HEALTH NET CUSTOMER SERVICE PHONE NUMBER
Toll-free 1-800-411-5741

NY OUTLOOK EPO ADVANTAGE PLATINUM ENROLLMENT FORM

Please complete this application in full, including your signature.
Use blue or black in only and be sure all copies are printed legibly.

Health Net®

ENROLLEE INFORMATION
(please print clearly)

Last Name: | First Name: | MI: | Social Security Number:

COMPLETE HOME ADDRESS | Street: | City: | State: | ZIP Code:

❑ Single (S) ❑ Married (M) ❑ Widowed (W) ❑ Separated (L) ❑ Divorced (D) ❑ Other (O)_____ | Home Phone: ( ) | Business Phone: ( )

EMPLOYMENT INFORMATION

Check box if you are actively employed ❑
Check box if you are retired ❑ | Union Affiliation: | Average Number of Hours Worked Per Week:
❑ Under 20 Hours ❑ 20-24 Hours ❑ 25-29 Hours ❑ 30 Hours

OTHER HEALTH COVERAGE INFORMATION

Will you be covered by another health plan when Health Net Coverage starts? ❑ Yes ❑ No	If yes, list name and address of other carrier:	Spouse's Social Security Number:
Is your spouse employed? ❑ Yes ❑ No	If yes, list employer's name and address:	Spouse's Daytime Phone Number: MO DAY Spouse's Date or Birth: / /
Will your spouse be covered by another health plan when Health Net coverage starts? ❑ Yes ❑ No	If yes, list name and address of other carrier:	Policy/Contract #:
Will your dependents be covered by another health plan when Health Net Coverage starts? ❑ Yes ❑ No	If yes, list name and address of other carrier:	Policy/Contract #:

MEDICARE INFORMATION

Are you covered by Medicare ❑ Yes ❑ No	Medicare #:	Effective Dates: Part A Part B
Is your spouse covered by Medicare? ❑ Yes ❑ No	Medicare #	Effective Dates: Part A Part B
Are other dependents covered by Medicare? ❑ Yes ❑ No	Name(s): Medicare #:	Effective Dates: Part A Part B

STUDENT INFORMATION

If dependent children listed are age 19 or older, do they attend school on a full-time basis? ❑ Yes ❑ No	If yes, list first name of child and school	If no, is the dependent child disabled? ❑ Yes ❑ No

List yourself and any eligible dependents to be covered. Attach extra sheet if necessary.

	Last Name	First Name	M.I.	Social Security #	Sex: M/F	Date of Birth MO DAY YR	Primary Care Physician's Name	*Physician's Access Number
Self								
Spouse								
Child								
Child								
Child								

*This number appears in your provider directory below physician address and number.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed to five thousand dollars and the stated value of the claim for each violation.

AGREEMENT (please sign and date): I understand the Health Net benefits and coverage as summarized in Health Net plan materials and that these benefits are administered strictly as specified in Health Net plan documents.

I authorize any physician, hospital, insurer or other organization or person having any records or information concerning the health and treatment (including psychiatric, substance abuse, and confidential HIV related information) of me and my family member(s) to furnish such records as may be requested by Health Net Insurance of New York, Inc., or its authorized representative for purposes relating to coverage. A photocopy or digital image of this authorization shall be considered as valid as the original. This authorization shall renew upon any subsequent renewal of coverage under this policy.

I certify that all dependents listed above are eligible for coverage under the terms of Health Net plan documents. I agree to notify Health Net and my employer within 31 days when such eligibility ceases. I understand that Health Net is not liable to provide coverage to ineligible dependents.

If I am required to contribute, I authorize my employer to deduct from my wage the amount required for the coverage selected. I certify that all of the information above is correct to the best of my knowledge.

This authorization is valid for 24 months and you may revoke the authorization at any time by sending a letter to that effect to the address listed below.

Signature _____ Date _____

HEALTH INFORMATION I acknowledge that health care providers may disclose health information about me or my dependents, including information regarding substance abuse or mental/emotional conditions, to Health Net. The plans use and disclose this information for purposes of treatment, payment and health plan operations, including but not limited to utilization management, quality improvement, disease or case management programs.

TO BE COMPLETED BY EMPLOYER

Name of employer or employing office:	Reason for Enrollment: MO DAY YR ❑ New Hire Date of Hire: / / ❑ Cobra Enrollment ❑ 18 Months ❑ 36 Months Date of Elig: ❑ Open Enrollment ❑ Other _____	Effective Date of Coverage:	Group #:	Subgroup:	Plan Code:

Signature _____ Date _____

Health Net Insurance of New York, Inc. • Health Net: One Far Mill Crossing, P.O. Box 904, Shelton, CT 06484-0944
White Copy - Health Net • Yellow Copy - Employer • Pink Copy - Subscriber