Health Net®

Individual & Family Enrollment Application

PART I. Tell us who you are enrolling and select the product:
Application must be typed or completed in blue or black ink.
THE APPLICATION MUST BE COMPLETED BY THE APPLICANT.

Requested Effective Date ☐☐/☐☐/☐☐☐☐

A. Reason for Application

FAMILY TYPE

☐ Self ☐ Self & Spouse/Domestic Partner
☐ Self & Child ☐ Self & Children
☐ Self, Spouse/Domestic Partner and Child(ren)

☐ ***Please check for Domestic Partner enrollment***

☐ Process as separate policies

ENROLLMENT TYPE

☐ New Enrollment ☐ Change Plan* ☐ Add Dependent*

**Member ID number (listed on your ID card):* _____

B. Billing options (please choose for both medical and life)

First Premium Payment (select one)

☐ Automated Bank Draft (Please complete the Simple Pay Option section)

☐ Pay by Check (Please include completed check and send with application. Amount must match monthly premium.)

☐ Credit card (Please complete the credit card section on application)

Monthly Premium Payments (select one)

☐ Automated Bank Draft (Please complete the Simple Pay Option section)

☐ Monthly Bill ($5.00 administrative fee applies; **not available with Term Life**)

☐ Credit card (Please complete credit card section; **not available with Term Life**)

C. Choice of Coverage

PPO* – Health Net Life Insurance Company: Available for 1st and 15th of the month effective dates

SimpleValue ☐ 30 ☐ 40 ☐ 50
with ☐ Generic Rx ***or*** ☐ Combo Rx

HSA (Compatible Plans) ☐ SimpleChoice ☐ SmartChoice

SimpleChoice ☐ 15 ☐ 25 ☐ 35 ☐ 40 ☐ 50
☐ FirstChoice PPO ☐ ValueChoice 1500

*As a convenience to you, if you have applied for Individual PPO coverage and do not meet the underwriting requirements for preferred premiums for the PPO plan for which you applied, Health Net may elect to offer you our **Modified Issue PPO option**. The Modified offer may be a plan that will have **a rate that is 20% or 50% higher** than the standard rate for which you applied. You will be automatically enrolled unless otherwise specified. Please check this box should you *not* wish to be automatically enrolled into the **Modified Issue PPO option** and the new rate.

☐ **NO, do not enroll me**

HMO – Health Net of California: Only available for the 1st of the month effective dates ☐ HMO 15 ☐ HMO 40

Add – Term Life Insurance Coverage
(Part VI must be completed)
☐ $15,000 ☐ $30,000 ☐ $50,000

Add – Dental and Vision Plus
☐ Dental & Vision Plus
Primary Dentist Number (HMO plans only): _____

PART II. Applicant Information (Note: For the most favorable rate, make the younger spouse/domestic partner the primary applicant.)

Primary Applicant's Last Name	First Name	MI	☐ Male ☐ Female
Home Address			
City	State	ZIP	County applicant resides in
Home Phone Number ( )	Work Phone Number ( )		Email address
Primary Applicant's Birth Date (mo/day/year) ☐☐/☐☐/☐☐☐☐	Primary Applicant's Social Security Number ☐☐☐ ☐☐ ☐☐☐☐		
Height	Weight (lbs)	Primary Care Physician ID # (if applicable)	Current Patient ☐ Yes ☐ No / Physician Group ID#

Type of Business:
☐ Self Employed/Consultant ☐ Unemployed (between jobs)
☐ Professional/Management ☐ Student ☐ Other:
☐ Employed (Non-managerial) ☐ Retired _____

Occupation:

Salary Range (optional):
☐ $18,000–30,000 ☐ $60,001–75,000
☐ $30,001–45,000 ☐ $75,001–90,000
☐ $45,001–60,000 ☐ $90,001+

Would you be interested in other Health Net or affiliated entities, products and services ☐ Yes ☐ No
May we contact you by email? ☐ Yes ☐ No
The release of your information may result in a Health Net representative or Authorized Agent contacting you.

In the past 6 months, have you been a resident of the United States? ☐ Yes ☐ No
If no, where was your last residence? _____

How did you hear about Health Net's Individual and Family coverage?
☐ Radio ☐ Mail ☐ Billboard ☐ Newspaper ☐ Yellow Pages ☐ Broker ☐ Internet
☐ Other: _____

Primary's Social Security Number

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 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. **To be processed under one Subscriber, all family members must reside at the same address.** *HMO only: If you are applying for HMO coverage, you must select a Physician Group and Primary Care Physician. You may choose the same or 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.

Relation	Last Name First Name MI	Social Security No.	Date of Birth	Height	Weight (lbs)	Primary Care Physical ID#	Current Patient	Physician Group ID#
☐ Husband ☐ Wife	Spouse/Domestic Partner	— —					☐ Yes ☐ No	
☐ Son ☐ Daughter	Child 1	— —					☐ Yes ☐ No	
Full Time Student? ☐ Yes ☐ No	Units Carried	Name of School						
☐ Son ☐ Daughter	Child 2	— —					☐ Yes ☐ No	
Full Time Student? ☐ Yes ☐ No	Units Carried	Name of School						
☐ Son ☐ Daughter	Child 3	— —					☐ Yes ☐ No	
Full Time Student? ☐ Yes ☐ No	Units Carried	Name of School						
☐ Son ☐ Daughter	Child 4	— —					☐ Yes ☐ No	
Full Time Student? ☐ Yes ☐ No	Units Carried	Name of School						

For additional dependents please attach another sheet with the requested information.

PART IV. (a) Statement of health (All questions must be answered. Include information for yourself and each family member applying for coverage. Please answer all questions "Yes" or "No." (IF "YES," PLEASE CIRCLE THE SPECIFIC **CONDITIONS**.) Complete Part B on page 4.

	Yes	No
1) A. Is either the applicant or spouse/domestic partner, or female dependent, whether or not listed on the application, currently pregnant?	☐	☐
B. If you are a male listed on this application, are you expecting a child with anyone, even if the mother is not listed on this application?	☐	☐
C. If you are a male listed on this application, has your spouse, even if not listed on this application, performed a home pregnancy test during the previous 90 days which has reacted positive?	☐	☐
D. During the previous 90 days, has any female applicant performed a home pregnancy test, which has reacted positive?	☐	☐
2) Have you or any applying family member had an abnormal physical exam, laboratory results, EKG, X-ray(s), MRI, CT scan or other diagnostic test(s), or been advised to have diagnostic test(s), treatment(s), surgery or hospitalization(s), or are you waiting for the results of any diagnostic test(s)?	☐	☐
3) Have you or any applying family member been seen by a health care practitioner, been a patient in a hospital, clinic, surgicenter, sanatorium or other medical facility as an inpatient or outpatient?	☐	☐

	Yes	No
4) Are you or any applying family member eligible for Medicare benefits as a result of disability or chronic illness?	☐	☐
5) Have you or any applying family member ever had any signs, symptoms, diagnosis of, or consulted a health care practitioner, received advice from a health care practitioner, sought treatment from a health care practitioner, had treatment recommended by a health care practitioner, received treatment from a health care practitioner, or been hospitalized for any of the following:		
A. Chest pain, high or low blood pressure, heart disease, heart murmur, palpitations or irregular heart beat, peripheral vascular disease, blood clot, phlebitis, varicose veins, blood disorder, anemia, enlarged lymph nodes, or any other heart, cardiovascular, or circulatory disorder?	☐	☐
B. Headaches, dizziness, paralysis, stroke, loss of consciousness, seizure disorder, sleep apnea, multiple sclerosis, cerebral palsy, or any other disorder of the brain or nervous system?	☐	☐

Primary's Social Security Number

PART IV. (a) Statement of health (continued)

	Yes	No
5) C. Disorder of the mouth, throat or esophagus, tonsillitis, ulcer(s), colitis, ulcerative colitis, spastic colitis, Crohn's disease, gall bladder disorder, chronic diarrhea, hernia, hemorrhoids, hepatitis, pancreatitis, intestinal or rectal problems, liver disease, cirrhosis, stomach disorder, or any other disorder of the digestive system?	☐	☐
D. Allergy, sinusitis, bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), pneumonia, tuberculosis, coughing up blood, or any other lung or respiratory disorder?	☐	☐
E. Asthma?	☐	☐
If "Yes," have you been hospitalized or been to an emergency room in the past 24 months?	☐	☐
Have you received any adrenaline or epinephrine injections?	☐	☐
F. Disorder of the kidney or bladder, infections, blood in urine, pyelonephritis, or any other disorder of the urinary tract?	☐	☐
G. Arthritis, rheumatoid arthritis, bursitis, gout, disorder of the back, spine, bone or joint, herniated, ruptured, or bulging disc, muscle or tendon pain, carpal tunnel syndrome, muscular dystrophy, fixation device or any other disorder of the musculoskeletal system?	☐	☐
H. Jaw problems, temporal mandibular joint syndrome (TMJ), pain or difficulty breathing, chewing or swallowing?	☐	☐
I. Diabetes, thyroid disorder, adrenal disorder, lupus, Raynaud's disease, chronic fatigue syndrome, Epstein-Barr virus, unintentional weight loss or anyother disorder of the metabolic system?	☐	☐
J. Cancer, melanoma, tumor, cyst, growth, leukemia, Hodgkin's disease, or any other malignancy or any unbiopsied or undiagnosed tumor, cyst or growth?	☐	☐
K. Psoriasis, keratosis, herpes, burn(s), birthmark(s), warts, or any other disorder of the skin?	☐	☐
L. Disorder of the eyes or sight, glaucoma, cataracts, disorder of the ears or hearing, ear infection (otitis media), disorder of the nose or breathing, deviated nasal septum?	☐	☐
M. Nervous, mental, emotional or obsessive compulsive disorder, behavioral disorder, panic attack(s), anxiety, depression, manic depression, schizophrenia, attention deficit disorder, ADHD, or eating disorder?	☐	☐

	Yes	No
N. Alcohol or substance abuse/dependency, counseling, member of a support group?	☐	☐
(i) Do you consume alcoholic beverages?	☐	☐
If "yes", please indicate the number of alcoholic beverages you consume weekly (a beverage is 12 ounces of beer, 6 ounces of wine, 1 ounce of liquor).		
Applicant ____ Spouse/Domestic Partner____		
O. Premature birth, developmental delay, congenital abnormalities, clubfoot, cleft lip or palate, or Down's syndrome?	☐	☐
P. Cosmetic or reconstructive surgery, including breast implants?	☐	☐
Q. Male reproductive system: disorder of the prostate, infections, impotency, sexual dysfunction, infertility, sexually transmitted disease or any other disorder of the reproductive system?	☐	☐
R. Female reproductive system: disorder of the breast, fibroid tumors, infertility, menstruation disorders, abnormal Pap test, infections, sexually transmitted disease, abnormal bleeding, endometriosis or any other disorder of the uterus or reproductive system?	☐	☐
6) Have you or any applying family member been diagnosed as having or been treated for AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS-Related Complex)?	☐	☐
7) Have you or any applying family member consulted any health care practitioner for any condition or symptom(s) for which a diagnosis has not been established?	☐	☐
8) During the past 12 months, have you or any applying family member smoked cigarettes, cigars, pipes, or used chewing tobacco?	☐	☐
9) During the past three years, have you or any applying family member consulted any health care practitioner for any reason not listed on this form?	☐	☐
10) During the past 12 months, have you or any applying family member experienced symptoms for which any health care practitioner has not been consulted?	☐	☐
11) Is the applicant or any applying family member currently taking medication? If "Yes," please complete section IV (b).	☐	☐
12) Has the applicant or any applying family member taken a prescription medication during the past 12 months for a period of more than two weeks? If "Yes," please complete Part IV (b).	☐	☐

Primary's Social Security Number

PART IV. (a) Statement of health (continued)

Female applicants only (applicable to all females listed on the application). Attach another page if more than two females are listed on the application.

Applicant Name:		
13) A. Have you had a menstrual period in each of the last six months, including within the last 30 days? If "No," please explain:	Yes ☐	No ☐
B. (i) Have you had a pelvic exam? If yes, date of last pelvic exam (Mo/Dy/Yr):	Yes ☐	No ☐
(ii) Have you had a pap smear? If yes, date of last pap smear (Mo/Dy/Yr):	Yes ☐	No ☐
(iii) Were the results of the exam(s) normal? If "No," please explain:	Yes ☐	No ☐

Applicant Name:		
13) A. Have you had a menstrual period in each of the last six months, including within the last 30 days? If "No," please explain:	Yes ☐	No ☐
B. (i) Have you had a pelvic exam? If yes, date of last pelvic exam (Mo/Dy/Yr):	Yes ☐	No ☐
(ii) Have you had a pap smear? If yes, date of last pap smear (Mo/Dy/Yr):	Yes ☐	No ☐
(iii) Were the results of the exam(s) normal? If "No," please explain:	Yes ☐	No ☐

PART IV. (b) Statement of health – If you answered "Yes" to any questions in Section IV (a), please identify the question number and explain in FULL DETAIL below. If additional space is necessary, please attach extra pages.

Question Number	Family member name and name used on doctor's records	Diagnosis, signs or symptoms, condition, treatment or recommendation	Still under treatment?	Dates of treatment or Hospitalization (Mo/Yr) Began	Ended	Full name, address & telephone number of every health care practitioner, clinic, hospital or any other medical facility (include ZIP code)
			☐ Yes ☐ No			
			☐ Yes ☐ No			
			☐ Yes ☐ No			
			☐ Yes ☐ No			
			☐ Yes ☐ No			
			☐ Yes ☐ No			

DOCTOR'S VISITS – Please provide information regarding the last health care practitioner visit or physical examination for ALL family members you wish to cover.

Name of Individual	Date of Visit	Reason for visit	Result of Visit	Full name, address & telephone number of every health care practitioner, clinic, hospital or any other medical facility (include ZIP code)

Primary's Social Security Number

PART IV. (b) Statement of health (continued)

MEDICATIONS – Please list all medications taken currently or within the last year by anyone listed on this application.

Name of Individual	Condition	Name of Medication	Prescribing Physician	Most Recent Refill Date	Strength (No. of milligrams)	Dosage & Frequency (How many pills and how often take)	Number of refills per year

PART V. Prior health coverage.

A. During the previous 62 days, have you been covered by health insurance? ☐ Yes ☐ No

If "Yes," Current Carrier: _____ Effective date: _____ Expected termination date: _____

☐ Individual & Family HMO ☐ Group HMO
☐ Individual & Family PPO ☐ Group PPO
☐ Disability, Short Term or Interim ☐ Other: _____

B. Has anyone on this application been a Health Net or Foundation Health Member in the last five years? ☐ Yes ☐ No

If "Yes," former Health Net or Foundation Health Member name: _____

Group Number (listed on your ID card):_____

Member ID Number (listed on your ID card): _____

C. HIPAA Guaranteed Issue Coverage

You may be considered for coverage under the HIPAA Guaranteed Issue plans. The plan does not require medical underwriting and the rates are higher compared to the other Individual Plans. If you qualify please request the complete benefit details and rates. If you meet every condition below you are eligible for guaranteed issue in accordance with HIPAA.

1. Have you had a total of at least 18 months of health care coverage (including COBRA or Cal-COBRA, if applicable) without more than a 63-day break (excluding any employer imposed waiting periods) in coverage? ☐ Yes ☐ No
2. Was your most recent coverage through a group health plan (COBRA and Cal-COBRA are considered group coverage)? ☐ Yes ☐ No
3. Currently are you eligible for coverage under a group health plan, Medicare or Medicaid? ☐ Yes ☐ No
   (If yes, you are not eligible for HIPAA coverage.)
4. Was your most recent coverage terminated because of nonpayment or fraud? ☐ Yes ☐ No
5. Were you eligible under COBRA or Cal-COBRA? ☐ Yes ☐ No

   Yes, start date: _____ End Date: _____

   If Yes, did you accept and exhaust all benefits that were available? ☐ Yes ☐ No

   If No, please explain: _____

   _____

PART VI. Individual Term Life Insurance – Underwritten by Health Net Life Insurance Company – Applicant Only.

Applicant Only

This insurance is not intended to replace any Life Insurance Policy currently in force. **Life Insurance requires an additional premium. (Must be at least 19 years old to enroll). The percentage indicated must equal 100%.**

Beneficiary (Full Name)	Relationship	%
Beneficiary (Full Name)	Relationship	%
Beneficiary (Full Name)	Relationship	%
SIGNATURE of APPLICANT		DATE

Primary's Social Security Number

PART VII. Individual & Family Plans Exception to Standard Enrollment – Statement of Accountability.

This is to be used when the Applicant cannot complete the application because of the reason(s) indicated below. The applicant must complete the appropriate section that applies to their enrollment. This form must be submitted with the Individual & Family Enrollment Application when applicable.

I, _____ personally read and completed the Individual & Family Enrollment Application for the Applicant named above because:

☐ Applicant does not read English ☐ Applicant does not speak English ☐ Applicant does not write English

Other (explain) _____

Under the penalty of perjury I attest that, I translated/read to the applicant the contents of the Individual & Family Enrollment Application, including Part IX "Conditions of Enrollment" and Part X "Important Provisions" of the Individual & Family Enrollment Application. I accurately listed all the requested personal and medical history disclosed by:

_____ (Name of applicant)

Signatures and date (required in ink).

SIGNATURE of APPLICANT	Today's Date	
SIGNATURE of TRANSLATOR	Today's Date	
TRANSLATOR'S/READER'S NAME (PRINT)	TRANSLATOR'S/READER'S PHONE NUMBER	
TRANSLATOR'S/READER'S ADDRESS		
TRANSLATOR'S/READER'S CITY	STATE	ZIP

PART VIII. Writing agent information – Without complete agent name and address, correspondence will not be sent.

Health Net Broker ID: J431

Kathy Hope
Name (Print)

5922 Midiron Circle
Address

Huntington Beach, CA 92649

Writing Agent's Signature/Number (Required)

Sub – Agent ID: _____
(Must be completed only if Sub-Agent Agreement is approved)

800-792-9114
Phone number

800-840-0057
Fax Number

Kathy@healthbroker.com
Email address

Date Signed (Required)

Writing Agent Certification

Are you aware of any information not disclosed in this application that might have a bearing on the risk? ☐ Yes ☐ No

Did you personally see the applicant signing the application (includes spouse/domestic partner, if applying)? ☐ Yes ☐ No

If "Yes," please explain: _____

PART IX. Conditions of enrollment

GENERAL CONDITIONS: Health Net reserves the right to reject any application for enrollment. Health Net may selectively accept the Applicant or only a dependent(s). There is no coverage unless this Application is accepted by Health Net's Underwriting 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. Cashing your check does not mean your application is approved. If rejected, your money will be returned to you. No other department, officer, agent or employee of Health Net is authorized to grant enrollment. An insurance agent cannot grant approval, change terms or waive requirements. Health Net may require that you take a medical examination and you will be responsible for payment of any related fees in such event. This application and all medical information or examination reports shall become a part of the Plan Contract or Insurance Policy.

Family Members who are covered under another Health Net Individual plan are not eligible for coverage hereunder. Should a Family Member enrolling for coverage, become covered under another Health Net Individual plan at a later date, his or her coverage under this plan will terminate on the effective date of coverage under the other Health Net Individual plan.

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PART IX. Conditions of enrollment (continued)

Any intentional or unintentional nondisclosure or misstatement of fact in application materials is cause for disenrollment and rescission of the Plan Contract or Insurance Policy and Health Net may recoup from the Subscriber (or from You or from the Applicant) any amounts paid for Covered Services obtained as a result of such nondisclosure or misstatement of fact. In addition, if a Subscriber makes a false statement or omission as to the Subscriber's or Family Member's health status or history on application materials, Health Net shall have no liability for the provision of coverage under the Plan Contract or Insurance Policy.

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, disease or case management programs. Health Net's Notice of Privacy Practices is included in the Plan Contract and Insurance Policy, and I may also obtain a copy of this Notice on the website at www.healthnet.com or through Health Net Customer Contact Center. Authorization for use and disclosure of protected health information shall be valid for a period of 30 months from the date of my signature below.

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, he or she 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 ENGLISH: If an Applicant does not read English, the translator and Applicant must sign and submit the **Statement of Accountability** for translating this entire Application (on page 6, PART VII of this Application).

PART X. 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. 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 are obligated to understand and abide by the terms, conditions and provisions of the Plan Contract or Insurance Policy. 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: I, the applicant, understand and agree that any and all disputes or disagreements between me (including any of my enrolled family members or heirs or personal representatives) and Health Net regarding the construction, interpretation, performance or breach of the Health Net Plan Contract or Insurance Policy, or regarding other matters relating to or arising out of my Health Net membership, whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or employees, are also involved, must be submitted to final and binding arbitration in lieu of a jury or court trial. 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 the extent permitted by law to have their dispute decided in a court of law before a jury. I also understand that disputes that I may have with Health Net involving claims or 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. A more detailed arbitration provision is included in the Plan Contract or Insurance Policy. My signature below indicates that I understand the terms of this Binding Arbitration Clause and agree to submit disputes to binding arbitration.

APPLICANT OR PARENT OR LEGAL GUARDIAN'S SIGNATURE IF APPLICANT IS UNDER 18 YEARS OLD	Date Signed
SPOUSE/DOMESTIC PARTNER'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

Applicant's Signatures (the applicant must personally sign his/her name and agree to the Arbitration Clause in order for the application to be processed)**, *required in ink.***

Health Net reserves the right to cancel, rescind, or terminate any policy where this Application and Agreement was signed by anyone other than the applicant. Neither Broker nor any other person may sign this Application and Agreement.

Make personal check payable to "Health Net." Return Completed Application to:
Health Net Individual and Family Enrollment, Post Office Box 1150 Rancho Cordova, California 95741–9847

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 Contract and Evidence of Coverage; "Insurance Policy" refers to Health Net Life Insurance Company Explanation of Your Insurance Plan, Health Net PPO Policy.

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Health Net®

Health Net's Pay Option – Monthly Automatic Payment for Individual & Family Plans

SIMPLE PAYMENT OPTION (Automatic Bank Draft) ☐ First month's payment ☐ Monthly premium payment

Monthly premium charge can be withdrawn directly from your personal checking account. The premium will be withdrawn from your bank account about ten days in advance of the due date.

Account Holder's Social Security Number	Transit Routing Number	Account Number
Bank Name		State

As a convenience, I request and authorize Health Net to pay and charge to the above account checks drawn on that account by and payable to the order of **"Health Net"** provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the Premium withdrawn from my account will be for the future bill period plus any past due balances and my first month's withdraw maybe for multiple periods if I did not submit a binder check or due to the timing of the set up. I agree that Health Net's rights in respect to each such check shall be the same as if it were a check written to Health Net and signed personally by me. This authority is to remain in effect until revoked by me in writing and until Health Net actually receives such notice, I agree that Health Net shall be fully protected in honoring any such check. *(Note: A 30-day notice is required to discontinue this service due to the time required to initiate this change with your bank.)*

Automatic Bank Draft (ABD) transmissions are submitted to the bank approximately the 20th of every month, for the following month's premium. It can take upwards of 6 weeks to process an ABD request. Therefore, your premium should be submitted with your request for ABD, and/or manual payment should continued to be remitted to Health Net, until such time that you receive confirmation of ABD commencement in writing from Health Net.

I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, I will be charged a $25 service charge for each occurrence. I understand Health Net shall be under no liability whatsoever even though such dishonor may result in the forfeiture of health coverage.

SIGNATURE of ACCOUNT HOLDER (Required to Process).	Date

CREDIT CARD ☐ First month's payment ☐ Monthly premium payment

Monthly premium charge can be charged directly to your credit card account. The premium will be charged to your credit card account approximately ten days in advance of the due date.

First Name (as on card)	Middle (as on card)	Last Name (as on card)	Card Type ☐ Visa ☐ MasterCard
Account Number 16-digits (complete)	Expiration Date (MM/YYYY)	***Signature Panel Code**	Cardholder's email address

Billing Address	City	State	**ZIP**[1]

***Signature Panel Code can be found on the back of your credit card. This 3-4 digit code is usually the last three digits located in the signature panel. This information is required in order for the credit card to be processed.**

As a convenience, I request and authorize Health Net or Health Net Life Insurance Company ("Health Net") to charge my credit card account identified above for the payment of my initial premium and/or my monthly premium. I understand that the Premium charged to my account will be for the future bill period plus any past due balances and that my first month's withdraw / charge may be for multiple periods depending upon date of approval and the bill period. This authority is to remain in effect until revoked by me in writing and until Health Net actually receives such notice, I agree that Health Net shall be fully protected in honoring any such charge. *(Note: A 30-day notice is required to discontinue this service due to the time required to initiate this change with your credit card company.)* I further agree that if my credit card is declined for payment, whether with or without cause and whether intentionally or inadvertently, I will be charged a $25 service charge for each occurrence. Credit card transmissions are submitted to the bank approximately the 20th of every month, for the following month's premium.

[1]**The zip code must match the cardholder's address otherwise the credit card cannot be processed.**

SIGNATURE of CREDIT CARD ACCOUNT HOLDER (Required to Process).	Date