Click to Print

Home

Simple Instructions

1. **Print and complete the application**

2. **Include a voided check**

3. **Fax or mail your application to:**

Fax: 1-800-501-9222

or

Mail: For free postage, cut and paste this label onto your envelope.

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL

FIRST-CLASS MAIL PERMIT NO. 679 NORTHRIDGE, CA

POSTAGE WILL BE PAID BY ADDRESSEE

HEALTH AND LIFE INSURANCE SERVICES
APPLICATION PROCESSING CENTER
9510 SYLVIA AVENUE
NORTHRIDGE, CA 91324-9904

Questions? Call: 1-800-243-8100

Health Net®
LIFE INSURANCE COMPANY

Health Net Life Insurance Company

Application *for a Medicare Supplement Policy*

For California Residents Only

Fax to: 1-800-501-9222

Please follow these application instructions:

1. Complete your application, provide any supporting information requested, sign and date it where indicated.
2. Mail your application in the prepaid envelope provided.
3. Please include your first payment. Your payment will be returned if your application is denied.
4. **NOTE:** If you do not choose an effective date and your policy is approved, your coverage will begin on the first day of the month following receipt of your application by Health Net Life.

If you have any questions regarding your enrollment, please call 1-800-243-8100 or TTY/TDD 1-800-929-9955.

Section I: Your personal information			
Last name:	First name:		MI:
Primary residence address (PO Box is not allowed):			
City:	State:	ZIP:	County:
Mailing address (only if different from primary residence address):			
City:	State:	ZIP:	
Home telephone #: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___	Email address:		Gender: ☐ Male ☐ Female
Date of birth: ___ ___/___ ___/___ ___ ___ ___ M M / D D / Y Y Y Y	Preferred language: ☐ English ☐ Other: _____		
Please indicate the type of Medicare plan you currently have? ☐ Medicare only ☐ Medicare Advantage HMO ☐ Medicare Advantage PDP ☐ Medicare Advantage PPO ☐ Medicare Advantage Private Fee-for-Service			
Which Health Net Life Medicare Supplement Plan are you applying for? ☐ A ☐ C ☐ F ☐ F+ (high deductible) ☐ G	Your requested start date: The 1st of month ___ ___/___ ___/___ ___ ___ ___ M M / D D / Y Y Y Y		

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.

Medicare claim #:

_____

HOSPITAL (Part A) effective date:

___ ___/___ ___/___ ___ ___ ___
M M / D D / Y Y Y Y

MEDICAL (Part B) effective date:

___ ___/___ ___/___ ___ ___ ___
M M / D D / Y Y Y Y

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY
JANE DOE

MEDICARE CLAIM NUMBER
000-00-0000-A

SEX
FEMALE

IS ENTITLED TO
HOSPITAL (PART A)
MEDICAL (PART B)

EFFECTIVE DATE
00-00-2012
00-00-2012

Section II: Medicare prescription drug plan information

Have you purchased a Medicare Prescription Drug Plan? ☐ Yes ☐ No

If you have answered "Yes" to the above question, answer the following two questions:

a. Which company did you purchase it from? _____

b. What was the effective date? ___ ___/___ ___/___ ___ ___ ___
M M / D D / Y Y Y Y

Section III: Current health plan information

If you have recently lost, or will be losing, another health plan's coverage and received their notice stating that you are eligible for guaranteed issue of Medicare Supplemental Coverage stating that you have certain rights to purchase a Medicare Supplement policy, you may be guaranteed acceptance in one or more of Health Net Life's Medicare Supplement plans. Please include a copy of that notice with this application.

PLEASE ANSWER ALL OF THE QUESTIONS BELOW BY MARKING "Yes" OR "No" WITH AN "X" TO THE BEST OF YOUR KNOWLEDGE:

1. a. Did you turn 65 years of age in the last six months? ☐ Yes ☐ No

   b. Did you enroll in Medicare Part B (Medical) in the last 6 months? ☐ Yes ☐ No

   If "Yes," what was the effective date? ___ ___/___ ___/___ ___ ___ ___
   M M / D D / Y Y Y Y

2. Are you covered for medical assistance through California's Medi-Cal program? ☐ Yes ☐ No
   NOTE TO APPLICANT: If you are eligible for Medi-Cal benefits with a "share of cost" and have not met your share of cost, please answer "No" to this question.

   If you have answered "Yes" to the above question, answer the following two questions:

   a. Will Medi-Cal pay your premiums for this Medicare Supplement policy? ☐ Yes ☐ No

   b. Do you receive benefits from Medi-Cal OTHER THAN payment toward your Medicare Part B premium? ☐ Yes ☐ No

Section III: Current health plan information (continued)

3. a. If you have had coverage from any Medicare plan other than Medicare within the past 63 days (for example, a Medicare Advantage plan or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under the plan, leave the END DATE blank. Start date: ___ ___/___ ___/___ ___ ___ ___ (M M / D D / Y Y Y Y) End date: ___ ___/___ ___/___ ___ ___ ___ (M M / D D / Y Y Y Y)	☐ Yes ☐ No
b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this Health Net Life Medicare Supplement plan?	☐ Yes ☐ No
If "Yes," have you received and completed the Notice to Applicant Regarding Replacement of Medicare Supplement Coverage or Medicare Advantage form?	☐ Yes ☐ No
c. Is this your first time in this type of Medicare plan?	☐ Yes ☐ No
d. Did you drop a Medicare Supplement plan to enroll in the Medicare Plan?	☐ Yes ☐ No
4. a. Do you have another Medicare Supplement policy in force?	☐ Yes ☐ No
b. If so, with what company and what plan do you have? _____	
c. If so, do you intend to replace your current Medicare Supplement policy with this policy?	☐ Yes ☐ No
If "Yes," have you received and completed the Notice to Applicant Regarding Replacement of Medicare Supplement Coverage or Medicare Advantage form?	☐ Yes ☐ No
5. a. Have you had coverage under any other health insurance coverage within the past 63 days (for example, an employer, union, or individual plan)?	☐ Yes ☐ No
b. If so, with what company and what kind of policy? _____	
c. What are your dates of coverage under the other plan? (If you are still covered under the other policy, leave "End date" blank.) Start date: ___ ___/___ ___/___ ___ ___ ___ (M M / D D / Y Y Y Y) End date: ___ ___/___ ___/___ ___ ___ ___ (M M / D D / Y Y Y Y)	
6. a. Are you under the age of 65?	☐ Yes ☐ No
b. If so, do you have end-stage renal disease (ESRD)?	☐ Yes ☐ No

Section IV: Guaranteed acceptance statement

If you think you qualify for guaranteed acceptance, please check the number of the qualifying criterion below as described in the accompanying Guaranteed Issue Guide. Please attach any supporting documents as outlined in the Guaranteed Issue Guide. **PLEASE NOTE:** If you are applying for coverage during a Medicare Supplement open enrollment or guaranteed issue period as specified in the accompanying Guaranteed Issue Guide, you do **NOT** need to complete the **Current Health Statement** portion of this application or sign a form required by the federal Health Insurance Portability and Accountability Act of 1996.

I qualify for guaranteed acceptance through an open enrollment or guaranteed issue period based on criterion number:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16

Section V: Current health statement

If you qualify for Guaranteed Acceptance, you do not need to complete this section.

Genetic Information Nondiscrimination Act of 2008 (GINA) compliance statement: This Current Health Statement is not a request for genetic information. In answering these questions, you should not include any genetic information. That is, please do not include any family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which you believe you may be at risk.

To the best of your knowledge, please answer "Yes," "No" or "Not sure" to each question in this section.

1. Are you currently hospitalized, confined to a nursing facility, or have you been hospitalized one or more times in the past two years?	☐ Yes ☐ No ☐ Not sure
2. Within the past year, have you had or been treated for internal cancer?	☐ Yes ☐ No ☐ Not sure
3. Within the past year, have you been advised to have joint replacement surgery that has not yet been performed?	☐ Yes ☐ No ☐ Not sure
4. Within the past two years, have you had an amputation caused by a disease, heart surgery, a cerebral vascular accident (stroke), liver disease, or kidney dialysis?	☐ Yes ☐ No ☐ Not sure
5. Do you have diabetes? Do you take insulin or oral medications for treatment of diabetes?	☐ Yes ☐ No ☐ Not sure ☐ Yes ☐ No ☐ Not sure
6. Are you presently receiving dialysis or have you ever had a kidney transplant?	☐ Yes ☐ No ☐ Not sure
7. Are you currently taking medication? **If you answered "Yes," please list on the following page all medications you are currently taking and the condition for which the medication is prescribed.**	☐ Yes ☐ No ☐ Not sure

If you answered "Yes" or "Not sure" to any of the questions above in Section V: Current Health Statement, please provide additional information and the dates associated with the condition, as well as current status of the condition in the space provided below. If additional space is required, please use additional sheets as necessary, then sign and date each sheet.

Condition, diagnosis or treatment date(s)	Explanation/current status

Section V: Current health statement (continued)

Medications	Most recent refill date	Condition for which medication is prescribed

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

Section VI: Preferred payment information

Please include your first payment along with your application. To determine your total monthly payment amount, refer to the Individual Medicare Supplement Plan Outline of Coverage for your medical plan premium.

If your application is approved, your check accompanying this application will be processed by Health Net Life electronically and will be shown as an Automated Clearing House (ACH) Debit on your bank statement. By signing this enrollment application, you agree to permit Health Net Life to process your check electronically. The payment will take 5–7 days to reflect in your Health Net Life account. You will receive a bill indicating the amount and the date your next payment is due. Health Net Life will also send you an approval letter, a policy and a member identification card as proof of approval. If your application is not approved, Health Net Life will not process your check accompanying this application and will return it to you.

Health Net Life has two options for you to pay for this policy if you are approved. You may pay monthly by check or Automatic Bank Draft (ABD). An ABD form is included in the information packet for your convenience or you may contact Health Net Life and request one.

☐ I will pay monthly by check. (Make checks payable to Health Net Life.)

☐ I have completed the ABD form and attached a voided check. I understand that, by using Health Net Life's ABD, my bank account will be automatically debited on or about the sixth (6th) of each month.

Insufficient fund fees: Returned checks or insufficient funds on Automatic Bank Drafts are subject to a $15.00 return fee.

Section VII: Signature section

IT IS IMPORTANT THAT YOU READ and UNDERSTAND THE FOLLOWING BEFORE YOU SIGN.
By completing this application and applying for this coverage, I agree to or with the following:

1. I am age 65 or older, or under age 65 and entitled to Medicare on the basis of Social Security disability benefits and do not have end-stage renal disease (ESRD), enrolled in Medicare Parts A and B, and reside within the state of California.
2. This application and the Statement of Health, together with the Health Net Life Policy and any endorsements, appendices and attachments thereto, will collectively constitute the entire agreement for coverage.
3. I will not receive coverage from Health Net Life unless they approve this application. Health Net Life is not liable for bills incurred before the effective date of coverage.
4. Only Health Net Life can approve this application. I understand that any insurance agent, broker or sales representative cannot grant approval, change terms or waive requirements.
5. I acknowledge receipt of the Outline of Coverage, the Guide to Health Insurance for People with Medicare and a copy of this application. I have read the Outline of Coverage and the terms, conditions and authorizations set forth herein. I certify that I meet the eligibility requirements set forth in the Outline of Coverage. I alone am responsible for the accuracy and completeness of this application and have answered all questions to the best of my knowledge and belief. I understand that I will not be eligible for coverage if any information is false or incomplete, and that coverage may be revoked based on such findings.
6. I authorize the United States Department of Health and Human Services, the Centers for Medicare & Medicaid Services, any health care provider, hospital or medical facility to furnish to any agent, designee, employee or representative of Health Net Life any and all records pertaining to claims payment or rejections, medical history, services rendered, or treatment given to myself for purposes of review, investigation or evaluation of this application **(except to those applicants eligible for guaranteed issue coverage, including applicants who are applying for coverage during an open enrollment period)** or a claim. I also authorize Health Net Life and its employees, participating providers, agents and representatives to disclose to any health care provider, health care service plan, insurer or self-insurer any such medical information obtained if such disclosure is necessary to allow the processing of a claim or if requested pursuant to legal process. This authorization shall become effective immediately and shall remain in effect for the term of coverage under the Policy. I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an individual (as described previously), the signature certifies that:
   a. the person is authorized under state law to complete this enrollment form on behalf of the named applicant and,
   b. documentation of the authority is available upon request by Health Net Life Insurance Company or other authorized regulatory agencies.

Note: Health Net Life requests that a copy of the authorization form, Durable Power of Attorney for Health Care, or similar document, be included with this application.

Section VII: Signature section (continued)

7. BINDING ARBITRATION AGREEMENT: I, the Applicant, understand and agree that any and all disputes between me (including any of my heirs or personal representatives) and Health Net Life, but not as to professional negligence (medical malpractice), must be submitted to final and binding arbitration instead of a jury or court trial. This Agreement to arbitrate includes any disputes arising from or relating to the Insurance Policy or my Health Net Life coverage stated under any legal theory. This agreement to arbitrate any disputes 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 to final and binding arbitration, all parties including Health Net Life are giving up their constitutional right to have their dispute decided in a court of law by a jury. My signature below indicates that I understand and agree with the terms of this Binding Arbitration Agreement and agree to submit any disputes to binding arbitration instead of a court of law.

Print name: _____

Signature: X _____ Date: ___ ___/___ ___/___ ___ ___ ___
M M / D D / Y Y Y Y

If you are the legally authorized representative, authorized to act on behalf of the individual under the laws of the state where the individual resides, you must provide a copy of the authorization form, Durable Power of Attorney for Health Care, or similar document and provide the following information:

Last name:	First name:	MI:
Address:		
City:	State:	ZIP:
Relationship to applicant:	Phone #: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___	

Section VIII: Broker information section only

The following items have been included with the application. Check all that apply:

☐ Proof of guaranteed issue ☐ Notice to Applicant Regarding Replacement of Coverage Form (RMSC)

Note: Applications received without the required documentation will not be processed. You will have 30 calendar days from the date of the Health Net Life notification letter to submit the documentation. Applications will be denied if the missing documentation is not received within this time frame.

A broker who assists an applicant in submitting an application to a health plan or insurer has a duty to assist the applicant in providing answers to health questions accurately and completely.

Broker Attestation

I, _____ (Name of broker)

(Note: You must select the appropriate box below. You may only select one box.)

☐ did not assist the applicant in any way in completing or submitting this application. All information was completed by the applicant with no assistance or advice of any kind from me.

☐ assisted the applicant in submitting this application. All information in the health questionnaire was completed by the applicant. I advised the applicant that he or she should answer all questions completely and truthfully and that no information requested on the application should be withheld. I explained that withholding information could result in cancellation of coverage in the future. The applicant indicated to me that he or she understood these instructions and warnings. To the best of my knowledge, the information on the application is complete and accurate. I understand that, if any portion of this statement by me is false, I may be subject to civil penalties of up to $10,000.

Today's date (required): ___ ___/___ ___/___ ___ ___ ___
M M / D D / Y Y Y Y

Broker signature (required): _____

Print broker name: _____

Phone #: 800-243-8100 ID #: U815

FMO/GA/Agency name: _____

Phone #: _____ ID #: _____

Broker rep received date: _____ Broker email address: _____

Health Net®
LIFE INSURANCE COMPANY

Automatic Bank Draft Authorization *Form*

Health Net Life Medicare Supplement

Subscriber / Reference ID #:	Medicare claim #:		Group #:
Subscriber last name:	First name:		MI:
Subscriber street address:			
City:	State:	ZIP:	Home telephone #: (__ __ __) __ __ __-__ __ __ __

Billing information

Account holder name (if different):			Account holder telephone # (if different): (__ __ __) __ __ __-__ __ __ __
Account holder address (if different):	City:	State:	ZIP:
The monthly premium charge can be withdrawn directly from your personal checking or savings account. Please select your account type: ☐ Checking ☐ Savings			
Transit routing number (9 digits):	Account number:		
Bank name:			
City:	State:	ZIP:	
Signature of account holder (required to process):			

I hereby authorize Health Net Life Insurance Company to debit the account shown above for my (the subscriber's) Health Net Life Insurance Company coverage when my premium payment is due. I authorize the bank or financial institution shown above to accept such debits without responsibility for their correctness.

I may terminate this Automatic Bank Draft Authorization at any time by giving Health Net Life Insurance Company written notification of termination or by calling **1-800-926-4178 (TTY/TDD 1-800-929-9955)** Monday through Friday, 8:00 a.m. to 8:00 p.m., except holidays, to request termination. I understand that such notification will become effective after Health Net Life Insurance Company has received the termination request and has had a reasonable amount of time to act on it (at least thirty (30) days).

If the amount of my Health Net Life Insurance Company premium should change for any reason, I will be notified in writing by Health Net Life Insurance Company at least thirty (30) calendar days prior to my account being debited.

Subscriber last name:	First name:	MI:
Medicare claim #:		

Automatic Bank Draft (ABD) transmissions are submitted to the bank on approximately the 6th of every month, for that month's premium. Therefore, your premium should be submitted with your request for ABD, and/or manual payment should continue to be submitted to Health Net Life Insurance Company by the first of the month for each month, until such time that you receive confirmation of ABD commencement in writing from Health Net Life Insurance Company.

In the interim, if a manual payment is received after the bank transmission has occurred (the 6th of the month), it may not be captured on the ABD transmit to the bank. Consequently, based upon the outstanding balance due at the time of transmission, your account may be drafted for more than one month's premium payment. If this occurs, your Health Net Life Insurance Company account will reflect the collected manual and automatic withdrawal premiums on the current billing statement/period. Conversely, if you manually pay your premium due, before the 6th of the month, your payment may be processed, whereby there will be no outstanding balance for the ABD to draft/process.

Once any outstanding balance is collected (if applicable), only your monthly premium will be deducted from your account on, or about, the 6th of the month for which payment is due. **Insufficient funds on Automatic Bank Drafts are subject to a $15.00 return fee.**

Subscriber signature:	Date:
Additional signature (as needed):	Date:

Please include a voided bank check with your authorization.
This will be used to verify bank information.

CA89647 (7/12)

Health Net®
LIFE INSURANCE COMPANY

Notice to Applicant Regarding Replacement of *Medicare Supplement* Coverage *or Medicare Advantage*

Save this notice! It may be important in the future.

If you intend to cancel or terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with coverage issued by Health Net Life Insurance Company, please review the new coverage carefully and replace the existing coverage ONLY if the new coverage materially improves your position. **Do not cancel your present coverage until you have received your new policy and are sure that you want to keep it.**

If you decide to purchase the new coverage, you will have 30 days after you receive the policy to return it to Health Net Life Insurance Company, for any reason, and receive a refund of your money.

If you want to discuss buying Medicare Supplement or Medicare Advantage coverage with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number, 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

Statement to applicant from the insurer and agent:
I have reviewed your current health insurance coverage. To the best of my knowledge, the replacement of insurance involved in this transaction does not duplicate coverage or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. In addition, the replacement coverage contains benefits that are clearly and substantially greater than your current benefits for the following reasons:

☐ Additional benefits that are: _____
☐ No change in benefits, but lower premiums
☐ Plan has outpatient prescription drug coverage and applicant is enrolled in Medicare Part D
☐ Disenrollment from a Medicare Advantage Plan. Reasons for disenrollment:
_____
☐ Fewer benefits and lower premiums
☐ Other reasons specified here: _____

(continued)

CA89666 (7/12)

Complete answers are very important

You do not need to answer questions about your medical and health history if you are applying for coverage during an open enrollment or guarantee issue period.

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer any and all questions on the application concerning your medical and health history. Failure to include all material medical information on an application requesting that information may provide a basis for Health Net Life Insurance Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of agent, broker or other representative:	Date:
Printed name of agent, broker or other representative:	
Applicant's printed name:	
Applicant's signature:	Date:
Medicare claim #:	

Health Net®
LIFE INSURANCE COMPANY

Health Net Life Insurance Company

Application *for a Medicare Supplement Policy*

1. You do not need more than one Medicare Supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medi-Cal and may not need a Medicare Supplement policy.
4. If, after purchasing this policy, you become eligible for Medi-Cal, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medi-Cal for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal. If you are no longer entitled to Medi-Cal, your suspended Medicare Supplement policy, or if that is no longer available, a substantially equivalent policy, will be reinstituted, if requested, within 90 days of losing Medi-Cal eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but it will otherwise be substantially equivalent to your coverage before the date of the suspension.
5. If you are eligible for, and have enrolled in, a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy, or if that is no longer available, a substantially equivalent policy, will be reinstituted, if requested, within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but it will otherwise be substantially equivalent to your coverage before the date of the suspension.
6. Counseling services are available in this state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the Medi-Cal program, including benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB). If you want to discuss buying Medicare Supplement insurance with a trained insurance counselor, call the California Department of Insurance toll-free telephone number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Insurance consumer toll-free telephone number (1-800-927-HELP), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free number (1-800-434-0222), or by accessing the Department of Insurance Internet website (www.insurance.ca.gov).