Small Business

2027 Application for Group Enrollment and Change

Medical plans are provided by Health Net of California, Inc. Life/AD&D insurance plans are underwritten by Health Net Life Insurance Company (together, "Health Net"). Health Net Dental HMO and PPO plans, other than pediatric dental, are offered and serviced by Dental Benefit Providers of California, Inc. (DBP). Vision plans, other than pediatric vision, are underwritten by Health Net Life Insurance Company and serviced by EyeMed Vision Care, LLC ("EyeMed").

Pediatric dental HMO and PPO plans are provided by Health Net of California, Inc. and administered by DBP.

Neither DBP nor EyeMed are affiliated with Health Net. Obligations under dental plans, other than pediatric dental, are not obligations of, and are not guaranteed by, Health Net.

Welcome to Health Net

Simple steps for completing the form:

1. Review the materials enclosed in your enrollment packet. Be sure that you understand the coverage options that are available to you by your employer.

2a. **If you are declining coverage** for yourself and/or your dependents, section 7 is required. Do not fill out any other sections.

2b. **If you are accepting coverage** for yourself and/or your dependents, sections 1, 2, 3, 5, and 8 are required.

The Affordable Care Act (ACA) requires Health Net to provide to the IRS confirmation of health care coverage for yourself, as the subscriber, and your covered dependents. The IRS uses this information to confirm each member has minimum essential coverage. In addition, California Senate Bill 78 requires all residents and their dependent to obtain and maintain monthly minimum essential coverage. The Social Security Numbers (SSN) are also provided to the Franchise tax Board. We request you provide an accurate Social Security number (SSN) or Tax Identification number (TIN) for yourself and each dependent you are enrolling. A Matricular ID # is requested for any enrollees residing in Mexico when enrolling on a Salud HMO y Más plan. For more information about the individual shared responsibility payment provision, go to http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision.

3. If you choose to enroll in the Full HMO, WholeCare HMO, SmartCare HMO, Salud HMO y Más, or Dental HMO (DHMO) plans, you must select your participating physician group (PPG), primary care physician (PCP) or dental provider. Be sure to fill in the names and numbers as they appear in Health Net's online ProviderSearch tool.

   Note: If you do not select a PPG, PCP and/or a dental provider, one will be selected for you.

4. If you choose to enroll in a PPO plan, you are not required to select a PPG or PCP to enroll.

5. Make a copy of the completed application for your records. **If a correction is needed, cross out the incorrect information, write the correct information clearly next to it, and ensure the change is legible.**

For administrative use only:

Existing Business/Group
PO Box 9103
Van Nuys, CA 91409-9103
www.healthnet.com

New Business/Group
Please send all completed paperwork to your designated account executive or broker.

FRM066463EP00_SBG_CA (6/26)
SBGEEFFORM 1/27

To be completed by employer	
Employer name:	
Requested effective date:	Employer group number *(medical)*:
Employee eligibility date *(new hire only)*: ☐ Same as hired date ☐ Other: _____	

health net™

Important: Please print all sections in black ink. You are entitled to see a Summary of Benefits and Coverage (SBC) before you choose a plan. Please contact your employer if you do not have the SBC for the plan you have selected.

1. Health plan information (All medical plans include pediatric dental and vision coverage.)

Full HMO Network[1]			SmartCare HMO Network[2]		
Platinum ☐ $10 ☐ $20 ☐ $30 ☐ $35	**Gold** ☐ $30 ☐ $35 ☐ $40 ☐ $50 ☐ $55	**Silver** ☐ $55	**Platinum** ☐ $10 ☐ $20 ☐ $30 ☐ $35	**Gold** ☐ $30 ☐ $35 ☐ $40 ☐ $50 ☐ $55	**Silver** ☐ $55
WholeCare HMO Network[1]			**Salud HMO y Más Network[3]**		
Platinum ☐ $10 ☐ $20 ☐ $30 ☐ $35	**Gold** ☐ $30 ☐ $35 ☐ $40 ☐ $50 ☐ $55	**Silver** ☐ $55	**Platinum** ☐ $0 ☐ $10 ☐ $20 ☐ $30 ☐ $35	**Gold** ☐ $30 ☐ $35 ☐ $40 ☐ $50 ☐ $55	**Silver** ☐ $55

Full PPO Network

☐ Platinum PPO 0/5	☐ Gold PPO 0/35	☐ Silver PPO 1750/50	☐ Bronze PPO 5800/60
☐ Platinum PPO 0/25	☐ Gold PPO 500/30	☐ Silver PPO 2250/55	☐ Bronze HDHP PPO 7800/0%
☐ Platinum PPO 250/15	☐ Gold PPO 500/20	☐ Silver PPO 2500/60 STD	
☐ Platinum PPO 500/20	☐ Gold PPO 750/25	☐ Silver PPO 2500/60 ALT	
	☐ Gold PPO 1000/30	☐ Silver PPO 2900/65	
	☐ Gold PPO 1500/35	☐ Silver HDHP PPO 1750/50%	
	☐ Gold HDHP PPO 1750/30%	☐ Silver HDHP 3500/35%	

Other plan(s):

_____

Dental (DHMO)	Dental (DPPO)		Vision (PPO)	
☐ HN Plus 150	☐ Classic 4 1500	☐ Essential 2 1000	☐ Elite 1010-1	☐ Supreme 010-2
☐ HN Plus 225	☐ Classic 5 1500 (w/ortho)	☐ Essential 5 1500 (w/ortho)	☐ Preferred 1025-2	☐ Preferred 1025-3
	☐ Classic 7 Unlimited	☐ Essential 6 1500	☐ Preferred Value 10-3	☐ Plus 20-1
	☐ Classic 11 Unlimited (w/ortho)	☐ Essential 10 3000 (w/ortho and implants)	☐ Exam Only	
		☐ Essential 11 5000 (w/ortho and implants)		

2. Reason for application

Changes to exsisting contract

- ☐ Plan change
- ☐ Change address (Mailing/Postal)
- ☐ Delete Dependent
- ☐ Change DOB
- ☐ Change Name
- ☐ Restore prior coverage
- ☐ Other: _____

- ☐ New hire/Newly eligible
- ☐ Open Enrollment
- ☐ Loss of Coverage

Special Enrollment Period
Qualifying event date: ____ /____ /_____

☐ **COBRA[4] Effective date:** ____ /____ /_____
COBRA qualifying event: _____
COBRA qualifying event date: ____ /____ /_____

Add spouse/dependent:

☐ Marriage ☐ Newborn/Adoption/Legal guardianship/Court order/Assumption of parent-child relationship
☐ Loss of prior coverage ☐ Domestic partnership ☐ Other (specify): _____

[1]Available in all or parts of Alameda, Contra Costa, El Dorado, Fresno, Kern, Kings, Los Angeles, Madera, Marin, Merced, Napa, Nevada, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare, Ventura, and Yolo counties.
[2]Available in all or parts of Los Angeles, Orange, Riverside, San Diego, San Bernardino, Santa Clara, and Santa Cruz counties.
[3]Available in Imperial and Orange County and select ZIP codes of Kern, Los Angeles, Riverside, San Diego, and San Bernardino counties.
[4]Provide the effective date COBRA first began, whether you were eligible for a total of 18 months or 36 months of COBRA (including Cal-COBRA).

3. Employee personal information

Last name:	First name:	MI:	☐ Male ☐ Female
Residence address:			
City:		State:	ZIP:
Mailing address (If applicable):			
City:		State:	ZIP:

Date of birth *(mm/dd/yyyy)*:	Social Security #/TIN/Matricular ID #:	Job title:
Telephone #: ( )	Work phone #: ( )	Email address:
Date of hire *(mm/dd/yyyy)*: / /	Dept. #:	Marital status: ☐ Single ☐ Married ☐ Domestic partner

If available, I would prefer to receive communication and plan information in Spanish: ☐ Yes ☐ No

Participating medical group name:	Primary care physician name:
PPG and Physician Enrollment ID#	Is this your current PCP? ☐ Yes ☐ No

4. Family information, please list all eligible family members to be enrolled.

(Attach additional sheets if necessary.)

Spouse/Domestic partner ☐ M ☐ F	Last name:	First name:	MI:
Residence/ Mailing address: ☐ Check here if same as subscriber			
City:		State:	ZIP:

Date of birth *(mm/dd/yyyy)*:	Social Security #/TIN/Matricular ID #:
Participating medical group name:	Primary care physician name:
PPG and Physician Enrollment ID#	Is this your current PCP? ☐ Yes ☐ No

4. Family information, please list all eligible family members to be enrolled. (continued)

(Attach additional sheets if necessary.)

☐ Son ☐ Daughter	Disabled Dependent: ☐ Yes ☐ No If "Yes", for dependents over the age of 26, please provide disabled dependent certificate.	
Last name:	First name:	MI:
Residence address: ☐ Check here if same as subscriber		
City:	State:	ZIP:
Date of birth *(mm/dd/yyyy)*:	Social Security #/TIN/Matricular ID #:	
Participating medical group:	Primary care physician name:	
PPG/PCP Enrollment ID #:	Is this your current PCP? ☐ Yes ☐ No	

☐ Son ☐ Daughter	Disabled Dependent: ☐ Yes ☐ No If "Yes", for dependents over the age of 26, please provide disabled dependent certificate.	
Last name:	First name:	MI:
Residence address: ☐ Check here if same as subscriber		
City:	State:	ZIP:
Date of birth *(mm/dd/yyyy)*:	Social Security #/TIN/Matricular ID #:	
Participating medical group:	Primary care physician name:	
PPG/PCP Enrollment ID #	Is this your current PCP? ☐ Yes ☐ No	

☐ Son ☐ Daughter	Disabled Dependent: ☐ Yes ☐ No If "Yes", for dependents over the age of 26, please provide disabled dependent certificate.	
Last name:	First name:	MI:
Residence address: ☐ Check here if same as subscriber		
City:	State:	ZIP:
Date of birth *(mm/dd/yyyy)*:	Social Security #/TIN/Matricular ID #:	
Participating medical group name:	Primary care physician name:	
PPG and Physician Enrollment ID#	Is this your current PCP? ☐ Yes ☐ No	

5. Do you or your dependents have other health care coverage?

☐ No ☐ Yes If "Yes," please complete this section including Medicare.

☐ Self	Name:		Name of other insurance carrier:		Prior coverage start date *(mm/dd/yy)*:	
Prior coverage end date *(mm/dd/yy)*:	Reason for ending coverage:		Group #/Policy ID #:	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:
☐ Spouse ☐ Domestic partner	Name:		Name of other insurance carrier:		Prior coverage start date *(mm/dd/yy)*:	
Prior coverage end date *(mm/dd/yy)*:	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? ☐ Yes ☐ No	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:
☐ Son ☐ Daughter	Name:		Name of other insurance carrier:		Prior coverage start date *(mm/dd/yy)*:	
Prior coverage end date *(mm/dd/yy)*:	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? ☐ Yes ☐ No	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:
☐ Son ☐ Daughter	Name:		Name of other insurance carrier:		Prior coverage start date *(mm/dd/yy)*:	
Prior coverage end date *(mm/dd/yy)*:	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? ☐ Yes ☐ No	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:
☐ Son ☐ Daughter	Name:		Name of other insurance carrier:		Prior coverage start date *(mm/dd/yy)*:	
Prior coverage end date *(mm/dd/yy)*:	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? ☐ Yes ☐ No	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:

6. Group term life insurance, if applicable. (Attach separate sheet for additional or contingent beneficiaries.)

Life/AD&D coverage: ☐ Yes ☐ No If "Yes", please complete this section

Life beneficiary (full name):	Relationship:	%
Life beneficiary (full name):	Relationship:	%
Life beneficiary (full name):	Relationship:	%
Life beneficiary (full name):	Relationship:	%

"Plan Contract" refers to the Health Net of California, Inc. and/or Dental Benefit Providers of California, Inc. Group Service Agreement and Evidence of Coverage; "Insurance Policy" refers to Health Net Life Insurance Company Group Policy and Certificate of Insurance.

7. Declination of coverage (Complete this section if any coverage is being declined by you or your eligible dependents.)

Employee personal information

Last name:	First name:	MI:	Social Security #/Matricular ID #:

Declining medical coverage for:
☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent(s)
Name(s): _____

Reason: ☐ Other group coverage through this employer ☐ Individual coverage
☐ Other group coverage by another group *(i.e., spouse's employer)*
☐ Other: _____

Declining dental coverage for:
☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent(s)
Name(s): _____

Reason: ☐ Other group coverage through this employer ☐ Individual coverage
☐ Other group coverage by another group *(i.e., spouse's employer)*
☐ Other: _____

Declining vision coverage for:
☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent(s)
Name(s): _____

Reason: ☐ Other group coverage through this employer ☐ Individual coverage
☐ Other group coverage by another group *(i.e., spouse's employer)*
☐ Other: _____

ONLY SIGN IF YOU ARE DECLINING COVERAGE – STOP AND READ CAREFULLY

I have decided to decline coverage for myself and/or my dependent(s). I acknowledge that my dependents and I may have to wait to be enrolled until the next annual Open Enrollment Period or Special Enrollment Period due to a qualifying event. The available coverages have been explained to me by my employer, and I have been given the chance to apply for the available coverages. Additionally, by signing below, I certify, to the best of my knowledge or belief, that the reason I am declining coverage is accurate as indicated by the check marks above.

Employee signature (or e-signature): _____ **Date:** _____
(Sign only if declining coverage. If signed in error, please cross out and initial.)

8. Acceptance of coverage (Signature required.)

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

ACKNOWLEDGMENT AND AGREEMENT: I understand and agree that by enrolling with or accepting services from Health Net and/or DBP 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 represent that I 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 to the best of my knowledge and belief, 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 *Evidence of Coverage or Certificate of Insurance* 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 Evidence of Coverage or Certificate of Insurance. Mandatory Arbitration may not apply to certain disputes if the Employer's plan is subject to ERISA, 29 U.S.C. §§ 1001461. 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.

Employee signature (or e-signature): _____ **Date:** _____
(Sign only if accepting coverage. If signed in error, please cross out and initial.)

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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, call us at the number listed on your ID card or call 1-800-522-0088 (TTY: 711).

Arabic
خدمات اللغة مجانية. يمكنك الحصول على مترجم فوري. ويمكنك الحصول على وثائق مقروءة لك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة الهوية، أو اتصل على مركز الاتصال التجاري (TTY: 711) 1-800-522-0088

Armenian
Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեզ համար: Օգնության համար զանգահարեք մեզ ձեր ID քարտի վրա նշված հեռախոսահամարով կամ զանգահարեք 1-800-522-0088 (TTY: 711).

Chinese
免費語言服務。您可使用口譯員。您可請人使用您的語言將文件內容唸給您聽，並請我們將有您語言版本的部分文件寄給您。如需協助，請致電您會員卡上所列的電話號碼與我們聯絡，或致電 1-800-522-0088 (TTY: 711)。

Hindi
बनिा लागत की भाषा सेवाएँ। आप एक दुभाषयिा प्राप्त कर सकते हैं। आपको दस्तावेज पढ़ कर सुनाए जा सकते हैं। मदद के लएि, आपके आईडी कार्ड पर दएि गए सूचीबद्ध नंबर पर हमें कॉल करें, या 1-800-522-0088 (TTY: 711)।

Hmong
Kev Pab Txhais Lus Dawb. Koj xav tau neeg txhais lus los tau. Koj xav tau neeg nyeem cov ntaub ntawv kom yog koj hom lus los tau. Xav tau kev pab, hu peb tau rau tus xov tooj ntawm koj daim npav los yog hu 1-800-522-0088 (TTY: 711).

Japanese
無料の言語サービス。通訳をご利用いただけます。文書をお読みします。援助が必要な場合は、IDカードに記載されている番号までお電話いただくか、1-800-522-0088 、(TTY: 711)。

Khmer
សេវាភាសាដោយឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ អ្នកអាចស្តាប់គេអានឯកសារឱ្យអ្នក។ សម្រាប់ជំនួយ សូមទាក់ទងយើងខ្ញុំតាមរយៈលេខទូរសព្ទដែលមាននៅលើកាតសម្គាល់ខ្លួនរបស់អ្នក ឬ ទាក់ទងទៅមជ្ឈមណ្ឌលទំនាក់ទំនងពាណិជ្ជកម្ម នៃក្រុមហ៊ុន 1-800-522-0088 (TTY: 711).។

Korean
무료 언어 서비스. 통역 서비스를 받을 수 있습니다. 귀하가 구사하는 언어로 문서의 낭독 서비스를 받으실 수 있습니다. 도움이 필요하시면 보험 ID 카드에 수록된 번호로 전화하시거나 1-800-522-0088 (TTY: 711).

Navajo
Saad Bee Áká E’eyeed T’áá Jíík’e. Ata’ halne’ígíí hóló. T’áá hó hazaad k’ehjí naaltsoos hach’į’ wóltah. Shíká a’doowoł nínízingo naaltsoos bee néího’dólzinígíí bikáa’gi béésh bee hane’í bikáá’ áajį’ hodíílnih éí doodaii’ 1-800-522-0088 (TTY: 711).

Persian (Farsi)
خدمات زبان به طور رایگان. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید که اسناد برای شما قرائت شوند. برای دریافت راهنمایی، با ما به شماره ای که روی کارت شناسایی شما درج شده تماس بگیرید یا با مرکز تماس بازرگانی 1-800-522-0088 (TTY: 711).

Panjabi (Punjabi)
ਬਨਿਾਂ ਕਸਿੇ ਲਾਗਤ ਤੋਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਆ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਚਿ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਤਿੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ ਕਰਿਪਾ ਕਰਕੇ 1-800-522-0088 (TTY: 711).

Russian
Бесплатная помощь переводчиков. Вы можете получить помощь устного переводчика. Вам могут прочитать документы. За помощью обращайтесь к нам по телефону, приведенному на вашей идентификационной карточке участника плана. Кроме того, вы можете позвонить в 1-800-522-0088 (TTY: 711).

Spanish
Servicios de idiomas sin costo. Puede solicitar un intérprete. Puede obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o comuníquese con el 1-800-522-0088 (TTY: 711).

Tagalog
Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng isang interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo. Para sa tulong, tawagan kami sa nakalistang numero sa inyong ID card o tawagan ang 1-800-522-0088 (TTY: 711).

Thai
ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังได้ สำหรับความช่วยเหลือ โทรหาเราตามหมายเลขที่ให้ไว้บนบัตรประจำตัวของคุณ หรือ โทรหาศูนย์ติดต่อเชิงพาณิชย์ของ 1-800-522-0088 (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. Để nhận trợ giúp, hãy gọi cho chúng tôi theo số được liệt kê trên thẻ ID của quý vị hoặc gọi 1-800-522-0088 (TTY: 711).

FLY1775151XH01w (10/24)