NY OUTLOOK POS ADVANTAGE PLATINUM ENROLLMENT FORM

Please complete this application full, including your signature.
Use blue or black ink only and be sure all copies are printed legibly.

HEALTH NET CUSTOMER SERVICE PHONE NUMBER

Toll-free: 1-800-441-5741

ENROLLEE INFORMATION (please print clearly)

Last Name: | First Name: | M.I. | Social Security Number:

COMPLETE HOME ADDRESS | Street: | City: | State: | ZIP Code:

❑ Single (S) ❑ Married (M) ❑ Widowed (W) ❑ Separated (L) ❑ Divorced (D) ❑ Other (O) ________

Home Phone: ( ) | Business Phone: ( )

EMPLOYMENT INFORMATION*

Check box if you are actively employed ❑

Check box if you are retired ❑

Union Affiliation:

Average Number of Hours Worked Per Week: ❑ Under 20 Hours ❑ 20-29 Hours ❑ 30+ Hours

OTHER HEALTH COVERAGE INFORMATION

Question		
Will you be covered by another health plan when Health Net coverage starts? ❑ Yes ❑ No	If yes, list name and address of other carrier:	Spouse's Social Security Number
Is your spouse employed? ❑ Yes ❑ No	If yes, list employer's name and address:	Spouse's Daytime Phone Number: Spouse's Date of Birth: MO / DAY / YR
Will your spouse be covered by another health plan when Health Net coverage starts? ❑ Yes ❑ No	If yes, list name and address of other carrier:	Policy/Contract #:
Will your dependents be covered by another health plan when Health Net coverage starts? ❑ Yes ❑ No	If yes, list name and address of other carrier:	Policy/Contract #:

MEDICARE INFORMATION

Question		
Are you covered by Medicare? ❑ Yes ❑ No	Medicare #:	Effective Dates: Part A Part B
Is your spouse covered by Medicare? ❑ Yes ❑ No	Medicare #:	Effective Dates: Part A Part B
Are other dependents covered by Medicare? ❑ Yes ❑ No	Name(s): Medicare #:	Effective Dates: Part A Part B

STUDENT INFORMATION

If dependent children listed are age 19 or older, do the attend school on a full-time basis? ❑ Yes ❑ No	If yes, list the name of child and school	If no, is this dependent child disabled? ❑ Yes ❑ No

List yourself and any eligible dependents to be covered. **If you or any enrollee had previous health care coverage, enter start and end date of coverage next to name.

	Dates of Prev. Coverage**	Last Name First Name M.I.	Social Security #	Sex M/F	Date of Birth MO DAY YR	Primary Care Physician's Name	*Physician's Access Number
Self							
Spouse							
Child							
Child							
Child							

*This number appears in your provider directory below physician address and telephone number.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

AGREEMENT (please sign and date): Your Evidence of Coverage and Certificate of coverage, respectively, are herein after, collectively referred to as your "Health Net contracts." I understand that in New York, coverage under the In-network portion of the Point-of-Service Plan is provided by Health net of New York, Inc.. The out-of-network coverage for the Point-of-Service Plan is underwritten by Health Net Insurance of New York, Inc.

I understand the Health Net benefits and coverage as summarized in the Health Net plan materials and that these benefits are administered strictly as specified in the Health Net Group Subscriber Contract. I authorize any physician, hospital, insurer or other organization or person having any records or information concerning the health and treatment (including psychiatric, substance abuse, and confidential HIV related information) or me and my family member(s) to furnish such records as may be requested by Health Net of the Northeast, Inc. or its authorized representative for purposes relating to coverage. A photocopy or digital image of this authorization shall be considered as valid as the original. This authorization shall renew upon any subsequent renewal of coverage under this policy. I understand that Health Net is not liable to provide coverage to ineligible dependants. If I am required to contribute, I authorize my employer to deduct from any compensation the amount required the amount required for the coverage selected. I certify that all information above is correct to the best of my knowledge.

Signature ____________ Date ________

HEALTH INFORMATION I acknowledge that health care providers may disclose health information about me or my dependents, including information regarding substance abuse or mental/emotional conditions to Health Net. The plans use and disclose this information of treatment, payment and health plan operations, including but not limited to utilization management, quality improvement, disease or case management programs.

TO BE COMPLETED BY EMPLOYER

Name of employer or employing office:	Reason for Enrollment: ❑ New Plan ❑ COBRA Enrollment ❑ 18 Months ❑ 36 months ❑ Open Enrollment ❑ Other — Date of Hire: MO / DAY / YR	Effective Date of Coverage:	Group #:	Subgroup:	Plan Code:

Company Signature ____________ Date ________

Health Net: One Far Mill Crossing, P.O. Box 904, Shelton, CT 06484-0944 White Copy-Health Net • Yellow Copy-Employer • Pink Copy-Subscriber

NY46807 (2/08) 6016099

Coverage is provided by subsidiaries of Health Net of the Northeast, Inc. and Health Net Life Insurance Co. Coverage may be provided by Health Net of New York, Inc. or Health Net Insurance of New York, Inc. in New York; Health Net of New Jersey, Inc. or Health Net Life Insurance Co. in New Jersey; and Health Net of Connecticut, Inc. or Health Net Life Insurance Co. in Connecticut. Health Net® is a registered service mark of Health Net, Inc. All rights reserved.

Health Net of the Northeast, Inc.
One Far Mill Crossing
Shelton, CT 06484

Application for Group Health Coverage
And Plan Specifications – New York

Please Print | Plan Number (Health Net Use only):

☐ New Plan ☐ Change of Plan | Requested Effective Date:

SECTION I: PLANHOLDER INFORMATION

Planholder (full legal name of company) | Tax ID#:

Mailing Address (street, apt/suite):

Mailing Address (city, state, zip):

Email Address: | Fax #: ( ) | Phone #: ( )

Name of Contact: | Title: | Phone #: ( )

Type of organization: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other (explain):

Total # of employees: | Total # of full-time employees: | Total # of full-time employees to be insured:

Amount of Binder Check: $ (one month's premium) | Nature of Business (specify): | Date established: | SIC:

Waiting Period for future employees: ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ 120 days ☐ 180 days

Do you have any affiliates, subsidiaries or branches? ☐ Yes ☐ No

Affiliate, subsidiaries or branches (legal name & location)	Nature of business	# of full-time employees in company	# of full-time employees to be insured

A Full-time employee means one who regularly works the number of hours in the normal workweek established by this planholder (not less than 20 hours per week for groups with 2-50 employees) at the planholder's normal place of business.

Are all full-time employees to be included? ☐ Yes ☐ No If "no" indicate class or classes to be excluded:

Percentage of employer contributions for medical coverage: Employee Coverage: _________ % Dependent Coverage: ________ %

# of Eligible Employees: ________ # of Employees on COBRA: ______ # of Total Employees: ________

# of Covered Employees: ______ # of Waivers: ________

SECTION II: SUPPLEMENTARY INFORMATION (*All questions must be answered)*

1) Has this planholder or any of its affiliates, either under its present name or any other name, ever applied for group insurance with Health Net? ☐ Yes ☐ No If "yes," furnish year, name of employer, plan number and date of cancellation:

2) If present carrier provided life insurance, are extended benefits provided in case of disability? ☐ Yes ☐ No

3) Does your planholder have any other insurance plan:
   a) Now in force and to be continued? ☐ Yes ☐ No
   b) That you are currently applying for? ☐ Yes ☐ No
   If "yes," give description of plan and name of carrier(s):

4) Name of prior group health carrier: | Cancellation date:

5) To the best of your knowledge, are there any current and former employees or their eligible dependents whose health insurance is being continued? ☐ Yes ☐ No
   Please provide the following information on health continuation for each current/former employee or dependent:

Employee/Dependent	Date of Birth	Continuation State/Federal	Continuation due to Disability / Non-Disability	Continuation Dates Start / Expiration

Be certain to read this entire application/plan specification: then sign, date, and have it witnessed on page 3.

SECTION III: AGENT/PRODUCER INFORMATION

Agent / Broker Name: ________________________ Health Net Agent Number / Tax ID / SSN: ___________________________

Agency Name: ______________________________ % of Credit: ____

Phone #: (_____)______________ ______________ Fax #: (_____)____

Address: ___________________________________ City: _________________ State: _______ Zip: __________

Signature: __________________________________ Date: _______________ Email Address: ____________________________

Agent / Broker Name: ________________________ Health Net Agent Number / Tax ID / SSN: ___________________________

Agency Name: ______________________________ % of Credit: ____

Phone #: (_____)_____________________________ Fax #: (_____)____

Address: ___________________________________ City: _________________ State: _______ Zip: __________

Signature: __________________________________ Date: _______________ Email Address: ____________________________

General Agent Name: ________________________ Health Net Agent Number / Tax ID / SSN: ___________________________

Agency Name: ______________________________ % of Credit: ____

Phone Number:(_____)________________________ Fax Number : (_____)____

Address: ___________________________________ City: _________________ State: _______ Zip: __________

Signature: __________________________________ Date: _______________ Email Address: ____________________________

SECTION IV: CERTIFICATION: *(For Groups of 2-50 Employees Only)*

A Small Employer is any person, firm, corporation, partnership or association actively engaged in business with corporate headquarters located in the State of New York who, on their APPLICATION DATE of coverage, employed AT LEAST TWO, BUT NOT MORE THAN FIFTY eligible employees. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return will be considered a single employer. Please be advised that the total number of employees should also include you as the employer.

COMPLETE IF YOU DO MEET THE DEFINITION OF A SMALL GROUP EMPLOYER:
I certify that **I qualify** as a Small Group Employer in that on the date of application for Major Medical coverage, we employ no less than two and no more than fifty employees.
I have reviewed the statements made by me on the supplement, and to the best of my knowledge and belief, they are true and complete.

Initial of Officer, Partner or Proprietor: ______________

-------------- WE MUST HAVE A COPY OF YOUR MOST RECENT STATE/FEDERAL QUARTERLY WAGE REPORT ----------------------

COMPLETE IF YOU DO NOT MEET THE DEFINITION OF A SMALL GROUP EMPLOYER:

I certify that **I am not** a Small Employer in the State of New York in accordance with New York AB 12350-A.

Initial of Officer, Partner or Proprietor: ______________

Please check the appropriate reason why you do not meet the definition of a Small Employer:

☐ Employs less than two or more than 50 employees
☐ Corporate Headquarters is located outside of the State of New York
☐ Other (please explain): ____

____

It is understood that only full-time employees shall be eligible. **For medical coverage only:** Full-time employees means one who regularly works the number of hours in the normal week established by this planholder *(not less than 20 hours per week for groups that qualify as a Small Group Employer and not less than 30 hours per week for groups that do not qualify as a Small Group Employer)* at the planholder's normal place of business. **For all other coverages**: Full-time employees means one who regularly works the number of hours in the normal work week established by this placeholder (but not less than 30 hours per week) at the planholder's normal place of business. It is further understood that no agent has power on behalf of Health Net to make or modify any request of application for insurance, or to bind said Insurance Company by making any promise or representation or by giving and receiving any information.

It is further understood that: (a) no insurance will be effective until the final offer of plan and rates by Health Net is accepted, in writing, by the employer; and (b) for coverages other than medical coverage, no individual shall become insured while not actively at work. No contract of insurance is to be implied in any way on the basis of completion and submission on this application.

Applicable to Accident and Health Coverages:
"Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime, and *shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."*

I have reviewed the statements made by me on this application, and to the best of my knowledge and belief, they are true and complete.

_______________________________________ _______________________
Signature of Title of Officer, Partner, Proprietor Date

____
Please print name of Title of Officer, Partner, Proprietor

_______________________________________ _______________________
Signature of Witness Date

SECTION V: MEDICAL PLANS

SELECTED MEDICAL PLANS CODE (input selected plan e.g., Outlook POS TWAE51)	SELECTED PRESCIPTION RIDERS CODE (input selected rider – e.g. G40):
☐ PLAN 1 ____________ ☐ PLAN 2 ____________ ☐ PLAN 3 ____________	☐ PLAN 1 ____________ ☐ PLAN 2 ____________ ☐ PLAN 3 ____________

ADDITIONAL RIDERS *(if applicable)*
☐ HIAA Buy-Up ☐ Pharmacy ☐ Vision ☐ Increase Dependent Age

Indicate whether the benefits listed below will be administered on a contributory or non-contributory basis:

EMPLOYEE COVERAGES	CONTRIB.	NON-CONTRIB.	DEPENDENT COVERAGE	CONTRIB.	NON-CONTRIB.
MEDICAL			MEDICAL		

RATES: PLEASE ATTACH ACTUAL RATE QUOTES FROM QUOTING VENDORS OR HEALTH NET WEB SITE

SECTION VI: REMARKS (Use this section for any additional information needed for Plan Specifications)

FOR HEALTH NET USE ONLY	
PLAN CODE: ______________________ Passport/HMO	**PLAN CODE: ________________________ Charter/HMO**
PLAN CODE: ______________________ Passport/POS	**PLAN CODE: ________________________Charter/POS**
PLAN CODE: ______________________ PPO	**PLAN CODE: ________________________Indemnity**

Please complete below if the following individual(s) is different from the contact person listed on page 1 of application:

VIP Correspondent: ________________________ Email: ________________________
Title: ________________________ Phone: ________________________

Billing Correspondent: ________________________ Email: ________________________
Title: ________________________ Phone: ________________________

Benefit Correspondent: ________________________ Email: ________________________
Title: ________________________ Phone: ________________________

CONTINGENCIES:

- We reserve the right to change rates during the policy year to account for federal or state mandates that may be enacted.
- Signature of this application implies that all information on the application is accurate to the best of your knowledge.
- Coverage is not in effect until this application is accepted by Health Net. Coverage is subject to all of the terms and conditions of all the plan documents.

Coverage is provided by subsidiaries of Health Net of the Northeast, Inc. and Health Net Life Insurance Co. Coverage may be provided by Health Net of New York, Inc. or Health Net Insurance of New York, Inc. in New York. Health Net® is a registered service mark of Health Net, Inc. All rights reserved.