Health Net®
A Better Decision

INDIVIDUAL & FAMILY HEALTH PLANS ENROLLMENT APPLICATION

IMPORTANT ENROLLMENT INSTRUCTIONS

Read all sections carefully. Answer all questions thoroughly. Omissions or incomplete responses could result in a request for medical records and a delay in processing of this application.

- **Print clearly in ink** and **return within 30 calendar days** from the date of signature.
- Primary applicants **must be residents of Arizona** and all applicants must be **under age 64 ½** to be eligible to apply.
- Persons who are eligible for Medicare coverage are **NOT** eligible for coverage under Health Net individual plans.
- If you need assistance to complete this form, please contact your broker or call Health Net toll free at **1-888-463-4875**.
- If you are applying for the HIPAA Portability Coverage described in Section 6, please attach the Certificate of Prior Creditable Coverage form issued to you by your former insurance carrier.
- The application **must be completed by the applicant** and not by insurance brokers.

Return the **completed application and first month's premium for all applicants** in the enclosed return address envelope.

Applications must be sent with the first month's premium payable by check or credit card. Make check payable to Health Net of Arizona, Inc. Do not send cash. Your Health Insurance and your Life Insurance premiums will be billed separately.

SECTION 1. TYPE OF APPLICATION

- ○ New Enrollment Application: Requested effective date:
  - ○ 1st of Month _____ ○ 15th of Month _____ ○ First Available _____
- ○ Plan Change (From and to a current Health Net plan): Subscriber ID # _____
- ○ Adding Dependent(s). Dependent(s) may only be added to your current plan/deductible option. Subscriber ID # _____
- ○ HIPAA Portability Coverage
- ○ Child Only Coverage

SECTION 2. TYPE OF COVERAGE

MEDICAL (Select one)

PPO PLANS—
DEDUCTIBLE/COINSURANCE OPTIONS

- ○ $500 / 80% / 60%
- ○ $1000 / 80% / 60%
- ○ $2500 / 80% / 60%
- ○ $5000 / 80% / 60%

HMO PLANS—
DEDUCTIBLE/COINSURANCE OPTIONS

- ○ $0 / 70%
- ○ $1000 / 70%

HIGH DEDUCTIBLE PPO PLANS—
HSA-COMPATIBLE

INDIVIDUAL PLANS	FAMILY PLANS
○ $1750 / 100% / 50%	○ $3500 / 100% / 50%
○ $2600 / 100% / 50%	○ $5150 / 100% / 50%
○ $2600 / 80% / 50%	○ $5150 / 80% / 50%

DENTAL / VISION PLAN (Optional)

○ Primary Applicant ○ Spouse ○ Child #1 ○ Child #2 ○ Child #3

INDIVIDUAL TERM LIFE INSURANCE (Optional) Underwritten by Health Net Life Insurance Company

Available only to Primary Applicants and Spouse who are **19 years of age and older** upon approval **and acceptance for health coverage**

○ Primary Applicant	○ $15,000 Policy	○ $30,000 Policy	○ $50,000 Policy
○ Spouse	○ $15,000 Policy	○ $30,000 Policy	○ $50,000 Policy

SECTION 3. ENROLLMENT INFORMATION

Eligible dependents include your spouse and/or unmarried children under 25. List all individuals for whom you are requesting coverage. Please provide Social Security Numbers for yourself and all dependents over one year of age. **Please print**. If enrolling a 'Child Only', please complete name, address and phone number information ONLY for the Parent/Legal Guardian.

NAME (Last, First, Middle Initial)	**SSN**	**SEX** (M/F)	**BIRTH DATE** (Mo/Day/Yr)	**RELATIONSHIP**	**HT** (Ft./In.)	**WT** #LBS	**PRIMARY CARE PROVIDER** (HMO ONLY)
			/ /	Primary Applicant			
			/ /				
			/ /				
			/ /				
			/ /				
			/ /				
Home Address (List street address; No P.O. Box)				City	State/Zip		County
Mailing Address (if different than home address)				City	State/Zip		County
Daytime Phone#				Alternate Phone#			

SECTION 4. PAYMENT INFORMATION

Please select one of the following payment options.

○ Monthly Bill ○ Credit Card Please complete Credit Card information below ○ Automatic Bank Account Withdrawal Please complete the Quick Pay Authorization Agreement

CREDIT CARD INFORMATION FOR MONTHLY PREMIUM PAYMENT

Credit Card Type: ○ MasterCard ○ Visa		
Name (As it appears on the card)	Card Number	Expires (Mo/Yr) /
Cardholder's Billing Address	City	State/Zip
Cardholder's Daytime Phone #	Bank or Card Issuer Name	

I hereby authorize Health Net of Arizona, Inc. or Health Net Life Insurance Company (Health Net) to charge my credit card account for the monthly premium for my Health Net Coverage, if Health Net approves my application for coverage. I understand that my monthly premium will be charged to my credit card subject to the approval of the application and that all future premium payments will be charged to my credit card monthly.

Signature Date

OR ○ Deduct **only the first month's premium** amount from my credit card.

I authorize Health Net to charge my credit card account for the first month's premium amount for all listed applicants upon approval. I understand the initial premium amount will be charged **only** upon approval of the application by Health Net and that the payment is not a retainer or credit.

Signature Date

SECTION 5. BENEFICIARY SELECTION FOR INDIVIDUAL TERM LIFE INSURANCE

Please note that Life insurance is issued at an additional premium. This amount will reflect on your bill.

Applicant's Beneficiary		Relationship	
Beneficiary's Address	City	State	Zip
Spouse's Beneficiary		Relationship	
Beneficiary's Address	City	State	Zip

SECTION 6. ELIGIBILITY FOR INDIVIDUAL PORTABILITY COVERAGE (Lost Group or COBRA Coverage)

If your group health care coverage provided by your employer or your COBRA continuation coverage has terminated within the past 63 days, you may be eligible for Individual Portability coverage. This coverage does not require medical underwriting and there is no pre-existing waiting period. In order to qualify for this coverage, you must meet specific criteria. If you think you may qualify for this coverage, please contact your broker or our Individual Sales Department for further information. They will also provide an Individual Portability Questionnaire for you to complete. **NOTE: Not all benefit plans are available for Individual Portability Coverage.**

SECTION 7. HEALTH QUESTIONNAIRE

In the past 10 years have you or any persons listed on this application been aware of, diagnosed or treated (including maintenance therapy), been injured, experienced pain or other symptoms, had a history of, had tests or X-rays/CT scans/MRIs, taken medications, been evaluated or advised by any type of health care professional regarding any of the following conditions in any of the listed categories? The categories below serve as examples only, are not all-inclusive and do not limit the extent of the information requested. **Fill in "YES" or "NO" for each line. Please circle the specific condition. DO NOT** leave any items blank, fill in with N/A or draw a line through an entire column.

Please check each item either Yes or No	Yes	No
1. Alcohol or Drug Abuse/Dependence		
a. Alcohol/Drug/Chemical Dependence	○	○
2. Bleeding/Blood/Circulatory Disorders		
a. Anemia/Bleeding/Hyper Coagulation	○	○
b. Blood Disorder/Leukemia/ITP	○	○
c. Aneurysm/Impaired Circulation	○	○
d. Elevated Cholesterol/Triglycerides *(If YES, please complete table in #37)*	○	○
e. Hypertension *(If YES, please complete table in #37)*	○	○
f. Phlebitis/Clots/Raynaud's/PVD/Varicose Veins	○	○
3. Bone/Joint/Muscle Conditions		
a. Back or Neck Pain/Strain	○	○
b. Disc Problems/Scoliosis/Lower Back Pain	○	○
c. Arthritis/Osteoporosis	○	○
d. Fibromyalgia/Chronic Fatigue Syndrome	○	○
e. Muscular Dystrophy/Polio Residuals	○	○
f. Carpal Tunnel/Tendonitis/Bursitis *(Specify site)*	○	○
g. Foot Disorders	○	○
h. Fractures	○	○
i. Screw/Plates/Rods/Pins/Braces/Prosthetics	○	○
j. Loss of Limb(s)/Paraplegia	○	○
k. Joint Disorders—Knee, Hip, Shoulder, Ankle	○	○
4. Congenital Conditions		
a. Birth Defects/Congenital Disorders	○	○
5. Ear/Nose/Throat/Eye		
a. Ear Infections (# _____ past 12 mos.)	○	○
b. Tubes Currently in ears Removed (date) / /	 ○ ○	 ○ ○
c. Hearing Problems	○	○
d. Deviated Septum/Malformation	○	○
e. Nasal Polyps/Sinusitis/Tonsillitis	○	○
f. Strabismus	○	○
g. Retina/Macular: Detach/Degeneration	○	○
h. Cataract(s)/Lens Implants/Glaucoma	○	○

Please check each item either Yes or No	Yes	No
6. Gastrointestinal Conditions		
a. Swallowing Problems/GERD/Reflux	○	○
b. Ulcers/Chronic Abdominal Pain/Gallbladder	○	○
c. Diverticulitis/Diverticulosis/Hemorrhoids/IBS	○	○
d. Ulcerative Colitis/Crohn's/Polyps	○	○
e. Hernia *(Specify type)*	○	○
f. Gastric Bypass/Bariatric Surgery	○	○
7. Glandular or Hormonal Disorders		
a. Diabetes/Abnormal Glucose (High/Low)	○	○
b. Thyroid: Hyper/Hypo	○	○
c. Goiter/Nodule Present	○	○
d. Adrenal/Pituitary Condition	○	○
8. Heart Conditions		
a. Angina/Chest Pain/Heart Attack	○	○
b. Arterio-Atherosclerosis/Coronary Artery Disease/ Congestive Failure/ Bypass	○	○
c. Heart Murmur/Arrhythmia/Pacemaker	○	○
d. Valve Disorder *(Specify type, cause)*	○	○
9. Immune System Disorders		
a. Lupus/Scleroderma/Gullian Barre	○	○
10. Kidney/Bladder Conditions		
a. Incontinence/Urinary Tract Infections	○	○
b. Kidney Infections/Kidney Stones	○	○
c. Kidney Failure/Nephritis	○	○
11. Liver Conditions		
a. Hepatitis A/B/C/Other	○	○
b. Cirrhosis/Liver Failure	○	○
c. Elevated Liver Enzymes	○	○
12. Mental Health/Behavioral Disorders		
a. Depression/Anxiety	○	○
b. Schizophrenia/Bipolar/Psychosis	○	○
c. Anorexia/Bulimia	○	○
d. Attention Deficit Hyperactivity Disorder/ Attention Deficit Disorder	○	○

Please check each item either Yes or No	Yes	No
12. Mental Health/Behavioral Disorders Cont'd		
e. Obsessive Compulsive Disorder/Panic Attacks	○	○
f. Psychiatric/Psychological Counseling	○	○
13. Neurological Conditions		
a. Brain Injury/Concussion/Seizures/ Cerebral Palsy/Tumors	○	○
b. Stroke/TIA/Paralysis	○	○
c. Headaches (Vascular or Migraine)	○	○
d. MS/Alzheimer's/Huntington's/ALS/Parkinson's	○	○
e. Meningitis/Encephalitis	○	○
f. Developmental/Speech Delay *(Specify type, cause)*	○	○
14. Organ		
a. Transplant (*Previous or pending*)	○	○
b. Cyst/Tumor/Growths/Mass/Polyps	○	○
c. Cancer (*Specify type, location, extent*)	○	○
15. Reproductive System Conditions		
a. Menstrual Irregularity	○	○
b. Infertility	○	○
c. Breast Disorders/Fibrocystic Nodules/Lumps/ Abnormal Mammogram	○	○
d. Abnormal Pap Smear/Dysplasia	○	○

Please check each item either Yes or No	Yes	No
e. Endometrial/Uterine/Cervical Disorders/Fibroids	○	○
f. Ovarian Cyst/Mass	○	○
g. Testicular/Prostate Problems: Mass/Lump	○	○
16. Respiratory Conditions		
a. Allergies/Asthma/Bronchitis/Pneumonia	○	○
b. Valley Fever/RSV/RAD	○	○
c. Sleep Apnea	○	○
d. Emphysema/TB/COPD	○	○
17. Sexually Transmitted Diseases		
a. Genital Herpes/HPV/Chlamydia/Gonorrhea b. Other *(Specify)*	○ ○	○ ○
18. Skin Conditions		
a. Psoriasis/Acne/Ulcers (*Specify site*)	○	○
b. Basal Cell/Squamous Cell/Melanoma	○	○
19. Specify any other condition(s) not listed above:		
a.	○	○
b.	○	○
c.	○	○
d.	○	○

○ Yes ○ No **20.** Has surgery (major or minor, cosmetic or non-cosmetic, inpatient or outpatient) **been performed** on any applicant in the past 10 years?

○ Yes ○ No **21.** Has surgery (major or minor, cosmetic or non-cosmetic, inpatient or outpatient) **been advised, but not yet performed**, for any applicant in the past 10 years?

○ Yes ○ No **22.** Has any type of therapy (physical, occupational, or speech) **been advised, but not yet received**, for any applicant in the past 10 years?

○ Yes ○ No **23.** Has any applicant **seen a medical care professional** (physician, nurse practitioner, therapist, chiropractor) in the past 24 months?

○ Yes ○ No **24.** Has any applicant **seen a mental health care professional** (psychologist, psychiatrist, therapist, or counselor) in the past 12 months? If **YES**, please **indicate number of visits** _____

○ Yes ○ No **25.** Has any applicant **been hospitalized or visited an emergency room** or Urgent Care Center in the past 24 months?

○ Yes ○ No **26.** Has any applicant **had psychiatric inpatient stays** in the past 5 years?

○ Yes ○ No **27.** Has any applicant **received any abnormal lab or test results** in the past 12 months?

○ Yes ○ No **28.** Has any applicant **EVER** been aware of, evaluated, advised, tested (other than routine screenings), diagnosed or treated for cancer or malignant neoplasms (e.g. tumors, leukemia, Hodgkin's or melanoma)?

○ Yes ○ No **29.** Has any applicant **EVER** been diagnosed or treated for AIDS (Acquired Immune Deficiency Syndrome) or AIDS-related conditions, or tested positive for the presence of antibodies for the AIDS virus (HIV)?

○ Yes ○ No **30.** Has any applicant discussed his/her level of alcohol consumption with a health care professional and/or been advised to either decrease their consumption of alcohol or stop drinking alcohol completely?

○ Yes ○ No **31.** Has any applicant **EVER** used illicit drugs by IV injections?

○ Yes ○ No **32.** Has any applicant **EVER** attempted suicide?

○ Yes ○ No **33.** To the best of your knowledge, **are you, your spouse, significant other or any dependent, now pregnant?**

○ Yes ○ No **34.** Is any person not named on this application currently pregnant by any person to be insured?

35. If you answered "YES" to any of the questions OR conditions in Section 7, 1 through 34, please explain below, providing full details. Attach additional pages if needed.

APPLICANT'S NAME	**QUESTION #** *(e.g.3.h. for Fractures)*
1. DURATION: From mo/yr ___________ To mo/yr ___________	**2. DIAGNOSIS, CONDITION, ILLNESS**
3. CONDITION STILL PRESENT? ○ Resolved on mo/yr ___________ ○ Ongoing Symptoms/Treatment *(Please provide details in Box 4)*	**4. DESCRIBE TREATMENTS, TESTING, PROGNOSIS.** *Provide details.*
5. FOLLOW UP NEEDED? ○ No, Resolved ○ Yes, Continuing Treatment *(Please provide details in Box 4)*	**6. NAMES/ADDRESSES OF PAST AND PRESENT PHYSICIANS & HOSPITALS**

APPLICANT'S NAME	**QUESTION #** *(e.g.3.h. for Fractures)*
1. DURATION: From mo/yr ___________ To mo/yr ___________	**2. DIAGNOSIS, CONDITION, ILLNESS**
3. CONDITION STILL PRESENT? ○ Resolved on mo/yr ___________ ○ Ongoing Symptoms/Treatment *(Please provide details in Box 4)*	**4. DESCRIBE TREATMENTS, TESTING, PROGNOSIS.** *Provide details.*
5. FOLLOW UP NEEDED? ○ No, Resolved ○ Yes, Continuing Treatment *(Please provide details in Box 4)*	**6. NAMES/ADDRESSES OF PAST AND PRESENT PHYSICIANS & HOSPITALS**

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3. CONDITION STILL PRESENT? ○ Resolved on mo/yr ___________ ○ Ongoing Symptoms/Treatment *(Please provide details in Box 4)*	**4. DESCRIBE TREATMENTS, TESTING, PROGNOSIS.** *Provide details.*
5. FOLLOW UP NEEDED? ○ No, Resolved ○ Yes, Continuing Treatment *(Please provide details in Box 4)*	**6. NAMES/ADDRESSES OF PAST AND PRESENT PHYSICIANS & HOSPITALS**

APPLICANT'S NAME	**QUESTION #** *(e.g.3.h. for Fractures)*
1. DURATION: From mo/yr ___________ To mo/yr ___________	**2. DIAGNOSIS, CONDITION, ILLNESS**
3. CONDITION STILL PRESENT? ○ Resolved on mo/yr ___________ ○ Ongoing Symptoms/Treatment *(Please provide details in Box 4)*	**4. DESCRIBE TREATMENTS, TESTING, PROGNOSIS.** *Provide details.*
5. FOLLOW UP NEEDED? ○ No, Resolved ○ Yes, Continuing Treatment *(Please provide details in Box 4)*	**6. NAMES/ADDRESSES OF PAST AND PRESENT PHYSICIANS & HOSPITALS**

SECTION 7. HEALTH QUESTIONNAIRE (CONTINUED)

36. ○ Yes ○ No **Is any applicant currently taking ANY medication OR taken ANY medication in the past 12 months? If you answered "YES", please complete the following table. Be sure to indicate any changes in dosage. Attach additional pages if needed.**

APPLICANT'S NAME	MEDICATION, DOSAGE, DOSAGE CHANGES & FREQUENCY	DURATION	DIAGNOSIS	PRESCRIBING PHYSICIAN
		From mo/yr _____ To mo/yr _____		
		From mo/yr _____ To mo/yr _____		
		From mo/yr _____ To mo/yr _____		
		From mo/yr _____ To mo/yr _____		
		From mo/yr _____ To mo/yr _____		
		From mo/yr _____ To mo/yr _____		

37. If any applicant answered "YES" to #2.d (Elevated Cholesterol, Triglycerides) or 2.e (Hypertension), please complete the following table with appropriate readings. Use extra pages for each additional applicant with the condition(s).

APPLICANT'S NAME	DATE	CHOLESTEROL	TRIGLYCERIDES	HDL	LDL	DATE	BLOOD PRESSURE READINGS
Readings within 3 months							/
Readings within 6 months							/
Readings within 12 months							/

38. ○ Yes ○ No **Has any applicant experienced a weight change greater than 10 lbs. in the past 12 months? If you answered "YES", please complete the following table. Add additional pages if needed.**

APPLICANT'S NAME	WEIGHT CHANGE DURING PAST 12 MONTHS	CAUSE OF WEIGHT CHANGE	
	○ Gained _____ lbs. ○ Lost _____ lbs.	○ Diet ○ Medication	○ Pregnancy ○ Unknown
	○ Gained _____ lbs. ○ Lost _____ lbs.	○ Diet ○ Medication	○ Pregnancy ○ Unknown

39. ○ Yes ○ No **Has any applicant ever used tobacco products? If "YES", please complete the following table.**

APPLICANT'S NAME	PACKS A DAY/ FREQUENCY	# OF YEARS	LAST USED

40. FEMALE APPLICANTS, please complete the following table.

APPLICANT'S NAME	DO YOU MENSTRUATE?	IF YES, HAVE YOU HAD A NORMAL PERIOD IN THE PAST 30 DAYS?	LAST PAP SMEAR	RESULTS	IF YOU DO NOT MENSTRUATE, PLEASE EXPLAIN
	○ Yes ○ No	○ Yes DATE / / ○ No	/ /	○ Normal ○ Abnormal	
	○ Yes ○ No	○ Yes DATE / / ○ No	/ /	○ Normal ○ Abnormal	

SECTION 8. CONDITIONS OF ENROLLMENT

GENERAL CONDITIONS: Health Net of Arizona, Inc. (HNAZ) and/or Health Net Life Insurance Company reserve the right to reject any application for enrollment. HNAZ and/or Health Net Life Insurance Company may selectively accept the Applicant and any, all or none of applying dependent(s). There is no coverage unless this Application is accepted by HNAZ and/or Health Net Life Insurance Company's Underwriting Department and a Notice of Acceptance is issued to the Applicant. No other department, officer, agent or employee of HNAZ and/or Health Net Life Insurance Company is authorized to grant enrollment. An insurance agent cannot grant approval, change terms or waive requirements. HNAZ and/or Health Net Life Insurance Company may require that you take a medical examination and you will be responsible for payment of any related fees in such event. This Application and any medical information or examination reports shall become a part of the Health Benefit Contract. Any intentional or unintentional non-disclosure, misstatement or omission of fact in application materials that is material to the underwriting decision, including information related to the Subscriber's or Family Member's health status or history, is cause for disenrollment, termination of Coverage AND rescission of the Health Benefit Contract and, in such instance, HNAZ and/or Health Net Life Insurance Company may recoup any amounts paid for Covered Services obtained as a result of such non-disclosure or misstatement of fact.

NOTICE OF INSURANCE INFORMATION PRACTICES: Pursuant to Arizona law: HNAZ and/or Health Net Life Insurance Company may collect personal information about you from sources other than the applicant during the underwriting process. The information collected by HNAZ and/or Health Net Life Insurance Company about you may, in certain circumstances, be disclosed to third parties without your authorization. You have the right to review information collected by HNAZ and/or Health Net Life Insurance Company and correct erroneous information. A full description of your rights regarding the information collected by HNAZ and/or Health Net Life Insurance Company is available from HNAZ and/or Health Net Life Insurance Company upon request.

USE AND DISCLOSURE OF 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 HNAZ. HNAZ will use and disclose this information for purposes of treatment, payment and health plan operations, including but not limited to utilization management, quality improvement, disease or case management programs as permitted by law.

IF SOLE APPLICANT IS A MINOR: If the sole Applicant under this Application is under 18 years of age, Applicant's parent or legal guardian must sign the application signature page as such. In such event, the parent or legal guardian does hereby agree to be legally responsible for the accuracy of information in this Application and for premium payment. If such responsible party is not the natural parent of the Applicant, copies of the court papers authorizing guardianship must be submitted with this Application.

PREMIUM PAYMENT ACKNOWLEDGEMENT: I understand and agree that in order to process my application, HNAZ requires that I submit a payment of one month's premium and that HNAZ will not cash my check or charge my credit card unless coverage is approved by the Underwriting Department. I understand that by collecting the first month's premium, HNAZ and/or Health Net life Insurance Company is not issuing coverage and is not assuming any risk for health coverage for me or any member of my family. I understand that insurance brokers have no authority to approve or bind coverage or to assign effective dates for coverage. I understand that coverage does not become effective immediately. I understand that I may be denied coverage as a result of underwriting. I understand that coverage, if any, is not effective until it is approved by HNAZ and/or Health Net Life Insurance Company in writing, regardless of whether HNAZ has cashed my check or charged my credit card. I understand that if my application is approved, I will receive a refund for any applicant on this application who chooses not to enroll in the plan, or if I, or any one of my family members is not approved for coverage by HNAZ and/or Health Net Life Insurance Company. I understand that if a 15th of the month effective date was selected and my coverage is approved, I will be billed for half of a monthly premium.

ACKNOWLEDGMENT AND AGREEMENT: I understand and agree that by enrolling or accepting services under a health plan with HNAZ and/or Health Net Life Insurance Company, I am, and any enrolled dependents are, obligated to understand and abide by all terms, conditions and provisions of the Health Benefit Contract. I have read and understand the terms on this Application and my signature on the application signature page indicates my acceptance of these terms and that the information entered in this Application is complete, true and correct. A photocopy of this is as valid as the original.

In addition, I understand and agree to the following:

- There is no coverage unless an application is approved by HNAZ and/or Health Net Life Insurance Company's Underwriting Department.
- HNAZ and/or Health Net Life Insurance Company is not liable for bills incurred before effective date of coverage.
- HNAZ and/or Health Net Life Insurance Company will notify me if my application is accepted. My effective date will also be subject to the receipt of my premium by HNAZ and/or Health Net Life Insurance Company.
- The broker selling HNAZ and/or Health Net Life Insurance Company health coverage does not have the authority to approve my application and cannot change any terms of the Agreement or waive any requirements.
- I am responsible for reporting to HNAZ and/or Health Net Life Insurance Company any changes in health status that occur before the effective date of the HNAZ and/or Health Net Life Insurance Company Plan Agreement or before receipt of premium, whichever is later. I understand any changes in health status may result in a change of the underwriting decision. This applies to every person listed on the application. I understand that my coverage may be rescinded if I fail to report a change.
- Applicants are responsible for obtaining medical records and any associated costs for obtaining those records.

X APPLICANT'S SIGNATURE (in ink)	Date signed	X APPLICANT'S SIGNATURE (in ink)	Date signed
X SPOUSE'S SIGNATURE (in ink)	Date signed	X SPOUSE'S SIGNATURE (in ink)	Date signed
X APPLICANT'S SIGNATURE (in ink)	Date signed	X PARENT or LEGAL GUARDIAN (circle) if sole applicant is under 18 years old	Date signed

ALL APPLICANTS 18 YEARS AND OLDER MUST SIGN APPLICATION.
PLEASE BE SURE ALL QUESTIONS ARE ANSWERED AND APPLICATION IS SIGNED AND DATED TO PREVENT APPLICATION FROM BEING RETURNED.

SECTION 9. BROKER INFORMATION

Broker's Name: William C. Stapleton	
Insurance Agency Name: HEALTH PLAN ONE	**HEALTH NET BROKER NUMBER**: 330538
GENERAL AGENT INFORMATION	
GA Name (If Applicable)	GA Number

Health Net®
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ifp
INDIVIDUAL & FAMILY PLAN

FLEXIBLE PAYMENT OPTIONS WE'VE GOT YOU COVERED



With Health Net's easy and flexible options, you choose the monthly premium payment method that works best for you!

- Automatic payment deductions from your bank account
- Charge it to your credit card
- Pay by check

Please see reverse side for Quick Pay authorization form.

HOW EASY IS IT? *You decide.*

AUTOMATIC PAYMENT DEDUCTIONS—NO HASSLES OR WORRIES

You can pay your monthly premiums through Quick Pay, an automatic deduction from your bank account. Simply fill out the Quick Pay authorization form on the reverse side and read the directions for processing your request. With Quick Pay, you'll have the confidence of knowing your monthly premium is paid on time—all the time.

CHARGE TO CREDIT CARD—NO LATE PAYMENTS

Charging your monthly premiums to your credit card is simple and fast. Just fill out the credit card portion of your Health Net Individual & Family Plan Enrollment Application and that's it. Each month, your payment will appear on your statement—a great option if you want flexibility and peace of mind.

PAY BY CHECK—THE OLD STANDBY

Payment by check is also an option. If you choose to pay your premium by check, you will receive a monthly statement. Checks should be made payable to Health Net of Arizona, Inc. and must reach Health Net by the payment schedule deadline.

For more information about payment options, please contact your insurance representative or call Membership Accounting at 1-800-723-6977.

Health Net®
A Better Decision

Twenty-Five Years of Providing Health Care Plans to Arizonans

ENROLLING IN QUICK PAY

Just follow the directions on the form below. It gives you easy to read instructions on how to get started paying your monthly premiums automatically through your bank account. Return this form along with your Individual & Family Plan enrollment application. If you are returning this form separately from your enrollment application, mail it to:

Health Net Northeast
P.O. Box 904
1 Far Mill Crossing
Shelton, CT 06484

HOW DOES IT WORK?

Once Quick Pay is authorized by your bank, you'll receive a copy of this agreement to verify the premium amount and date of first debit. Deductions are withdrawn from your account around the 4th of each month and reflected on your bank statement. Health Net will not send you any billing notices while you are enrolled in Quick Pay. Until you receive confirmation from Health Net that Quick Pay is in effect, you must continue to pay your monthly premiums as you are billed.

WHAT IF YOU WANT TO STOP QUICK PAY?

To discontinue Quick Pay, simply notify Health Net in writing that you wish to cancel your participation. Canceling Quick Pay does not cancel your Health Net coverage, unless specifically stated in your letter.

For more information about payment options, please contact your insurance representative or call Membership Accounting at 1-800-723-6977.

HEALTH NET'S QUICK PAY AUTHORIZATION AGREEMENT

To start Quick Pay, complete and sign this form. **Attach a BLANK CHECK from your account and write "VOID" on it.** DO NOT submit a deposit slip. The ABA ROUTING NUMBER is the 9-digit number located at the bottom left corner of your check, or you may call your bank for the number.

Applicant Name _____ Daytime Phone ( )

Member # (if applicable) _____

Account Number _____ ○ Checking ○ Savings

Financial Institution Name _____

Branch Address _____

City _____ State _____ Zip _____

ABA Routing # _____

I hereby authorize Health Net of Arizona, Inc. ("Health Net") and my financial institution named above to debit my bank account between the **3rd and the 10th of the month for the amount of my monthly plan premium**. I understand my premium amount may vary due to enrollment status changes, which may include retroactive premiums due.

I understand that if there are insufficient funds at the time my account is debited, the amount will be debited again within 3-5 business days. **I understand a service fee of $25.00 (in addition to any bank fees) will be assessed by Health Net for all dishonored payments**. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, Health Net shall be under no liability whatsoever. I will not hold Health Net responsible for delay, loss, or misapplication of funds due to incorrect or incomplete information supplied by me or my bank, or failure of my bank to correctly debit my account. Health Net may initiate, if necessary, any adjustments for any debit recorded in error.

I understand that this authorization will remain in effect until I notify Health Net in writing that I no longer desire this service. I understand Health Net and my bank have the right to discontinue this service without advance notice if either elects to do so.

I also understand that by canceling this service, I am not canceling my health care coverage unless specified in my written notification to Health Net. Once the notice is received by Health Net's Billing Department, a reasonable period of time (up to 10 business days) is required to revoke this agreement.

Account Holder(s) Signature(s) _____ Date _____

A copy of this agreement will be returned to you as a confirmation of the amount and date of your initial debit. Until you receive the confirmation from us, please continue to pay as you are billed. Please allow a minimum of two weeks processing time.

For A/R use only: Confirmation of Quick Pay

Current premium amount to be debited $ _____ Date of first debit _____ A/R Initials _____

Health Net®
A Better Decision

Twenty-Five Years of Providing Health Care Plans to Arizonans

AZ30291 (6/06)