arizona and/or Health Net Life Insurance Company (Health Net) to disclose the following information: (please check all that apply)

__ Application, Enrollment, Eligibility Information
__ Claims/Explanation of Benefit Information
__ Prior Authorization
__ Premium Billing/Payment Information
__ Transition of Care Information
__ Pharmacy Information
__ Medical Records
__ Account Information

__ I authorize Health Net of Arizona to release information that may include record of drug, alcohol and/or psychiatric treatment.

__ I authorize Health Net to release confidential HIV/AIDS related information including AIDS Related Complex (ARC) or confidential communicable disease related information.

PURPOSE OF DISCLOSURE/USE

__ Assist with obtaining a health care policy
__ Assist with claims processing/payment
__ Assist with account/premium reconciliation
__ Other: _____

PERSON WHOSE INFORMATION MAY BE RELEASED

Name: _____

PERSON TO WHOM INFORMATION MAY BE DISCLOSED

Name: _____

Agency/Company: _____

Address: _____

City, State, ZIP: _____

General Agency: _____

DURATION OF AUTHORITY

This Authorization is effective immediately and will expire 180 days from the date the form is signed. You may revoke this Authorization by giving written notice to IFP Underwriting Department, 1230 W. Washington, Suite 401, Tempe, Arizona 85281, but any revocation will not apply to any action Health Net takes in reliance on this Authorization prior to revocation. You are entitled to a copy of this Authorization. You may refuse to sign this Authorization. It is possible for the confidential information disclosed pursuant to this Authorization to be subject to redisclosure by the recipient and no longer protected by the federal health information privacy regulations. Health Net shall not be responsible for any such disclosure, whether or not permitted by law.

Print name (member/applicant or authorized representative): _____

Signature: _____ Date: _____

Relationship (if signed by other than member/applicant): _____

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