

1 HEALTH PLAN INFORMATION

PPO Standard	HSA	HMO Standard	HMO SILVER NETWORK Standard	EOA Standard	H ⁿ OPTIONS	SALUD CON HEALTH NET
<input type="checkbox"/> PPO 10 <input type="checkbox"/> PPO 20 <input type="checkbox"/> PPO 30 <input type="checkbox"/> PPO 40	<input type="checkbox"/> HSA 10 (1500) <input type="checkbox"/> HSA 20 (2500) <input type="checkbox"/> HSA 30 (3500) <input type="checkbox"/> HSA 40 (4500)	<input type="checkbox"/> HMO 10 <input type="checkbox"/> HMO 20 <input type="checkbox"/> HMO 30 <input type="checkbox"/> HMO 40	<input type="checkbox"/> HMO 10 <input type="checkbox"/> HMO 20 <input type="checkbox"/> HMO 30 <input type="checkbox"/> HMO 40	<input type="checkbox"/> EOA 10 <input type="checkbox"/> EOA 20 <input type="checkbox"/> EOA 30 <input type="checkbox"/> EOA 40	<input type="checkbox"/> Options PPO 250 <input type="checkbox"/> Options PPO 500 <input type="checkbox"/> Options PPO 1500 <input type="checkbox"/> Options PPO 1750 <input type="checkbox"/> Options PPO 3000 (HSA compatible) <input type="checkbox"/> Options PPO 4000 (HSA compatible) <input type="checkbox"/> Options HMO 25 <input type="checkbox"/> Options HMO 35 <input type="checkbox"/> Options EOA 25 <input type="checkbox"/> Options EOA 35	<input type="checkbox"/> Salud HMO y más (available in Los Angeles and Orange counties) <input type="checkbox"/> Salud PPO (available in Los Angeles, Orange and Ventura counties) <input type="checkbox"/> Salud Mexico (available in San Diego and Imperial counties) <input type="checkbox"/> Salud EPO (available in Los Angeles, Orange and Ventura counties)
Value	POS	Value	Value	Value		FLEX NET
<input type="checkbox"/> PPO 10 <input type="checkbox"/> PPO 20 <input type="checkbox"/> PPO 30 <input type="checkbox"/> PPO 40	<input type="checkbox"/> POS 10 <input type="checkbox"/> POS 20	<input type="checkbox"/> HMO 10 <input type="checkbox"/> HMO 20 <input type="checkbox"/> HMO 30 <input type="checkbox"/> HMO 40	<input type="checkbox"/> HMO 10 <input type="checkbox"/> HMO 20 <input type="checkbox"/> HMO 30 <input type="checkbox"/> HMO 40	<input type="checkbox"/> EOA 10 <input type="checkbox"/> EOA 20 <input type="checkbox"/> EOA 30 <input type="checkbox"/> EOA 40		<input type="checkbox"/> Indemnity (Out of service area only)

ENHANCED CHOICE <input type="checkbox"/> (Allows all medical plans except Silver Network)	<input type="checkbox"/> SILVER CHOICE <input type="checkbox"/> H ⁿ OPTIONS	DENTAL DHMO <input type="checkbox"/> Advantage 150 Plan <input type="checkbox"/> Advantage 225 Plan	DPPO <input type="checkbox"/> HB Plan _____ <input type="checkbox"/> HC Plan _____ <input type="checkbox"/> HD Plan _____	VISION PPO <input type="checkbox"/> Preferred 1025-2 <input type="checkbox"/> Preferred 1025-3 <input type="checkbox"/> Value 10-2	OPTIONAL RIDER <input type="checkbox"/> Chiropractic <input type="checkbox"/> Acupuncture <input type="checkbox"/> Combined (all riders for HMO, Salud HMO, EOA and POS only)
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Medical and Life/AD&D plans are provided by Health Net of California, Inc. and/or Health Net Life Insurance Company (together, the "Health Net Entities"). Dental plans are provided by SafeGuard Health Plans, Inc. and/or its affiliate, SafeHealth Life Insurance Company, (together "SafeGuard Entities"). Vision plans are provided by Fidelity Security Life Insurance Company and serviced by Eyemed Vision Care LLC (together the "Fidelity Entities").

Neither the SafeGuard Entities nor The Fidelity Entities are affiliated with the Health Net Entities. Obligations under dental and vision plans are not obligations of, and are not guaranteed by, the Health Net Entities.

Application is hereby made for a Group Policy provided by the Health Net Entities, the SafeGuard Entities, and/or the Fidelity Entities, the provisions of which are to be made available to all eligible employees, as defined, and their eligible dependents desiring coverage hereunder. The following information regarding employee data is being submitted to allow the Health Net Entities, the SafeGuard Entities and/or the Fidelity Entities to determine the eligibility of employees seeking enrollment.

2 EMPLOYER GROUP INFORMATION (If adding Dental or Vision to your existing coverage, please complete ALL sections of this form; for all other changes to existing coverage, please complete only sections 2,3,5 & 6.)

Company Name	DBA	Group #	SIC Code
Type of Business	How Long in Business	Effective Date / (Renewal Date)	
Company Contact	E-mail Address	Telephone #	Fax #
Mailing Address (if P.O. Box, please provide physical address)	City	State	Zip
Billing Address (if Different)	City	State	Zip

3 EMPLOYER CONTRIBUTION (Note: Employer contribution for health is a minimum of 50%¹ and for life is 100% (2-9) Enrollees and 25% (10-50 Enrollees)

Employee Health: _____% or, \$ _____² Employee Life: _____% Employee Dental: _____% Employee Vision: _____%
 Dependent Health: _____% or, \$ _____² Dependent Life: _____% Dependent Dental: _____% Dependent Vision: _____%

NOTE: Dental and Vision can be either voluntary (i.e., the employer contributes less than 50% of the premium) or employer sponsored (i.e., the employer contributes a minimum of 50% of the premium). If employer sponsored, you must complete the employee contribution. If you select Dental or Vision and no contributions are indicated, it is presumed that the plans will be voluntary.

¹Enhanced Choice, Silver Choice and Hⁿ Options require 50% of the lowest cost plan (excluding Salud), or \$100 minimum.
²Flat dollar contribution applies to Enhanced Choice, Silver Choice and Hⁿ Options only.

4 ELIGIBILITY INFORMATION

- Probationary Period for New Hires/Rehires - First of the month following; Date of hire 1 mo. 2 mos. 3 mos. __mos. (6 max)
- Number of hours worked per week required to be eligible for medical insurance coverage: 20 30

	MEDICAL	LIFE	DENTAL	VISION
3. Number of Eligible Employees (include eligible owner(s))	_____	_____	_____	_____
4. Total Number of Health Net Enrollees (excluding COBRA enrollees)	_____	_____	_____	_____
5. Number of Health Net COBRA Enrollees (applying for health coverage)	_____	_____	_____	_____
6. Number of Waivers (Please include an enrollment form with Section 9 "Declination of Coverage" indicated.)	_____	_____	_____	_____
7. What type of COBRA ³ are you subject to:	<input type="checkbox"/> Federal COBRA	<input type="checkbox"/> Cal-COBRA		
If Federal COBRA, how would you like your COBRA enrollees to be billed:	<input type="checkbox"/> Group Billed	<input type="checkbox"/> Member Billed		
8. Within the last 12 months, has the employer held a Health Net contract?	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
9. Do the eligible enrollees represent a carve-out either by class, location or union affiliation?	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
10. Has the group supplied the most recent quarter of their DE-6 with this application?	<input type="checkbox"/> YES	<input type="checkbox"/> NO ⁴		

³Note: Generally, employers who normally employed 20 or more employees during the previous calendar year are subject to federal COBRA. Employers who employed 2-19 employees on at least 50% of its working days the previous calendar year are subject to Cal-COBRA. Please consult your legal counsel if you need help determining which law applies to you.
⁴If a DE-6 is not available, please provide a letter of explanation and supporting documentation, subject to underwriting approval, with this group service agreement application.

5 LIFE AND AD&D BENEFIT SELECTION (If Health Net Life is selected, all full time employees are eligible.)

(Note: Option A is for 2-50 employees. Options B-G vary by group size.)

- Option A – \$15,000 flat amount for all employees.
- Option B – A flat amount higher than \$15,000; maximum \$100,000 \$ _____

Dependent Life: (choose one)

- High: \$5,000 spouse, \$2,000 child, \$200 infant (14 days-6 mos.)
- Low: \$2,000 spouse, \$1,000 child, \$100 infant (14 days-6 mos.)

- Option C – One (1) X Annual Salary; _____ or two(2) X Annual Salary; maximum \$50,000.
- Option D – One (1) X Annual Salary; _____ or one and a half (1.5) X Annual Salary; _____ or two (2) X Annual Salary; maximum \$100,000.
- Option E – Graded benefits by job title: Class I (officers, managers, supervisors) – \$25,000; Class II (all other employees) – \$15,000.
- Option F – Graded benefits by job title: Class I (officers, managers, supervisors) – \$50,000; Class II (all other employees) – \$25,000.
- Option G – Graded benefits by job title: Class I (officers, managers, supervisors) – \$100,000; Class II (all other employees) – \$50,000.

6 PRE-TAX SOLUTIONS (e.g. IRS code sections 125 and 321; Premium only plans and Flex plans)

If you are interested in learning about the tax savings potential for your employees and company, please contact Total Administrative Services Corporation (TASC) at 1-800-422-4661.

7 CURRENT CARRIER (List current carrier if any)

Is your company currently active with other health insurance? Yes No

If so, will you be canceling your other health insurance if approved with Health Net? Yes No

Health and/or Life: _____ **Worker's Compensation:** _____

Will one or both of the Health Net Entities be the only carrier(s)? Yes No If no, name of other carrier: _____

Plan offered: _____

Number of Enrollees not covered by Worker's Compensation: (Employers required to have Worker's Compensation must have a policy in effect to be eligible with Health Net.) _____

8 HEALTH QUESTIONNAIRE (For new groups only)

All employer groups must answer YES or NO to the following questions. Employer groups of 6-9 enrolling employees must have each employee complete the Health Questionnaire with the Enrollment form.

1. To your knowledge is there any employee, dependent of an employee, or person to be covered who has received more than \$5,000 of medical care in the past two (2) years? Yes No
2. To your knowledge is any employee, dependent of an employee, or person to be covered unable to work due to injury or illness? Yes No
3. To your knowledge has any employee, dependent of an employee, or person to be covered been denied life insurance coverage in the last two years? Yes No
4. To your knowledge are there any current pregnancies or recent hospitalization for any employee, dependent of an employee, or person covered? Yes No
5. To your knowledge has any employee, dependent of an employee, or person to be covered ever had, consulted for, had treatment rendered, been advised to have treatment or received treatment, or been hospitalized for any of the following conditions: Cardiovascular disease or heart attack; disorder of the kidney, stomach, intestines or liver; mental or nervous condition; central nervous system disorders; diabetes; respiratory disorders or cancer? Yes No
6. To your knowledge has any employee, dependent of an employee, or person to be covered ever been diagnosed as having AIDS or aids-related complex (ARC) by a medical professional? Yes No

For each "YES" answer, please provide the person(s) name and submit their completed employee health questionnaire.

9 ONLINE AUTHORIZATION (eServices)

Please complete this section to register and receive your bills online and/or process eligibility online. You will be notified by e-mail once your online account is created. Type of access requested (please check all that apply):

- Process Eligibility & Billing Process Eligibility only Process Billing only
- Allow Employee Eligibility Access (no billing for Employee permitted)

Please indicate below all parties who should be granted online access:

- Employer only Broker only Employer and Broker

10 UNDERWRITING CRITERIA

General Conditions

The issuance of coverage and a Group Service Agreement and/or Group Policy is subject to Underwriting review and approval by the Health Net Entities, the Safeguard Entities and/or the Fidelity Entities and receipt of first month's premium. The initial quoted rates are subject to the Health Net Entities, the Safeguard Entities and/or the Fidelity Entities review and revision based on actual enrollment and any other variations in the group from conditions outlined in the Underwriting Assumptions.

Coverage will be effective on the noted effective date if the application is accepted and approved by the Health Net Entities, the Safeguard Entities and/or the Fidelity Entities as appropriate within specified time requirements.

11 DISCLAIMER AGREEMENT

Please complete all of the information requested before signing this application. Please initial any changes.

This is an application only. Coverage and the issuance of a Group Service Agreement is subject to review and approval by Health Net Entities, the SafeGuard Entities and/or Fidelity Entities and receipt of first month's premium.

The undersigned hereby acknowledge that the preceding information constitutes true and complete representations to Health Net Entities, the SafeGuard Entities and/or Fidelity Entities. Should it be determined at the time of enrollment and/or at a future date that there are misstatements in this application, Health Net Entities, the SafeGuard Entities and/or Fidelity Entities may at their respective sole options either rescind the quote or initiate termination of the respective group contract(s).

Upon policy anniversary date, submission of renewal premium will confirm acceptance of that renewal and subsequent premium year.

Applicant, in the event this application is accepted, agrees to make authorized payroll dues deductions for such eligible employees who enroll under the agreement(s)/Policy and to forward such amounts in advance of the due date to the Health Net Entities, the Safeguard Entities and/or the Fidelity Entities, together with the reports necessary to maintain accurate and complete membership records. Furthermore, applicant agrees to comply with the applicable regulations pertaining to membership requirements, additions to the group and deletions from the group. Please return this application to your Health Net of California, Inc. and/or Health Net Life Insurance Company Account Executive or Broker as specified.

This "APPLICATION FOR GROUP SERVICE AGREEMENT" and any attached Addendum together with the Health Net Entities, the Safeguard Entities and/or the Fidelity Entities Group Policies (as referenced herein) and the employee enrollment forms form the entire agreement between the parties.

For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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

Arbitration Agreement: On behalf of Group Applicant, I understand and agree that any and all disputes or disagreements between Group (or enrolled members) and the Health Net Entities, the Safeguard Entities and/or the Fidelity Entities regarding the construction, interpretation, performance or breach of the Health Net Entities, the Safeguard Entities and/or the Fidelity Entities Group Policies, or regarding other matters relating to or arising out of the Health Net Entities, the Safeguard Entities and/or the Fidelity Entities Group Policies, whether stated in tort, contract or otherwise, must be submitted to final and binding arbitration in lieu of a jury or court trial. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties, including the Health Net Entities, the Safeguard Entities and/or the Fidelity Entities are giving up their constitutional rights to the extent permitted by law to have their dispute decided in a court of law before a jury. I also understand that disputes with the Health Net Entities, the Safeguard Entities and/or the Fidelity Entities involving claims for medical, services 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. A more detailed arbitration provision is included in the Health Net Entities, the Safeguard Entities and/or the Fidelity Entities Group Policies.

Effective July 1, 2002, members who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. § 1001 et seq., a federal law regulating benefit plans, are not required to submit disputes about certain "adverse benefit determinations" made by Health Net Entities, the Safeguard Entities and/or the Fidelity Entities to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by Health Net Entities, the Safeguard Entities and/or the Fidelity Entities to deny, reduce, terminate or not pay for all or a part of a benefit. However, members and Health Net Entities, the Safeguard Entities and/or the Fidelity Entities may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

Officer of the Company Signature	Officer Title	Date
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12 BROKER INFORMATION

Broker Name	Health Net Broker ID #	Broker Lic. #	Date Submitted
Agency Name	Telephone #	Fax #	E-mail Address
Address	City	State	Zip
Broker/Consultant Signature	Date	General Agent / ID #	

13 WHERE WOULD YOU LIKE YOUR ADMINISTRATION KIT MAILED?

Broker Employer

14 FOR HEALTH NET USE ONLY

Underwriter Signature	Date	Approved: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision Declined: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Billing #	Effective Date
SBG Representative Signature	Date	Group # (Health)	Policy Holder # (Life)	Medical Plan

Health Net of California Inc. offers the following products: ELECT Open Access, HMO, SELECT POS, Salud con Health Net HMO y más.
Health Net Life Insurance Company offers the following products: EPO, Flex Net, PPO, Salud con Health Net EPO and PPO, Life and AD&D insurance.
SafeHealth Life Insurance Company offers the following product: PPO Dental.
SafeGuard Health Plans, Inc. offers the following product: Dental HMO.
Fidelity Security Life Insurance Company offers the following product serviced by EyeMed Vision Care, LLC: PPO Vision.

