HEALTH NET OF ARIZONA, INC.
2010 MEDICARE ADVANTAGE
SHORT ENROLLMENT REQUEST FORM

Name of Plan You are Enrolling In:

Plan	Premium
☐ Health Net Ruby 1 (HMO)	$36 per month
☐ Health Net Ruby 3 (HMO)	$59 per month
☐ Health Net Ruby 4 (HMO) Maricopa & Pinal	$0 per month
☐ Health Net Ruby 4 (HMO) Cochise, Pima, & Santa Cruz	$0 per month
☐ Health Net Green (HMO)	$0 per month
☐ Health Net Amber (HMO)	$24.70* per month *actual premium based on Low Income Subsidy status

Please check one box below if you would like to enroll in Optional Supplemental Benefits – Gold Benefits for an additional monthly premium:

Option	Premium
☐ Optional Supplemental Benefits – Gold Option 1	$29 per month
☐ Optional Supplemental Benefits – Gold Option 2	$17 per month

☐ I currently have the Gold Benefits Option ___ and wish to continue for an additional monthly premium of $____.

Name: ________________________________

Medicare Number: ______________________

(Note: may use "member number" instead of "Medicare number")

Home Phone Number:

Permanent Street Address:

City: State: ZIP Code:

Mailing Address: (only if different from your Permanent Street Address):

Street Address: ________________ City: __________ State: _____ ZIP Code: _________

Please fill out the following:

I am currently a member of the ________________________ plan in Health Net of Arizona, Inc., with a monthly premium of $__________.

I would like to change to the ________________________ plan in Health Net of Arizona, Inc.
I understand that this plan has different health benefits and a monthly premium of $ ___________.

Name of chosen Primary Care Physician (PCP), clinic or health center:

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:

☐ Spanish ☐ Large print ☐ Audio tape

Please contact Health Net at 1-800-977-7522 if you need information in another format or language than what is listed above. Our office hours are 8:00 a.m. to 8:00 p.m., 7 days a week. TTY users should call 1-800-977-6757.

White Copy – Health Net Yellow Copy – Writing Agent Pink Copy – Member

Your Plan Premium

For plans with no premium: If we determine that you owe a late enrollment penalty, we need to know how you would prefer to pay it. You can pay by mail or Electronic Funds Transfer (EFT) each month. You can also pay your premium by automatic deduction from your Social Security benefit check each month.

For all plans with premiums: You can pay your monthly plan premium by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security Check each month.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a coupon book.

Please select a premium payment option:

- ☐ **Get a coupon book**
- ☐ **Electronic Funds Transfer (EFT)**
- ☐ **Automatic deduction from your monthly Social Security benefit check.** (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

PLEASE READ THIS IMPORTANT INFORMATION.

Please Read and Sign Below:

Health Net of Arizona, Inc., is a plan that has a contract with the Federal government.
I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Health Net, he/she may be paid based on my enrollment in Health Net.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Health Net will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand that people with Medicare aren't covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Health Net coverage begins, I must get all of my health care from Health Net, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Health Net and other services contained in my Health Net Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HEALTH NET WILL PAY FOR THE SERVICES.**

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I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Health Net or by Medicare.

Signature:	**Today's date:**

If you are the authorized representative, you must sign above and provide the following information:

Name: ______________________________

Address: ______________________________

Phone Number: (_____)______-________________

Relationship to Enrollee: ______________________________

Health Net Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment): ______________________________

Requested Effective Date of Coverage: ______________________________

Effective Date of Coverage: ____________ Plan/Group ID #:______________ Plan Code: ______________

PCP Code: ________________ PPG Code: __________________ Batch Number: ______________

Application Date: _______________________ Health Net Member ID: ______________________

EFT/Voided Check Received: Y / N Initial Payment Check Received: Y / N Faxed In: Y / N

Election Period (check one):

ICEP/IEP: _____ OEP/New: _____ OEPI: _____ AEP: _____ SEP (type): _______________ Not eligible: ______

Application Pended due to: ______________________________

Producer Name:______________________________ Phone #:____________________ ID # __________

FMO/GA/Agency Name:__________________________ Phone #:____________________ ID # __________

Sales Rep Name:______________________________ Phone #:____________________ ID # __________

Producer Received Date:______________________________

6019600 AZ60504 (8/09) CMS ID# H0351_2010_0126 CMS approval: (10/09)

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