

HEALTH NET OF ARIZONA
 2010 MEDICARE ADVANTAGE INDIVIDUAL
 ENROLLMENT REQUEST FORM



Please contact Health Net if you need information in another language or format (Braille).

TO ENROLL IN HEALTH NET, PLEASE PROVIDE THE FOLLOWING INFORMATION:			
Are you a current Health Net member? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", list your Health Net ID #: _____			
Please check which plan you want to enroll in:			
<input type="checkbox"/> Health Net Ruby 1 (HMO) \$36 per month	<input type="checkbox"/> Health Net Green (HMO) \$0 per month		
<input type="checkbox"/> Health Net Ruby 3 (HMO) \$59 per month	<input type="checkbox"/> Health Net Amber (HMO)* \$24.70 per month <i>(premium will be paid by the government)</i>		
<input type="checkbox"/> Health Net Ruby 4 (HMO)	<i>*You must meet specific enrollment criteria to enroll in this plan. Please contact Health Net or your sales representative for more information.</i>		
<input type="checkbox"/> Maricopa and Pinal \$0 per month			
<input type="checkbox"/> Health Net Ruby 4 (HMO)			
<input type="checkbox"/> Cochise, Pima, Santa Cruz \$0 per month			
HEALTH NET RUBY 1 (HMO), RUBY 4 (HMO), AND GREEN (HMO) MEMBERS ONLY:			
Please check if you would like to enroll in Optional Supplemental Benefits - Gold Benefits.			
<input type="checkbox"/> Gold Benefits Package 1 - Acupuncture, Chiropractic, Dental, and Vision		\$29 per month	
<input type="checkbox"/> Gold Benefits Package 2 - Dental, and Vision		\$17 per month	
<i>Health Net Amber (HMO) and Ruby Option 3 (HMO) members are not able to elect the Gold Benefits options.</i>			
LAST Name:	FIRST Name	Middle Initial:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Birth Date: (___ / ___ / _____) (M M / D D / Y Y Y Y)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: ()	Alternate Phone Number: <i>(Optional)</i> ()
Permanent Residence Street Address: (P.O. Box is not allowed)			
City:	State:	ZIP Code:	County:
Mailing Address: (Only if different from your Permanent Residence Address)			
Street Address:	City:	State:	ZIP Code:
Emergency Contact: (Optional) _____			
Phone Number: () _____ - _____ Relationship to you: _____			
E-mail Address: (Optional)			

White Copy – Health Net

Yellow – Writing Agent

Pink Copy – Member

PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card.
- OR -
- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.



SAMPLE ONLY

Name: _____

Medicare Claim Number _____ Sex ____

Is Entitled To _____ Effective Date _____
HOSPITAL (Part A) _____
MEDICAL (Part B) _____

PAYING YOUR PLAN PREMIUM

Skip this section if you have selected a \$0 premium plan and no Gold Benefits and do not owe a late enrollment penalty. 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 choose to pay your premium by automatic deduction from your Social Security benefit check each month.

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 benefit check each month.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, 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 will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible 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. 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) from your bank account each month. Please complete a "Quick Pay" form and provide a voided check from your bank account.
- 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 AND ANSWER THESE IMPORTANT QUESTIONS:

1. Do you have End-Stage Renal Disease (ESRD)? Yes No
If you answered “yes” to this question and you don’t need regular dialysis anymore, or if you have had a successful kidney transplant, **please attach a note or records** from your doctor showing you don’t need dialysis or have had a successful kidney transplant.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal Employee Health Benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Do you currently have prescription drug coverage with Health Net? Yes No

Will you have other prescription drug coverage in addition to Health Net? Yes No

If “yes”, please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage: _____

3. Are you a resident in a long-term care facility, such as a nursing home? Yes No

If “yes”, please provide the following information:

Name of Institution: _____

Street Address of Institution: _____

Phone Number: (_____) _____ - _____

4. Are you enrolled in your state Medicaid program? Yes No

If “yes”, please provide your Medicaid number: _____

For *Amber (HMO)* plan applicants, please identify the type of Medicaid program, if known (i.e., full AHCCCS, QMB, SLMB, QI-1): _____

If on full AHCCCS, name of the Managed Medicaid plan: _____

5. Do you or your spouse work? Yes No

Please list the name of a Primary Care Physician (PCP): _____

PCP Access Number: _____

Is this your current PCP? Yes No

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

Please contact Health Net at 1-800-333-3930 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 TTY 1-800-977-6757.



PLEASE READ THIS IMPORTANT INFORMATION.

If you currently have health coverage from an employer or union, joining Health Net could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Health Net. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

PLEASE READ BELOW AND SIGN ON THE NEXT PAGE

By completing this enrollment application, I agree to the following:

Health Net of Arizona, Inc., is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: November 15 - December 31 of every year), or under certain special circumstances.

Health Net serves a specific service area. If I move out of the area that Health Net serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Health Net, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Health Net when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually 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.**

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 Health Net 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 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.

ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. In addition, you can join a Medicare Advantage plan during the open enrollment period between January 1 and March 31 of each year, as long as you don't add or drop your prescription drug coverage (i.e. if you have Medicare prescription drug coverage you can only change to another plan with Medicare prescription drug coverage; if you don't have Medicare prescription drug coverage you can only change to another plan without Medicare prescription drug coverage). Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- I am new to Medicare.
- I recently moved outside of the service area for my current plan, or I recently moved and this plan is a new option for me. I moved on (insert date)_____.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I get extra help paying for Medicare prescription drug coverage.
- I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date)_____.
- I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date)_____.
- I recently left a PACE program on (insert date)_____.
- I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). I lost my drug coverage on (insert date)_____.
- I am leaving employer or union coverage on (insert date)_____.
- I belong to a pharmacy assistance program provided by my state.
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date)_____.
- None of these statements applies to me.*

*Please contact Health Net at 1-800-333-3930 (TTY users should call 1-800-977-6757) to see if you are eligible to enroll. We are open 8:00 a.m. to 8:00 p.m., 7 days a week.

My proposed effective date of coverage with Health Net is _____ .
 Health Net will notify you of the actual effective date of coverage.

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: _____

Do you have Power of Attorney / Conservator authority? (Optional) Yes No
 If "yes", please attach documentation of this authority.

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): _____

Application Pended due to: _____

Producer Name: _____ Phone #: _____ ID # _____

FMO/GA/Agency Name: _____ Phone #: _____ ID # _____

Sales Rep Name: _____ Phone #: _____ ID # _____

Producer Received Date: _____

White Copy – Health Net

Yellow – Writing Agent

Pink Copy – Member