

**Enrollment Application/Change of Status**

Group Name	Division	Group ID Number	Effective Date of Application (to be completed by the Benefits Administrator)
Reason for Application: <input type="checkbox"/> Open Enrollment <input type="checkbox"/> I have Health Net dental coverage. I am adding Health Net vision <input type="checkbox"/> I have Health Net vision coverage. I am adding Health Net dental <input type="checkbox"/> Terminate Employee <input type="checkbox"/> Terminate Dependent(s) listed below <input type="checkbox"/> Add Dependent(s) listed below <input type="checkbox"/> New Name (indicate below) Former Name: _____ <input type="checkbox"/> New Address (indicate below) <input type="checkbox"/> New Hire/Newly Eligible - <input type="checkbox"/> Qualifying Event (reason) _____ Date of Hire or Qualifying Event ____/____/____			<b>The Employer certifies that applicant meets all contractual eligibility requirements as defined in the Group Agreement or Policy.</b>

**Personal Information**

Social Security Number	Last Name	First Name	M.I.	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Hours Worked Per Week
Street Address		City (complete name)	State	Zip Code	Home Phone ( )	Work Phone ( )

**Benefit/Dependent Information**

**Check all new benefits requested**

Relationship to Employee	Last Name (if different)	First Name	M.I.	Date of Birth	Sex M / F	*Over aged dependent Disabled Full-time Student	Dependent Add/Delete	HMO Vision	PPO Vision	Indemnity Vision	Dental PPO	Dental Indemnity	Dental DHMO	**Dental DHMO Office Selected	Existing Patient
Self								<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse				Month Day Year	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> add <input type="checkbox"/> delete	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Child				Month Day Year	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/> add <input type="checkbox"/> delete	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Child				Month Day Year	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/> add <input type="checkbox"/> delete	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Child				Month Day Year	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/> add <input type="checkbox"/> delete	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No

\* If you have a Dependent Child(ren) who is over 19 and is permanently disabled and dependent upon you for support, please provide the appropriate supporting documentation. Please see your Human Resources representative for details.

**\*If you have a Dependent Child(ren) between the ages of 19 and 24 who is a full-time student and a dependent as defined by the IRS, please provide the following information:**

School Name	Number of Credit hours (minimum of 12 hours)	School Start Date
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\*\* New Employee and eligible Dependent(s) enrolling in a Dental HMO plan MUST indicate a dental office. If a dental office is not indicated, you and your Dependent(s) will be automatically assigned to an office selected by Health Net Dental.

**IMPORTANT PROVISIONS:**

*Please read and retain with your personal records*

**Please read the consent for use and disclosure of Dental/Medical Information and the Binding Arbitration agreement below and indicate your agreement to these conditions.**

**Authorization to release dental records** - Authorization to release dental records - I hereby authorize the release and disclosure to review, or to obtain a copy of, any and all dental records which pertain to me or any member of my family, maintained by my chosen selected general dentist and/or specialist, to Health Net and/or any designated agent or representative for the purposes of dental treatment, care and for SafeGuard's quality assessment and utilization reviews, which will be kept strictly confidential. This authorization shall remain valid for the term of this coverage.

**Binding Arbitration:** Each and every disagreement, dispute or controversy, which remains unresolved, concerning the construction, interpretation, performance or breach of this contract, or the provision of dental/vision care services under this contract after exhausting our complaint procedures, arising between the organization, a member or the heir-at-law or personal representative of such person, as the case may be, and our company, its employees, officers or directors, or participating dental/vision Provider or their dental/vision care groups, partners agents, or employees, may be voluntarily submitted to arbitration in accordance with the American Arbitration Association rules and regulations, whether such dispute involves a claim in tort, contract or otherwise. This includes, without limitation, all disputes as to professional liability or malpractice, that is as to whether any dental/vision services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered. It also includes, without limitation, any act or omission which occurs during the term of this contract but which gives rise to a claim after the termination of this Contract. Arbitration shall be initiated by written notice to the President, Health Net Dental/Vision, c/o SafeGuard Health Plans, Inc. P.O. Box 30900, Laguna Hills, California 92654-0900. The notice shall include a detailed description of the matter to be arbitrated.

**Authorization**

**If applicable, I hereby authorize payroll deduction. I understand that I must remain in the plan(s) indicated above throughout the duration of the Group Agreement or Policy. Should I choose not to enroll myself and/or my eligible Dependent(s) during the open enrollment period, I understand that I will be unable to enroll myself and/or my Dependent(s) until the next annual open enrollment period. My signature below confirms that I understand all agreements, including my agreement to submit disputes to binding arbitration. I have read and understand the terms on the reverse of this application, and my signature below indicates my acceptance of these terms and that the information I have entered above is true and correct. The Plan reserves the right to rescind or terminate coverage if any material misrepresentation is made in the Enrollment Application.**

Employee Signature	Date
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## **IMPORTANT!**

*Please read and retain the goldenrod copy of this form with your personal records.*

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

Health Net Dental/Vision Indemnity/PPO policies are underwritten by SafeHealth Life Insurance Company ("SafeHealth"). Health Net Dental/Vision Managed Care plans are provided by SafeGuard Health Plans, Inc. ("SafeGuard"). Obligations of SafeGuard or SafeHealth are not the obligations of or guaranteed by Health Net, Inc. or its affiliates.