TO BE COMPLETED BY EMPLOYER	
Employer name: FIRST CHRISTIAN CHURCH OF ROWLAND HEIGHTS	
Requested effective date:	Employer group number *(medical)*: BWV71A
Employee eligibility date *(new hire only)*: ☐ Same as hired date ☐ Other: _____	

Health Net®

Important: Please print all sections in black ink. You are entitled to see a Summary of Benefits and Coverage (SBC) before you choose a plan. Please contact your employer if you do not have the SBC for the plan you have selected.

1. Health plan information (All medical plans include pediatric dental and vision coverage.)

FULL HMO NETWORK[1]

Platinum	Gold	Silver
☐ $10 ☐ $20 ☐ $30	☐ $30 ☐ $35 ☐ $40 ☐ $50	☐ $50

SMARTCARE HMO NETWORK[2]

Platinum	Gold	Silver
☐ $10 ☐ $20 ☐ $30	☐ $30 ☐ $35 ☐ $40 ☐ $50	☐ $50

WHOLECARE HMO NETWORK[1]

Platinum	Gold	Silver
☐ $10 ☐ $20 ☐ $30	☐ $30 ☐ $35 ☐ $40 ☐ $50	☐ $50

SALUD HMO Y MÁS NETWORK[3]

Platinum	Gold	Silver
☐ $10 ☐ $20 ☐ $30	☐ $30 ☐ $35 ☐ $40 ☐ $50	☐ $50

COMMUNITYCARE HMO NETWORK[4]

Silver ☐ $50

Bronze ☐ CommunityCare Bronze 60 HMO 6300/65 + Child Dental

PURECARE HSP NETWORK[1]

- ☐ PureCare Platinum 90 HSP 0/15 + Child Dental
- ☐ PureCare Gold 80 HSP 250/25 + Child Dental
- ☐ PureCare Silver 70 HSP 2250/50 + Child Dental
- ☐ PureCare Bronze 60 HSP 6300/65 + Child Dental

FULL PPO NETWORK

- ☐ Platinum 90 PPO 0/15 + Child Dental
- ☐ Platinum 90 PPO 250/15 + Child Dental Alt
- ☐ Gold 80 PPO 0/30 + Child Dental Alt
- ☐ Gold 80 PPO 250/25 + Child Dental
- ☐ Gold 80 PPO 500/20 + Child Dental Alt
- ☐ Gold 80 PPO 1000/30 + Child Dental Alt
- ☐ Gold 80 Value PPO 750/15 + Child Dental Alt
- ☐ Silver 70 PPO 2250/50 + Child Dental
- ☐ Silver 70 PPO 2250/55 + Child Dental Alt
- ☐ Silver 70 HDHP PPO 1400/40% + Child Dental Alt
- ☐ Silver 70 Value PPO 1700/50 + Child Dental Alt
- ☐ Bronze 60 PPO 6300/65 + Child Dental
- ☐ Bronze 60 HDHP PPO 5600/20% + Child Dental Alt

ENHANCEDCARE PPO NETWORK[5]

- ☐ EnhancedCare Platinum 90 PPO 250/15 + Child Dental Alt
- ☐ EnhancedCare Gold 80 PPO 0/30 + Child Dental Alt
- ☐ EnhancedCare Gold 80 PPO 500/20 + Child Dental Alt
- ☐ EnhancedCare Gold 80 PPO 1000/30 + Child Dental Alt
- ☐ EnhancedCare Gold 80 Value PPO 750/15 + Child Dental Alt
- ☐ EnhancedCare Silver 70 PPO 2250/55 + Child Dental Alt
- ☐ EnhancedCare Silver 70 HDHP PPO 1400/40% + Child Dental Alt
- ☐ EnhancedCare Silver 70 Value PPO 1700/50 + Child Dental Alt
- ☐ EnhancedCare Bronze 60 HDHP PPO 5600/20% + Child Dental Alt

OTHER PLAN(S):

_____

DENTAL (DHMO)

- ☐ HN Plus 150
- ☐ HN Plus 225

DENTAL (DPPO)

- ☐ Classic 5 1500 (w/ortho)
- ☐ Essential 6 1500
- ☐ Essential 5 1500 (w/ortho)
- ☐ Essential 2 1000
- ☐ Classic 4 1500

VISION (PPO)

- ☐ Elite 1010-1
- ☐ Preferred 1025-2
- ☐ Preferred Value 10-3
- ☐ Exam Only
- ☐ Supreme 010-2
- ☐ Preferred 1025-3
- ☐ Plus 20-1

2. Reason for application

- ☐ Plan change
- ☐ Change address/name
- ☐ Delete dependent (list names below)
- ☐ Other: _____

☐ New hire ☐ Open Enrollment

Special Enrollment Period

Qualifying event date: ____ /____ /_____

☐ **COBRA**[6] Effective date: ____ /____ /_____

Qualifying event: _____

Qualifying event date: ____ /____ /_____

Add dependent:

☐ Marriage ☐ Newborn/Adoption/Legal guardianship/Court order/Assumption of parent-child relationship

☐ Loss of prior coverage ☐ Domestic partnership ☐ Other (specify): _____

Employee name: _____ Last 4 digits of Social Security #/TIN: __ __ __ __

3. EMPLOYEE PERSONAL INFORMATION

Last name:	First name:	MI:	☐ Male ☐ Female
Residence address:			
City:	State:	ZIP:	County:
Date of birth *(mm/dd/yyyy)*:	Social Security #/TIN/Matricular ID #:		Job title:
Telephone #: ( )	Work phone #: ( )		Email address:
Date of hire: / /	Dept. #:		Marital status: ☐ Single ☐ Married ☐ Domestic partner
If available, I would prefer to receive communication and plan information in Spanish: ☐ Yes ☐ No			
Participating physician group:		Primary care physician:	
PPG/PCP Enrollment ID # (4-digit PPG and 6-digit PCP numbers):		Is this your current PCP? ☐ Yes ☐ No	
Dental HMO provider name:		Dental HMO provider ID #:	

4. Family information, please list all eligible family members to be enrolled.
(Attach additional sheets if necessary.)

Spouse/Domestic partner ☐ M ☐ F	Last name:	First name:	MI:
Residence address: ☐ Check here if same as subscriber			
City:		State:	ZIP:
Date of birth *(mm/dd/yyyy)*:		Social Security #/TIN/Matricular ID #:	
Participating physician group:		Primary care physician:	
PPG/PCP Enrollment ID # *(4-digit PPG and 6-digit PCP numbers)*:		Is this your current PCP? ☐ Yes ☐ No	
Dental HMO provider name:		Dental HMO provider ID #:	

☐ Son ☐ Daughter	Last name:	First name:	MI:
Residence address: ☐ Check here if same as subscriber			
City:		State:	ZIP:
Date of birth *(mm/dd/yyyy)*:		Social Security #/TIN/Matricular ID #:	
Participating physician group:		Primary care physician:	
PPG/PCP Enrollment ID # *(4-digit PPG and 6-digit PCP numbers)*:		Is this your current PCP? ☐ Yes ☐ No	
Dental HMO provider name:		Dental HMO provider ID #:	

Employee name: _____ Last 4 digits of Social Security #/TIN: __ __ __ __

4. Family information, please list all eligible family members to be enrolled. (continued)
(Attach additional sheets if necessary.)

☐ Son ☐ Daughter	Last name:	First name:	MI:
Residence address: ☐ Check here if same as subscriber			
City:		State:	ZIP:
Date of birth *(mm/dd/yyyy)*:		Social Security #/TIN/Matricular ID #:	
Participating physician group:		Primary care physician:	
PPG/PCP Enrollment ID # *(4-digit PPG and 6-digit PCP numbers)*:		Is this your current PCP? ☐ Yes ☐ No	
Dental HMO provider name:		Dental HMO provider ID #:	

☐ Son ☐ Daughter	Last name:	First name:	MI:
Residence address: ☐ Check here if same as subscriber			
City:		State:	ZIP:
Date of birth *(mm/dd/yyyy)*:		Social Security #/TIN/Matricular ID #:	
Participating physician group:		Primary care physician:	
PPG/PCP Enrollment ID # *(4-digit PPG and 6-digit PCP numbers)*:		Is this your current PCP? ☐ Yes ☐ No	
Dental HMO provider name:		Dental HMO provider ID #:	

Employee name: ______________________ Last 4 digits of Social Security #/TIN: __ __ __ __

5. Do you or your dependents have other health care coverage?

☐ No ☐ Yes If "Yes," please complete this section including Medicare.

☐ Self	Name:		Name of other insurance carrier:		Prior coverage start date *(mm/dd/yy)*:	
Prior coverage end date *(mm/dd/yy)*:	Reason for ending coverage:		Group #/Policy ID #:	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:
☐ Spouse ☐ Domestic partner	Name:		Name of other insurance carrier:		Prior coverage start date *(mm/dd/yy)*:	
Prior coverage end date *(mm/dd/yy)*:	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? ☐ Yes ☐ No	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:
☐ Son ☐ Daughter	Name:		Name of other insurance carrier:		Prior coverage start date *(mm/dd/yy)*:	
Prior coverage end date *(mm/dd/yy)*:	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? ☐ Yes ☐ No	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:
☐ Son ☐ Daughter	Name:		Name of other insurance carrier:		Prior coverage start date *(mm/dd/yy)*:	
Prior coverage end date *(mm/dd/yy)*:	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? ☐ Yes ☐ No	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:
☐ Son ☐ Daughter	Name:		Name of other insurance carrier:		Prior coverage start date *(mm/dd/yy)*:	
Prior coverage end date *(mm/dd/yy)*:	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? ☐ Yes ☐ No	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:

6. Group term life insurance, if applicable. (Attach separate sheet for additional or contingent beneficiaries.)

Life/AD&D coverage: ☐ Yes ☐ No

Life beneficiary (full name):	Relationship:	%
Life beneficiary (full name):	Relationship:	%
Life beneficiary (full name):	Relationship:	%
Life beneficiary (full name):	Relationship:	%

[1]Available in all or parts of Alameda, Contra Costa, El Dorado, Fresno, Kern, Kings, Los Angeles, Madera, Marin, Merced, Napa, Nevada, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare, Ventura, and Yolo counties.

[2]Available in all or parts of Los Angeles, Orange, Riverside, San Diego, San Bernardino, Santa Clara, and Santa Cruz counties.

[3]Available in Orange County and select ZIP codes of Kern, Los Angeles, Riverside, San Diego, and San Bernardino counties.

[4]Available in Los Angeles, Orange and San Diego counties.

[5]Available in Los Angeles County.

[6]Provide the effective date COBRA first began, whether you were eligible for a total of 18 months or 36 months of COBRA (including Cal-COBRA).

"Plan Contract" refers to the Health Net of California, Inc. and/or Dental Benefit Providers of California, Inc. Group Service Agreement and Evidence of Coverage; "Insurance Policy" refers to Health Net Life Insurance Company, Unimerica Life Insurance Company Group Policy and Certificate of Insurance.

Employee name: _____ Last 4 digits of Social Security #/TIN: __ __ __ __

7. Declination of coverage (Complete this section if any coverage is being declined by you or your eligible dependents.)

EMPLOYEE PERSONAL INFORMATION

Last name:	First name:	MI:	Social Security #/Matricular ID #:

Declining medical coverage for:
☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent(s)
Name(s): _____

Reason: ☐ Other group coverage through this employer ☐ Individual coverage
☐ Other group coverage by another group *(i.e., spouse's employer)*
☐ Other: _____

Declining dental coverage for:
☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent(s)
Name(s): _____

Reason: ☐ Other group coverage through this employer ☐ Individual coverage
☐ Other group coverage by another group *(i.e., spouse's employer)*
☐ Other: _____

Declining vision coverage for:
☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent(s)
Name(s): _____

Reason: ☐ Other group coverage through this employer ☐ Individual coverage
☐ Other group coverage by another group *(i.e., spouse's employer)*
☐ Other: _____

IF YOU ARE DECLINING COVERAGE – STOP AND READ CAREFULLY

I have decided to decline coverage for myself and/or my dependent(s). I acknowledge that my dependents and I may have to wait to be enrolled until the next annual Open Enrollment Period or Special Enrollment Period due to a qualifying event. The available coverages have been explained to me by my employer, and I have been given the chance to apply for the available coverages. Additionally, by signing below, I certify, to the best of my knowledge or belief, that the reason I am declining coverage is accurate as indicated by the check marks above.

Employee signature: _____ **Date:** _____
(Sign only if declining coverage. If signed in error, please cross out and initial.)

8. Acceptance of coverage (Signature required.)

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

ACKNOWLEDGMENT AND AGREEMENT: I understand and agree that by enrolling with or accepting services from Health Net and/or DBP I and any enrolled dependents are obligated to understand and abide by the terms, conditions and provisions of the Plan Contract or Insurance Policy. I represent that I have read and understand the terms of this application, and my signature below indicates that the information entered in this application is complete, true and correct to the best of my knowledge and belief, and I accept these terms.

BINDING ARBITRATION AGREEMENT: I, the Applicant, understand and agree that any and all disputes between me (including any of my enrolled family members or heirs or personal representatives) and Health Net, except disputes concerning adverse benefit determinations as defined in 45 CFR 147.136, arising from or relating to the *Evidence of Coverage* or *Certificate of Insurance* or my Health Net coverage, must be submitted to individual, final and binding arbitration instead of a jury or court trial, and that I am waiving all rights to class arbitration. This agreement to arbitrate applies even if other parties, such as health care providers or their agents or employees, are involved in the dispute. I understand that, by agreeing to submit all disputes, except disputes concerning adverse benefit determinations, to final and binding arbitration, all parties including Health Net are giving up their constitutional right to have their dispute decided in a court of law by a jury. I also understand that disputes that I may have with Health Net involving claims for medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) are also subject to final and binding arbitration. I understand that a more detailed arbitration provision is included in the *Evidence of Coverage* or *Certificate of Insurance*. Mandatory Arbitration may not apply to certain disputes if the Employer's plan is subject to ERISA, 29 U.S.C. §§ 1001-1461. My signature below indicates that I understand and agree with the terms of this Binding Arbitration Agreement and agree to submit any disputes, except disputes concerning adverse benefit determinations, to binding arbitration instead of a court of law.

Employee signature: _____ **Date:** _____
(Sign only if accepting coverage. If signed in error, please cross out and initial.)