



Oregon Large Group Enrollment and Change Form

Please note: All fields must be filled out legibly and completely.
Any missing or illegible information might delay your enrollment in the plan.

For plan use only
Ref #:

1. Group information (To be completed by the group.)

Group name:		Group ID #:	Enrollment reason(s): <input type="checkbox"/> New hire <input type="checkbox"/> Rehire <input type="checkbox"/> Open enrollment <input type="checkbox"/> Plan change <input type="checkbox"/> Dependent change <input type="checkbox"/> Delete self or Dependent <input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Court order			
Employee date of hire:	Date employee became eligible: <input type="checkbox"/> Same as hire date <input type="checkbox"/> Other: _____	Effective date:	<input type="checkbox"/> Adoption (legal document required) <input type="checkbox"/> Loss of other coverage <input type="checkbox"/> COBRA or State Continuation <input type="checkbox"/> Employee entered eligible class (indicate: <input type="checkbox"/> Part-time to full-time <input type="checkbox"/> Temporary to permanent <input type="checkbox"/> Hourly to salaried, etc.) <input type="checkbox"/> CHIP <input type="checkbox"/> Other			
Employee job title:	Employee class:	Dept #:	<input type="checkbox"/> New <input type="checkbox"/> Change	Date of event:	Employee type: <input type="checkbox"/> Retired <input type="checkbox"/> Salaried <input type="checkbox"/> Hourly	Hours/week:
Employer initials:	Date:	If COBRA, indicate number of months eligible for coverage: <input type="checkbox"/> 18 months <input type="checkbox"/> 29 months <input type="checkbox"/> 36 months State Continuation eligibility period of coverage cannot exceed 9 months. COBRA qualifying event:				

2. Employee information (Employee completes sections 2 through 3.)

Employee name: (last) (first) (MI)		Home phone: ()		Email address:	
Married? If yes, list spouse as waiving or enrolling in section 3 below. <input type="checkbox"/> Married/Registered Domestic Partner <input type="checkbox"/> Unmarried				Social Security # ¹ :	
Home address:		City:	County:	State:	ZIP:
Mailing address (if different than home address):		City:	County:	State:	ZIP:

3. Enrollment information

Medical plan choice: _____
If PPO HDHP, please select 1 of the following options ☐ Integrated HSA or ☐ Integrated HSA/Opt Out ☐ Integrated HRA ☐ Dental ☐ Vision

Add	Waive/ Drop	If waiving coverage, select reason	Relationship to employee and gender	Name (last) (first) (MI)	Date of birth	Social Security # ¹	EPO ² /POS/CommunityCare only – Primary care provider information	Current patient?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other group coverage <input type="checkbox"/> Individual <input type="checkbox"/> Other: _____	<input type="checkbox"/> Self <input type="checkbox"/> Male <input type="checkbox"/> Female	Same as above			(last, first name)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other group coverage <input type="checkbox"/> Individual <input type="checkbox"/> Other: _____	Write relationship here: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female				(last, first name)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other group coverage <input type="checkbox"/> Individual <input type="checkbox"/> Other: _____	Write relationship here: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female				(last, first name)	<input type="checkbox"/> Yes <input type="checkbox"/> No

3. Enrollment information (continued)

Add	Waive/ Drop	If waiving coverage, select reason	Relationship to employee and gender	Name (last) (first) (MI)	Date of birth	Social Security # ¹	EPO ² /POS/CommunityCare only – Primary care provider information	Current patient?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other group coverage <input type="checkbox"/> Individual <input type="checkbox"/> Other: _____	Write relationship here: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female				(last, first name)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other group coverage <input type="checkbox"/> Individual <input type="checkbox"/> Other: _____	Write relationship here: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female				(last, first name)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other group coverage <input type="checkbox"/> Individual <input type="checkbox"/> Other: _____	Write relationship here: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female				(last, first name)	<input type="checkbox"/> Yes <input type="checkbox"/> No

Does a Dependent have a different mailing address? ☐ No ☐ Yes; complete the following: Name of Dependent(s) (last, first, MI): _____

Dependent's mailing address: _____ City: _____ State: _____ ZIP: _____

Is any child over the Dependent age limit applying for coverage due to disability? ☐ No ☐ Yes; complete and attach the Disabled Dependent Certification Form.

If your employer's coverage has not yet renewed in 2014, has any person applying for coverage had health insurance coverage at any time during the last 63 days before your enrollment with Health Net? ☐ No ☐ Yes; attach your Certificate of Creditable Coverage from your current or prior health plan. You may be eligible for prior coverage credit toward pre-existing or other coverage limitations. If your employer's coverage has not yet renewed in 2014, this plan may impose a pre-existing condition exclusion.

Effective date of coverage: _____ End date of coverage: _____

Do you and/or your Dependent(s) have health coverage that will remain in effect when your Health Net coverage begins? ☐ No ☐ Yes; attach your Coordination of Benefits Form. Please list other insured's date of birth: _____

If Medicare, indicate: ☐ Part A ☐ Part B Effective date: _____ Medicare ID #: _____;

In applying for enrollment as indicated on this enrollment form, I declare that, to the best of my knowledge, all of the information on this form is true and complete, and all of the persons for whom I am requesting enrollment are eligible for coverage. I have also read and understand the provisions below. The changes on this form supersede all previous forms submitted. If I decline coverage for myself and/or Dependents, I acknowledge that those declined will have to wait to be enrolled until the next Open Enrollment period or qualifying event.

Employee signature: _____ Date: _____

¹ Federal regulations require this information for enrollment

² Exclusive Provider Organization

Health Net Health Plan of Oregon, Inc.
13221 SW 68th Pkwy., Ste. 200
Tigard, OR 97223
www.healthnet.com
1-888-802-7001

If your employer's coverage has not yet renewed in 2014, this plan may impose a pre-existing condition exclusion. This means that if you have a medical condition before coming onto our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a 6-month period. Generally, this 6-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy, to a child who is enrolled in the plan within 31 days after birth, adoption, or placement for adoption, nor to enrollees under the age of nineteen (19). The pre-existing condition exclusion does not apply to physical or mental injuries sustained as a result of domestic or sexual violence or treatment received for such injuries. You can reduce the length of this exclusion period by the number of days of your prior "Creditable Coverage."

Definition: "Creditable Coverage" means health care coverage under a group or individual Health Benefit Plan, Medicare, Medicaid, military-sponsored health care, a medical care program of the Indian Health Service or of a tribal organization, a state health benefits risk pool, a Federal Employees' Health Benefit Plan (FEHBP), a public health plan, or a Health Benefit Plan under the Peace Corps Act, except coverage consisting solely of coverage of benefits for which credit is not required under applicable law. Coverage is creditable only if there had not been a gap in coverage exceeding 63 days under Oregon contract or 90 days under Washington contract.

If you are declining enrollment for yourself or your Dependents (including your spouse or Registered Domestic Partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this plan if you or your Dependents lose eligibility for that other coverage (or if your employer stops contributing toward your or your Dependents' other coverage). However, you must request enrollment within 31 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. If you previously declined enrollment in this plan for yourself or your Dependents because of coverage under a Medicaid plan or CHIP plan, you can enroll within 60 days of loss of such coverage. If you become eligible for premium assistance under a Medicaid plan or CHIP plan, you or your Dependents can enroll in this plan within 60 days of becoming eligible for premium assistance.

**IMPORTANT: THE FOLLOWING TERMS ARE A PART OF THIS APPLICATION. YOU MUST READ THEM CAREFULLY.
DO NOT SIGN THE APPLICATION ABOVE UNTIL YOU UNDERSTAND THESE TERMS.**

I, the applicant (employee) on my behalf and on behalf of every covered Dependent listed on this form or added in the future, hereby:

1. Agree that in the event any health care benefits provided to me or any covered Dependent by Health Net Health Plan of Oregon, Inc. (Health Net of Oregon) and/or its representatives are the primary responsibility of Medicare or of any coverage for work-related injuries, illness or conditions, or of any third party on account of any injury, illness, condition, or damage, I will fully inform Health Net of Oregon and/or its representatives and will execute such assignments, liens or other documents which may be necessary to enable Health Net of Oregon and/or its representatives to recover the value of services provided. I further agree that in the event I, any Dependent or any of my family members collect benefits, damages or reimbursement from Medicare, or any other third party with respect to such injury, illness, condition, or damage, I will immediately reimburse Health Net of Oregon and/or its representatives to the full extent of services provided by Health Net of Oregon and/or its representatives in accordance with the group contract/policy; and
2. Agree to be bound by each and every provision of the group contract/policy (including all schedules and attachments which are a part of the group contract/policy) as now in effect and as may be amended in the future, and agree that all my rights are as specifically set forth in the group contract/policy; and
3. Authorize my employer to deduct from my earnings any amount required to cover my share of the premiums or prepayment fees, if any, payable under the group contract; and
4. Acknowledge that I have selected a Primary Care Physician/Provider from the current Health Net of Oregon participating provider network, (for Exclusive Provider Organization (EPO), Triple Option/POS and CommunityCare plans); that this list identifies participating providers as of the date of publication; that changes in a provider's status, and additions to or deletions from this list may occur; and that Health Net of Oregon and/or its representatives neither warrant nor guarantee the availability of any specific participating provider; and
5. Acknowledge that Health Net of Oregon and/or its representatives' benefits are only available if obtained in compliance with all provisions of the group contract/policy; and
6. Acknowledge that all participating providers are independent contractors and are not agents, servants, officers, employees, partners, or joint venturers of or with, and are not controlled by, Health Net of Oregon and/or its representatives; that the participating providers, including primary care physicians, are responsible for the delivery of, or arrangement for, all medical services to me and my Dependents; and Health Net of Oregon and/or its representatives are not and will not be responsible for the deliberate or negligent acts or omissions of any such participating provider or any nonparticipating provider.

Send this application to: Health Net Health Plan of Oregon, Inc.
PO Box 9103
Van Nuys, CA 91409-9103