CUSTOMER SERVICE PHONE NUMBER

Toll-free: 1-888-747-7823

Health Net Insurance of New York, Inc. ENROLLMENT FORM
Product: PPO ADVANTAGE PLATINUM
Please complete this application in full, including your signature.
Use blue or black ink only and be sure all copies are printed legibly.

Health Net®

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 ☐ 20-24 Hours ☐ 25-29 Hours ☐ 30+ Hours

OTHER HEALTH COVERAGE INFORMATION

Will you be covered by another health plan when Health Net INY 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: MO DAY YR Spouse's Date of Birth: / /
Will your spouse be covered by another health plan when Health Net INY 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 INY coverage starts? ☐ Yes ☐ No	If yes, list name and address of other carrier:	Policy/Contract #:

MEDICARE INFORMATION

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 they attend school on a full-time basis? ☐ Yes ☐ No	If yes, list first name of child and school	If no, is the dependent child disabled? ☐ Yes ☐ No

List yourself and any eligible dependents to be covered. Attach extra sheet if necessary.

	Last Name	First Name	M.I.	Social Security #	Sex: M/F	Date of Birth MO DAY YR
Self						
Spouse						
Child						
Child						
Child						

Please attach a copy of the certificate of credible coverage, if any, for each person listed.

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 to five thousand dollars and the stated value of the claim for each such violation.

AGREEMENT (please sign and date): I understand the Health Net Insurance of New York, Inc. (Health Net INY) benefits and coverage as summarized in the Health Net INY plan materials and that these benefits are administered strictly as specified in the Health Net INY plan documents.

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) of me and my family member(s) to furnish such records as may be requested by Health Net INY 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 certify that all dependents listed above are eligible for coverage under the terms of the Health Net INY plan documents. I agree to notify Health Net INY and my employer within 31 days when such eligibility ceases. I understand that Health Net INY is not liable to provide coverage to ineligible dependents.

If I am required to contribute, I authorize my employer to deduct from my wage the amount required for the coverage selected. I certify that all the information above is correct to the best of my knowledge.
This authorization is valid for 24 months and you may revoke the authorization at any time by sending a letter to that effect to the address listed below.

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 for purposes of treatemt, 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: MO DAY YR ☐ New Hire Date of Hire: / / ☐ COBRA Enrollment ☐ 18 months ☐ 36 months Date of Elig: ☐ Open Enrollment ☐ Other_____	Effective Date of Coverage:	Group #:	Subgroup:	Plan Code:

Company Signature _____ Date _____

Health Net Insurance of New York, Inc. • One Far Mill Crossing, P.O. Box 904, Shelton, CT 06484-0944
You must complete the Pre-existing Condition Questionnaire on the reverse of this page.
Please send the signed original of this form to your employer, and retain a copy for your records.

Health Net Insurance of New York, Inc.
Pre-existing Condition Questionnaire

1. Do you or your dependent(s) have a physical or mental condition for which medical advice, diagnosis, care or treatment was received or recommended within the six (6) months prior to completing and signing this enrollment form? ☐ Yes ☐ No

2. During the past six months, have you or any dependent to be covered:

a. been examined or treated by a physician or other health care provider for any condition, illness or injury? ☐ Yes ☐ No

b. been advised to have treatment, surgery or testing that has not been done? ☐ Yes ☐ No

c. been admitted to a hospital or other health care facility as an inpatient? ☐ Yes ☐ No

d. taken prescribed medications? ☐ Yes ☐ No

Please give details for any "Yes" answers to questions 1 or 2. Attach a separate sheet if more space is needed for answers. The separate sheet should be signed and dated.

Question # and letter	Name of Person	Relationship to Subscriber	Condition	Duration of Symptoms, Treatment Degree of Recovery	Date	Name & Address of Hospitals, Practitioners

Date: _____

Signature of Subscriber: _____ Subscriber's Social Security Number: _____