Health Net Health Plan of Oregon, Inc.
888-802-7001

Oregon Enrollment and Change Form

PLEASE NOTE: ALL FIELDS MUST BE FILLED OUT LEGIBLY AND COMPLETELY
ANY MISSING OR ILLEGIBLE INFORMATION MIGHT DELAY YOUR ENROLLMENT IN THE PLAN.

FOR PLAN USE ONLY
Ref#

1. GROUP INFORMATION (to be completed by the group)

Group Name		Group ID	**Enrollment Reasons:** ☐ New Hire ☐ Rehire ☐ Open Enrollment ☐ Plan Change ☐ Dependent Change ☐ Delete Self or Dependent ☐ Marriage ☐ Birth ☐ Court Order ☐ Adoption (legal document required) ☐ Loss of Other Coverage ☐ COBRA or State Continuation ☐ Employee Entered Eligible Class (indicate part-time to full-time, temporary to permanent, hourly to salaried, etc.) ☐ CHIP ☐ Other	
Employee Date of Hire / /	Date Employee Became Eligible ☐ Same as hire date ☐ Other / /	Effective Date / /	☐ New ☐ Change	Date of Event / /
Employee Job Title	Employee Class (if applicable)		If COBRA, indicate number of months eligible for coverage: ☐ 18 months ☐ 29 months ☐ 36 months If State Continuation, eligible period of coverage cannot exceed 9 months. Attach COBRA or State Continuation election form.	
Employer Initials	Date / /	Employee Type: ☐ Retired ☐ Salaried ☐ Hourly	Hours/Week:	

2. EMPLOYEE INFORMATION (employee to complete sections 2 through 3)

Employee Name (Last) (First) (MI)		☐ Married / Registered DP * ☐ Unmarried	Home Phone ( )	E-mail address	
Social Security Number**	Home Address	City	County	State	Zip
Mailing Address (if different than home address)		City	County	State	Zip

3. ENROLLMENT INFORMATION

Medical plan choice:________________________ ☐ Dental

Add	Drop	Waive	If waiving covearge, select reason	Relationship to Employee & Gender	Last Name	First Name	MI	Date of Birth	Social Security Number **	Tobacco Use	HMO/POS ONLY – Primary Care Provider Information	Current Patient?
☐	☐	☐	☐ Other Group Coverage ☐ Individual ☐ Other___________________	☐ **Self** ☐ Male ☐ Female	Same as above	Same as above		/ /		☐ Yes ☐ No	(Last, First Name)	☐ Yes ☐ No
☐	☐	☐	☐ Other Group Coverage ☐ Individual ☐ Other___________________	Write in relationship here ☐ Male ☐ Female				/ /		☐ Yes ☐ No	(Last, First Name)	☐ Yes ☐ No
☐	☐	☐	☐ Other Group Coverage ☐ Individual ☐ Other___________________	Write in relationship here ☐ Male ☐ Female				/ /		☐ Yes ☐ No	(Last, First Name)	☐ Yes ☐ No
☐	☐	☐	☐ Other Group Coverage ☐ Individual ☐ Other___________________	Write in relationship here ☐ Male ☐ Female				/ /		☐ Yes ☐ No	(Last, First Name)	☐ Yes ☐ No
☐	☐	☐	☐ Other Group Coverage ☐ Individual ☐ Other___________________	Write in relationship here ☐ Male ☐ Female				/ /		☐ Yes ☐ No	(Last, First Name)	☐ Yes ☐ No
☐	☐	☐	☐ Other Group Coverage ☐ Individual ☐ Other___________________	Write in relationship here ☐ Male ☐ Female				/ /		☐ Yes ☐ No	(Last, First Name)	☐ Yes ☐ No

Does a dependent have a different mailing address? ☐ No ☐ Yes, complete the following: Name of dependent(s) (Last, First, MI) ____
Dependent's mailing address: ______________________________________ City ___________________ State ___________________ Zip ______________

Is any child over the dependent age limit applying for coverage due to disability? ☐ No ☐ Yes, complete and attach the *Disabled Dependent Certification Form.*

Has any person applying for coverage had health insurance coverage at any time during the last 63-days before your enrollment with Health Net? ☐ No ☐ Yes, attach your *Certificate of Creditable Coverage* from your current or prior health plan. You may be eligible for prior coverage credit towards pre-existing or other coverage limitations. Effective Date of Coverage: / / End Date of Coverage: / /

Do you and/or your dependent(s) have health coverage that will remain in effect when your Health Net coverage begins? ☐ No ☐ Yes, attach your *Coordination of Benefits Form* Please list other insured's DOB: / /
If Medicare indicate: ☐ Part A ☐ Part B Effective Date: / / Medicare ID Number: _________________________ ; ☐ Part A ☐ Part B Effective Date: / / Medicare ID Number: _________________________

In applying for enrollment as indicated on this application, I declare that to the best of my knowledge, all of the information on this form is true and complete, and all of the persons for whom I am requesting enrollment are eligible for coverage. I have also read and understand the provisions below. The changes on this form supersede all previous forms submitted. If I decline coverage for myself and/or Dependents, I acknowledge that those declined will have to wait to be enrolled until the next Open Enrollment period or qualifying event.

Employee Signature ____ Date Signed / /

*Domestic Partner **Federal regulations require this information for enrollment

This plan imposes a preexisting condition exclusion. This means that if you have a medical condition before coming onto our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a 6-month period. Generally, this 6-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy, to a child who is enrolled in the plan within 31 days after birth, adoption, or placement for adoption, nor to enrollees under the age of nineteen (19). The preexisting condition exclusión does not apply to physical or mental injuries sustained as a result of domestic or sexual violence or treatment received for such injuries. You can reduce the length of this exclusion period by the number of days of your prior "Creditable Coverage".

Definition: "Creditable Coverage" means health care coverage under a group or individual Health Benefit Plan, Medicare, Medicaid, military-sponsored health care, a medical care program of the Indian Health Service or of a tribal organization, a state health benefits risk pool, a Federal Employees' Health Benefit Plan (FEHBP), a public health plan, or a Health Benefit Plan under the Peace Corps Act, except coverage consisting solely of coverage of benefits for which credit is not required under applicable law. Coverage is Creditable only if there had not been a gap in coverage exceeding 63 days.

If you are declining enrollment for yourself or your Dependents (including your spouse or Registered Domestic Partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this plan if you or your Dependents lose eligibility for that other coverage (or if your employer stops contributing toward your or your Dependents' other coverage). However you must request enrollment within 31 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. If you previously declined enrollment in this plan for yourself or your Dependents because of coverage under a Medicaid plan or CHIP plan, you can enroll within 60 days of loss of such coverage. If you become eligible for premium assistance under a Medicaid plan or CHIP plan, you or your Dependents can enroll in this plan within 60 days of becoming eligible for premium assistance.

IMPORTANT: THE FOLLOWING TERMS ARE A PART OF THIS APPLICATION. YOU MUST READ THEM CAREFULLY. DO NOT SIGN THE APPLICATION ABOVE UNTIL YOU UNDERSTAND THESE TERMS.

I, the applicant (employee) on my behalf and on behalf of every covered Dependent listed on this form or added in the future hereby:

1. Agree that in the event any health care benefits provided to me or any covered Dependent by Health Net Health Plan of Oregon, Inc. (Health Net of Oregon) and/or its representatives are the primary responsibility of Medicare or of any coverage for work-related injuries, illness or conditions or of any third party on account of any injury, illness, condition or damage, I will fully inform Health Net of Oregon and/or its representatives and will execute such assignments, liens or other documents which may be necessary to enable Health Net of Oregon and/or its representatives to recover the value of services provided. I further agree that in the event I, any Dependent or any of my family members collect benefits, damages or reimbursement from Medicare or any other third party with respect to such injury, illness, condition or damage, I will immediately reimburse Health Net of Oregon and/or its representatives to the full extent of services provided by Health Net of Oregon and/or its representatives in accordance with the group contract/policy; and
2. Agree to be bound by each and every provision of the group contract/policy (including all schedules and attachments which are a part of the group contract/policy) as now in effect and as may be amended in the future, and agree that all my rights are as specifically set forth in the group contract/policy; and
3. Authorize my employer to deduct from my earnings any amount required to cover my share of the premiums or prepayment fees, if any, payable under the group contract; and
4. Acknowledge that I have selected a Primary Care Physician/Provider from the current Health Net of Oregon Participating Provider network, (for HMO and Triple Option/POS plans); that this list identifies Participating Providers as of the date of publication; that changes in a provider's status, and additions to or deletions from this list may occur, that Health Net of Oregon and/or its representatives neither warrants nor guarantees the availability of any specific Participating Provider; and
5. Acknowledge that Health Net of Oregon and/or its representatives benefits are only available if obtained in compliance with all provisions of the group contract/policy; and
6. Acknowledge that all Participating Providers are independent contractors and are not agents, servants, officers, employees, partners or joint venturers of or with and are not controlled by Health Net of Oregon and/or its representatives; that the Participating Providers, including Primary Care Physicians, are responsible for the delivery of or arrangement for all medical services to me and my Dependents; and Health Net of Oregon and/or its representatives is not and will not be responsible for the deliberate or negligent acts or omissions of any such Participating Provider or any Non-Participating Provider.

Send this application to: **Health Net Health Plan Plan of Oregon, Inc.**
P.O. Box 9103
Van Nuys, CA 91409-9103

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