



Post Office Box 9103 • Van Nuys, California 91409-9103

COBRA ENROLLMENT

Previous Company Name

Group #	Effective Date
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Please fill out the entire enrollment form. It cannot be processed without all shaded information.

I elect to continue group coverage as provided under federal law. The qualifying event was:

- | | | |
|--|---|--|
| <input type="checkbox"/> Termination of employment | <input type="checkbox"/> Child no longer eligible | <input type="checkbox"/> Death of subscriber |
| <input type="checkbox"/> Reduction of hours worked | <input type="checkbox"/> Divorce / separation from subscriber | <input type="checkbox"/> Disability |

Date qualifying event occurred

Mo / Day / Yr

Subscriber Name

Subscriber Social Security #

COBRA Applicant Information

Applicant Name	Applicant Social Security #	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Coverage With: <input type="checkbox"/> Health Net <input type="checkbox"/> Other Insurance Company	Name of Other Insurance Company
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Eligible Family Members: Family members who were not covered under your previous group plan may not be included on this form. Dependents who are newly eligible, according to the terms of your Health Net Group Agreement, may be added by filling out a Membership Change form.

Medical Group and Primary Care Physician must be indicated. Eligible members must receive all medical care through the selected medical group and reside within the geographical service area to assure reasonable access to care.

Member Information

Please list eligible members to be enrolled. Members must reside within the geographical service area established by Health Net to assure reasonable access to care. Please note that an incorrect date of birth may result in delay or nonpayment of claims.

		Birth Date	Social Security # / Telephone #	Medicare	HMO, SELECT, and ELECT members:	Medical Group / Primary Care Physician selection						
SELF	<input type="checkbox"/> Male	Last Name	First Name	MI	Mo / Day / Yr	Home #	<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Select medical group for each family member. Indicate name and number of medical group. 2. If the medical group you've selected has an "X" after the number (e.g., IPA 135X), be sure to indicate a Primary Care Physician for yourself and for each family member enrolling in that group.	PMG / IPA #	Medical Group Name		
	<input type="checkbox"/> Female	Home Address	City	State	ZIP	()			Physician Last Name	Physician First Name	MI	
SPOUSE	<input type="checkbox"/> Male	Last Name	First Name	MI	Mo / Day / Yr	Social Security #	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dependent Disabled? Full-Time Student? Over 50% Support?	PMG / IPA #	Medical Group Name		
	<input type="checkbox"/> Female	Home Address	City	State	ZIP	Home #			Physician Last Name	Physician First Name	MI	
DEPENDENT	<input type="checkbox"/> Son	Last Name	First Name	MI	Mo / Day / Yr	Social Security #	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dependent Disabled? Full-Time Student? Over 50% Support?	PMG / IPA #	Medical Group Name		
	<input type="checkbox"/> Daughter	Home Address	City	State	ZIP	Home #			Physician Last Name	Physician First Name	MI	
DEPENDENT	<input type="checkbox"/> Son	Last Name	First Name	MI	Mo / Day / Yr	Social Security #	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dependent Disabled? Full-Time Student? Over 50% Support?	PMG / IPA #	Medical Group Name		
	<input type="checkbox"/> Daughter	Home Address	City	State	ZIP	Home #			Physician Last Name	Physician First Name	MI	
DEPENDENT	<input type="checkbox"/> Son	Last Name	First Name	MI	Mo / Day / Yr	Social Security #	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dependent Disabled? Full-Time Student? Over 50% Support?	PMG / IPA #	Medical Group Name		
	<input type="checkbox"/> Daughter	Home Address	City	State	ZIP	Home #			Physician Last Name	Physician First Name	MI	

Other Health Insurance Are you or have you and/or any of your eligible family members been covered by other medical coverage within the last six months? Yes No If yes, complete the section below. Please list all current or prior medical coverage. Failure to provide complete information may result in significant delay of claims processing. (Attach additional sheets if necessary)

Covered Person's Name	Policy Holder Name(s)	Insurance Company Name(s)	Type of Coverage	Policy No.	Effective Date	Termination Date (If Applicable)
			<input type="checkbox"/> Health <input type="checkbox"/> Other			
			<input type="checkbox"/> Health <input type="checkbox"/> Other			

QUESTIONS? HMO members please call 1-800-522-0088. SELECT, ELECT, PPO, and Flex Net members please call 1-800-676-6976. Telecommunications Device for the Deaf, 1-800-995-0852. Para los que hablan español llamen al 1-800-331-1777.

Health Net HMO, SELECT and ELECT are underwritten by Health Net. Health Net PPO and Flex Net are underwritten by **Health Net Life Insurance Company**.

Authorization to obtain or release medical information explanation: This authorization to obtain and release medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act, effective January 1, 1980, Section 56 et. seq. of the California Civil Code. Your cooperation is appreciated.

Authorization to obtain or release medical information: I hereby authorize my physician, health care practitioner, hospital, clinic or other medical or medically related facility to furnish an agent, designee or representative of Health Net any and all records pertaining to medical history, services rendered or treatment given to anyone enrolled hereunder or added hereunder for purpose of review, investigation or evaluation of an application or a claim. I authorize Health Net or its agents, designees or representatives to disclose to a hospital or health care service plan, self-insurer or insurer any such medical information obtained if such disclosure is necessary to allow the processing of any claim. This authorization shall become effective immediately and shall remain in effect as long as is necessary to

enable Health Net to process claims.

Arbitration Agreement: I understand that any dispute or controversy, except medical malpractice, that may arise regarding the performance, interpretation or breach of the agreement between myself (and / or any enrolled family member) and Health Net or any Participating Medical Group/ Independent Physicians Association, whether arising in contract, tort or otherwise, must be submitted to arbitration in lieu of a jury or court trial.

Applicant Signature X	Date
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Health Net Coverage For Emergency Services

Emergency Care is any otherwise covered medical service you receive which meets the following conditions: The service is due to an injury or a sudden and unexpected illness of sufficient severity, including severe pain and active labor, that, if you do not receive immediate treatment, it presents a serious threat to your health, could seriously impair your physical functions, or could cause a serious dysfunction of any organ or body part.

Urgently Needed Care is any otherwise covered medical service you receive for treatment of an injury or unexpected illness and is required immediately to prevent the serious deterioration of your health, when contacting your PMG or returning to your PMG's Service Area would cause a delay in treatment.

HMO, SELECT, ELECT Member

EMERGENCY CARE

In the event of an Emergency or Urgently Needed Services, immediately telephone your Medical Group and follow instructions given. If it is not possible to notify the PMG before receiving care notify your PMG as soon as possible after receiving care.

In an Emergency, if you are outside of the Participating Medical Group Service Area (more than 30 miles from your Medical Group), go directly to the nearest hospital emergency room for treatment and notify your Medical Group.

PPO, Flex Net

EMERGENCY CARE

If you require Emergency Services, please call the appropriate number before receiving care, or within 48 hours.

Health Net Treatment Review: OPTIONS 1-800-774-4776
FLEX NET 1-800-762-2003