



Application For Group Benefits (2-99 Employees Enrolled)

Health Net®

TYPE OR PRINT LEGIBLY

Brk: Assurance Benefits
PO Box 41454 Phx 85080

APPLICATION INSTRUCTIONS	
1. Answer all questions completely and accurately.	5. Submit a completed "Certified List of Employees" form.
2. Do not cancel your existing coverage until you receive written notification of approval.	6. Submit the proper individual enrollment applications for every eligible employee and COBRA continuant enrolling for coverage. For groups 2-50 employees, submit the proper "Medical Evaluation" form for each employee and COBRA continuant.
3. Submit the most recent prior carrier billing statement, listing those currently insured and current rates.	7. Submit Enrollment Form including the "Waiver of Group Health" section for all employees waiving coverage for themselves and/or their dependent(s).
4. Submit the most recent unemployment tax and wage report (UC-018). Submit a "Sole Proprietor, Partner, or Corporate Officer Statement" for employees not listed on the unemployment tax and wage report.	8. Submit a group deposit check for the first month's premium.

SECTION I — EMPLOYER INFORMATION

*Group Number(s)—Include all service areas (Health Net Use Only)

Company Name (Legal name including any d.b.a.s)		Federal Tax ID #	
Corporate Address Street			Renewal Date
City	State	ZIP	County
Administrative Contact Name (Signatory)	E-mail Address	Chief Executive Officer Name	E-mail Address
Mailing/Billing Address		Physical Address	
Benefits Contact Name	E-mail Address	Phone #	Fax #
Billing Contact Name	E-mail Address	Phone #	Fax #
No. of Years in Business	Nature of Business	Standard Industry Code (SIC)	
<input type="checkbox"/> Corporation <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Partnership <input type="checkbox"/> Other _____		Do you maintain an IRS Section 125? <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION II — PLAN INFORMATION

PLAN	BENEFITS REQUESTED	<input type="checkbox"/> Health Only	<input type="checkbox"/> Life Only	<input type="checkbox"/> Health & Life	Requested Effective Date _____
	<input type="checkbox"/> HMO _____ (copayment)	<input type="checkbox"/> POS Plus _____ (PCP copay/specialist copay)	<input type="checkbox"/> PPO _____ (PCP copay/specialist copay/deductible/coinsurance)	<input type="checkbox"/> Indemnity _____	
(Health Net Use Only)	Cont # (HMO) _____	(POS) _____	(PPO) _____	(Indemnity) _____	
RIDER	<input type="checkbox"/> Vision <input type="checkbox"/> Chiropractic (HMO only) <input type="checkbox"/> Dental <input type="checkbox"/> Alternative Care				

COUNTIES (Check each county where employer has offices and note number of eligibles employees)

<input type="checkbox"/> Pima <input type="checkbox"/> Maricopa <input type="checkbox"/> Cochise <input type="checkbox"/> Coconino <input type="checkbox"/> Gila <input type="checkbox"/> Graham <input type="checkbox"/> Greenlee <input type="checkbox"/> Apache <input type="checkbox"/> Navajo
#Elig. EEs.
<input type="checkbox"/> La Paz <input type="checkbox"/> Mohave <input type="checkbox"/> Pinal <input type="checkbox"/> Santa Cruz <input type="checkbox"/> Yavapai <input type="checkbox"/> Yuma <input type="checkbox"/> Out-of-State
#Elig. EEs.

SECTION III — LIFE AND AD&D BENEFIT SELECTION (Note: Options A & B are for 2-50 employees, Options A, B, C, D & E are for 10-99 employees)

<input type="checkbox"/> Option A — \$15,000 flat amount for all employees. <input type="checkbox"/> Option B — A flat amount higher than \$15,000; maximum \$50,000 \$ _____ <input type="checkbox"/> Option C — One (1) x Annual Salary: \$50,000 maximum benefit. <input type="checkbox"/> Option D — Graded benefits by job title: Class I (officers, managers, supervisors) — \$30,000; Class II (all other employees) — \$15,000. <input type="checkbox"/> Option E — Graded benefits by job title: Class I (officers, managers, supervisors) — \$50,000; Class II (all other employees) — \$25,000.	Dependent Life (choose one) <input type="checkbox"/> High: \$5,000 spouse, \$2,000 child, \$200 infant (14 days-6 mos.) <input type="checkbox"/> Low: \$2,000 spouse, \$1,000 child, \$100 infant (14 days-6 mos.)
--	---

* Assigned once group is approved by Underwriting.

SECTION IV — GROUP UNDERWRITING, ENROLLMENT, ELIGIBILITY, CONTRIBUTION AND PARTICIPATION

1. For all eligible employees, the employer agrees to contribute an amount equal to at least 50% of the employee premium. (Health Net requires a minimum of 75% participation of eligible employees and a minimum of 50% of total full-time employees)

The employer agrees to contribute: Class I Definition _____

Class I Employees $\frac{\text{HEALTH / LIFE}}{\text{_____ / _____}}$ Dependents $\frac{\text{HEALTH / LIFE}}{\text{_____ / _____}}$
(Indicates Dollar Amount or Percentage) (Indicates Dollar Amount or Percentage)

Class II Definition _____

Class II Employees $\frac{\text{HEALTH / LIFE}}{\text{_____ / _____}}$ Dependents $\frac{\text{HEALTH / LIFE}}{\text{_____ / _____}}$
(Indicates Dollar Amount or Percentage) (Indicates Dollar Amount or Percentage)

2. New employee eligibility and enrollment requirements

New employees are eligible upon the first billing date following the completion of a (0, 1, 2, 3, 4, 5 or 6-month) waiting period. (New employee waiting period must not exceed six months.) Please indicate the waiting period for each Class:

Class I _____ month(s) Class II _____ month(s)

CONTRIBUTIONS

For all eligible employees, the employer agrees to contribute an amount equal to at least 50% of the employee premium. Health Net requires a minimum of 75% participation of eligible employees and a minimum of 50% of total full-time employees. **The employer must submit the most recent copy of their Arizona Unemployment Tax and Wage Report listing all employees and Certified List of Employees.**

INITIAL GROUP ENROLLMENT REQUIREMENTS

- 3. Eligibility requirements **will be** waived at enrollment (all full-time employees will enroll and waiting periods will be waived at initial enrollment).
- Eligibility requirements **will not be** waived at enrollment (all employees must satisfy the employer waiting period before enrolling).

4. Full-time employees are defined as those working a minimum of 30 or more hours per week.

5. Total number of employees (including those in the waiting period):

Full-time employees _____ Part-time employees _____
Total number of employees _____

6. Total number of employees eligible for coverage _____

7. Total number of employees applying for coverage _____

(Health Net requires a minimum of 75% participation of eligible employees and a minimum of 50% of total full-time employees)

The employer must submit the most recent copy of their Arizona unemployment tax and wage report listing all employees and a Certified List of Employees.

8. Number of employees terminated in the last 12 months _____

9. Is the group required to provide COBRA continuation coverage? Yes No

10. Total number of COBRA continuants _____

11. List all Employees/Dependents on COBRA (use separate sheet of paper, if necessary)

Name	Initial COBRA effective date	COBRA end date
_____	_____	_____
_____	_____	_____

12. BANKRUPTCY

- A) In the past 36 months, has the Company or any affiliated entity filed for protection or operated under federal/state bankruptcy laws? Yes No
- B) In the past 36 months, has any creditor filed or threatened to file a petition requesting the Company or any affiliated entity to be put into bankruptcy? Yes No
- C) Give details to any question(s) with a Yes answer _____

13. Workers' Compensation

Does the employer provide Workers' Compensation for all employees including the owners? Yes No

If no, list employees not covered and indicate why not covered (use separate sheet of paper, if necessary)

Name

Reason not covered under Workers' Compensation

14. List the previous group health carriers for the last five years

Name of carrier

Type of Coverage (PPO, HMO, POS Plus, etc.)

15. Are there any employees/dependents who are not actively performing their duties full-time due to a disabling illness, injury or pregnancy? Yes No

If yes, please list employee

Name

Disability, injury or illness

16. Are there any employees/dependents who reside outside of the State of Arizona? Yes No

If yes, please list employee

Name

Location (city, state, ZIP)

SECTION V — HEALTH INFORMATION

Please complete the following questions to the best of your knowledge. This information is necessary to evaluate your group's application by Health Net and/or Health Net Life Insurance Co. In order to protect the individuals involved, do not disclose the name of any employee or dependent.

1. Are you aware of any employee, dependent or COBRA enrollee currently disabled? Yes No If yes, explain _____

2. Are you aware of any employee, dependent or COBRA enrollee who incurred expenses of \$5,000 or more in the last 18 months? Yes No If yes, explain _____

3. Are you aware of any employee, dependent or COBRA enrollee who has been advised that necessary surgery or hospitalization is required (including pregnancy)? Yes No If yes, explain _____

4. Are you aware of any employee, dependent or COBRA enrollee who has had an organ transplant such as kidney, liver, heart or lung? Yes No If yes, explain _____

5. Are you aware of any employee or dependent presently or soon to be on COBRA? Yes No If yes, explain _____

6. Are you aware of any employee, dependent or COBRA enrollee who is currently being treated or diagnosed as having cancer, heart/lung disease, high blood pressure, diabetes or AIDS? Yes No If yes, explain _____

7. Please list any known medical conditions _____

SECTION VI — BROKER INFORMATION

Broker (1) Name Bgarcia	Health Net Broker (1) Number
Arizona Department of Insurance License Number	Broker (1) Commission Split
Agency Name A Assurance Benefits	Broker (1) Phone Number 623-322-4608
Broker (1) Address PO Box 41454 Phx 85080	Broker (1) Fax Number 623-322-4607
Broker (1) Tax ID Number	Health Net Account Executive Name
Account Executive Code	Health Net Account Manager Name

Broker (2) Name	Health Net Broker (2) Number
Arizona Department of Insurance License Number	Broker (2) Commission Split
Agency Name	Broker (2) Phone Number
Broker (2) Address	Broker (2) Fax Number
Broker (2) Tax ID Number	Health Net Account Executive Name
Account Executive Code	Health Net Account Manager Name

SECTION VII — IMPORTANT READ CAREFULLY

I certify that the Company named above has not had more than three (3) prior insurance carriers in the last five (5) years. I understand that this information may be verified by outside sources such as Equifax, or other investigative firms, which Health Net of Arizona, Inc. and/or Health Net Life Insurance Co. deems appropriate for finalizing its approval. Health Net and/or Health Net Life Insurance Co. reserves the right to retroactively adjust the rates provided if information, including medical information, subsequently received from the group of its eligible employees/dependents indicates this information was incomplete, inaccurate or a material misrepresentation was made in the application, and such information would have materially affected the rate calculation. Further, the proposal quotation may be invalidated or an enrolled group may be retroactively terminated and all premiums refunded if any material misrepresentations or omissions are found.

I understand that Health Net and Health Net Life Insurance Company are relying on the information provided herein and consider it material to the insurance risk assumed by Health Net and by Health Net Life Insurance Company.

Renewal premiums for small groups are based on the following factors: 1) the medical inflation rate; 2) changes in coverage; 3) changes to the demographic characteristics of the group, 4) changes in the geographic area in which your business resides; and 5) the actual or expected claims costs for your group as permitted by law. Premiums are guaranteed for one year and will not be changed mid-year except for : 1) statutory changes mandating a mid-year benefit change; 2) a material change in the nature of your business or industry; or 3) any changes in benefits or enrollment criteria requested by you.

The Company certifies that the information provided on this document is complete and accurate. The Company shall notify Health Net and/or Health Net Life Insurance Co. promptly of any changes in this information that may affect the eligibility of employees or their dependents, including the addition of any newly hired eligible employees or dependents and the termination or resignation date of any employees who are terminated by the employer. All coverages, enrollment provisions, eligibility requirements, benefits, limitations and exclusions have been thoroughly explained to eligible employees.

Acceptance of this Application is subject to final approval by Health Net and/or Health Net Life Insurance Co. and shall be based upon all information supplied by the group, the requested benefits, and any other information obtained from outside sources which Health Net and/or Health Net Life Insurance Co. deems appropriate. Upon acceptance by Health Net and/or Health Net Life Insurance Co., this Application shall be attached to and shall become part of the Group Enrollment Agreement (the "GEA"). The GEA may be terminated by Health Net and/or Health Net Life Insurance Co. for the Group's failure to meet certain obligations under the GEA, including, but not limited to, maintaining the agreed-upon Group contribution and employee and/or dependent participation levels as set forth in the Contract.

Official Legal Company Name _____

dba if Applicable _____

Group Telephone Number _____

Owner/Officer/Partner Signature for Group _____

Signature

Date

Title

Location (City, State)

Broker _____

Signature

Date

Location (City, State)

Health Net Authorized Signature _____

Signature

Date

Title