

# Enrolling is Simple Just Follow these 4 Easy Steps

## HealthNet of Arizona - Individual Application

### Step 1:

**COMPLETE THE APPLICATION IN BLACK INK.** Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our office at:  
Office (480) 502-6869 Fax (480) 894-9707

### Step 2:

**WE RECOMMEND THAT YOU FAX YOUR COMPLETED APPLICATION** to our office @ (480) 894-9707 so we can review it and determine that the application is complete.

If unable to fax then simply mail your application along the first months premium (Payable to HealthNet of Arizona)

#### Mailing Address:

Authorized Benefit Plans, Inc.  
2131 E. Broadway Rd Suite #24  
Tempe, Arizona 85282

### Step 3:

**WE WILL CONTACT YOU, REVIEW YOUR APPLICATION,** determine if your application is complete and ready for underwriting review.

### Step 4:

**MAIL YOUR COMPLETED APPLICATION** to our office along the first months premium (Payable to HealthNet of Arizona)

#### Mailing Address:

Authorized Benefit Plans, Inc.  
2131 E. Broadway Rd Suite #24  
Tempe, Arizona 85282

Sincerely,

Authorized Benefit Plans, Inc  
2131 E. Broadway Rd #24  
Tempe, Arizona 85282

Office: (480) 502-6869

Fax: (480) 894-9707

Email: [phil@insurance4az.com](mailto:phil@insurance4az.com)

Website: [www.insurance4az.com](http://www.insurance4az.com)



# Individual & Family Health Plans

PPO Plans are underwritten by Health Net Life Insurance Company and administered by Health Net of Arizona, Inc.

## ENROLLMENT INFORMATION

Please fill in all boxes & blanks, sign and date or we will need to return the application for your completion. Thank you.

## IMPORTANT INSTRUCTIONS

- Please answer all questions in full to avoid a delay in processing.
- **PRINT clearly in black INK and return within 30 days from the date of signature.**
- Primary applicants must be residents of Arizona and all applicants must be under age 64-1/2. Applicants eligible for Medicare benefits are not eligible for coverage.
- If you need help completing this form, please contact your Broker:
- **The application must be completed by the applicant and not by insurance brokers.**
- If you are applying for the Portability Coverage described in Section F of this application, please attach the Certificate of Prior Creditable Coverage issued to you by your former insurance carrier.

Mail the completed application to your broker:

REQUESTED EFFECTIVE DATE:  1st of \_\_\_\_\_  15th of \_\_\_\_\_ If left blank you will be given the next available effective date.  
MONTH MONTH

### A. TELL US WHO YOU ARE ENROLLING

#### TYPE OF COVERAGE:

- Individual Subscriber Only     Subscriber & Dependent     Family     Child Only     Individual Portability Coverage
- Change of Coverage

#### PLAN SELECTION: (Choose only one)

##### HMO PLANS

- A42000TO** (\$25/\$40, \$300/\$150)
- ATB000TO** (\$15/\$30, \$250 deductible, 80% coinsurance)
- A45000TU** (\$25/\$40, \$1,000 deductible, 70% coinsurance)
- \_\_\_\_\_

##### PPO PLANS\* (Personal care physician/specialist, deductible, coinsurance)

- ABD1203R** (\$20/\$35, \$500 deductible, 90/60% coinsurance)
- ABE1213R** (\$20/\$35, \$500 deductible, 80/60% coinsurance)
- ABF1223R** (\$20/\$35, \$1000 deductible, 90/60% coinsurance)
- ABG1233R** (\$20/\$35, \$1000 deductible, 80/60% coinsurance)
- ABH1243S** (\$25/\$40, \$2500 deductible, 80/60% coinsurance)
- ABJ1253S** (\$25/\$40, \$5000 deductible, 80/60% coinsurance)
- ABM1283S** (\$25/\$40, \$5000 deductible, 50/30% coinsurance)
- ABQ1313S** (\$2500 deductible, 80/60% coinsurance)
- \_\_\_\_\_

\*Please note that the PPO Plans are underwritten by Health Net Life Insurance Company and administered by Health Net of Arizona.

#### INDIVIDUAL TERM LIFE INSURANCE: (Underwritten by Health Net Life Insurance Company) - Available to applicants & spouse

- Applicant                       \$15,000 LIFE                       \$30,000 LIFE                       \$50,000 LIFE
- Spouse                             \$15,000 LIFE                       \$30,000 LIFE                       \$50,000 LIFE

Evidence of Insurability is required for all Individual Term Life Insurance amounts. Coverage will not become effective until approved in writing by Health Net Life Insurance Company. **Applicant and Spouse must be age 19 and older.**

#### PAYMENT INFORMATION

- How would you like to make payments in the future?
  - Please bill me for my Health and/or Life Insurance Premium(s)
  - Please deduct my premiums for my Health and/or Life Insurance from my bank account using Automatic Bank Withdrawal. (Please complete the Health Net Quick Pay form.)

**Your Health Insurance and your Life Insurance Premiums will be billed separately.**

**Attach first month's premium here or complete the credit card information on page 5.**  
(Send check or money order payable to Health Net of Arizona. Do not send cash.)

- **Attach 1 month's premium if requesting a 1st of the month effective date.**
- **Attach 1-1/2 month's premium if requesting a 15th of the month effective date.**

**B. ENROLLMENT INFORMATION**

**IF APPLYING FOR AN HMO PLAN, PLEASE SELECT A PRIMARY CARE PHYSICIAN (PCP) FROM THE HEALTH NET PROVIDER DIRECTORY.** You may select the same or different PCP for each enrolling family member. If you need assistance selecting a PCP, call our Customer Contact Center at 1-800-289-2818.

**IF ENROLLING A CHILD ONLY, PLEASE LIST NAME, HOME ADDRESS, HOME PHONE AND BUSINESS PHONE FOR PARENT/LEGAL GUARDIAN.**

<b>PRIMARY APPLICANT</b>		Also use this section for parent/legal guardian if applying for child only coverage.					
LAST NAME		FIRST NAME		MI	APPLICANT OR PARENT/LEGAL GUARDIAN SS NO. - -		
HOME ADDRESS			CITY	STATE	COUNTY	ZIP	
HOME PHONE NO.	BUSINESS PHONE NO.		DATE OF BIRTH Mo Day Year		SEX M <input type="checkbox"/> F <input type="checkbox"/>	HEIGHT FT. IN.	WEIGHT
APPLICANT'S OCCUPATION		APPLICANT'S EMPLOYER NAME				FAX NO.	
PRIMARY CARE PHYSICIAN (IF PURCHASING an HMO) LAST NAME					FIRST NAME		PREFERRED LANGUAGE <input type="checkbox"/> ENGLISH <input type="checkbox"/> SPANISH
CURRENT PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, PLEASE LIST CURRENT DOCTOR'S NAME				PREVIOUS DOCTOR'S NAME			

**IF YOU WANT YOUR BILL MAILED TO A DIFFERENT ADDRESS, COMPLETE THIS SECTION**

ADDRESS	CITY	STATE	ZIP
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**SPOUSE**

Only your spouse and eligible unmarried children under the age of 25 may be included for family enrollment. If a listed family member's last name is different from yours, please explain on a separate sheet of paper.

LAST NAME		FIRST NAME		MI	DATE OF BIRTH Mo Day Year		SEX M <input type="checkbox"/> F <input type="checkbox"/>	HEIGHT FT. IN.	WEIGHT
SPOUSE'S OCCUPATION		SPOUSE'S EMPLOYER				SPOUSE'S SOCIAL SECURITY NO. - -			
PRIMARY CARE PHYSICIAN (IF PURCHASING an HMO) LAST NAME				FIRST NAME					
CURRENT PATIENT? IF NO, PLEASE LIST CURRENT DOCTOR'S NAME <input type="checkbox"/> YES <input type="checkbox"/> NO					PREVIOUS DOCTOR'S NAME				

**CHILD #1**

If enrolling more than 3 children, please fill out another application and be sure to answer all questions on the application, sign, date and attach the completed application to this application. Be sure all questions are answered on both applications.

LAST NAME		FIRST NAME		MI	DATE OF BIRTH Mo Day Year		SEX M <input type="checkbox"/> F <input type="checkbox"/>	HEIGHT FT. IN.	WEIGHT	
PRIMARY CARE PHYSICIAN (IF PURCHASING an HMO) LAST NAME							FIRST NAME			SOCIAL SECURITY NO. - -
CURRENT PATIENT? IF NO, PLEASE LIST CURRENT DOCTOR'S NAME <input type="checkbox"/> YES <input type="checkbox"/> NO					PREVIOUS DOCTOR'S NAME					

**CHILD #2**

LAST NAME		FIRST NAME		MI	DATE OF BIRTH Mo Day Year		SEX M <input type="checkbox"/> F <input type="checkbox"/>	HEIGHT FT. IN.	WEIGHT	
PRIMARY CARE PHYSICIAN (IF PURCHASING an HMO) LAST NAME							FIRST NAME			SOCIAL SECURITY NO. - -
CURRENT PATIENT? IF NO, PLEASE LIST CURRENT DOCTOR'S NAME <input type="checkbox"/> YES <input type="checkbox"/> NO					PREVIOUS DOCTOR'S NAME					

**CHILD #3**

LAST NAME		FIRST NAME		MI	DATE OF BIRTH Mo Day Year		SEX M <input type="checkbox"/> F <input type="checkbox"/>	HEIGHT FT. IN.	WEIGHT	
PRIMARY CARE PHYSICIAN (IF PURCHASING an HMO) LAST NAME							FIRST NAME			SOCIAL SECURITY NO. - -
CURRENT PATIENT? IF NO, PLEASE LIST CURRENT DOCTOR'S NAME <input type="checkbox"/> YES <input type="checkbox"/> NO					PREVIOUS DOCTOR'S NAME					

CHILDREN OR CHILD ONLY COVERAGE

**C. STATEMENT OF HEALTH**

**Fill in YES or NO for each item (All questions must be answered)**

In the past 10 years, have you or any person on this application been aware of, been diagnosed, been treated (including maintenance therapy), been injured, experienced pain or other symptoms, had a history of, had tests or x-rays/CT scans/MRIs, taken medications, been evaluated or advised by any type of health care professional regarding the following categories/conditions? The categories below are only examples and do not limit the extent of the information requested. **Fill in the "YES" and "NO" boxes for each category listed. Do not leave any items blank, do not write N/A (not applicable), and do not draw a line through the columns.**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>1.</b> Allergies (Sinusitis, Rhinitis, Allergy Shots)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>16.</b> Female Organs (Uterus, Cervix, Ovaries), Menstrual Disorder/ Irregular Bleeding, Fibroids, Abnormal Pap, Infertility	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>29.</b> Male Organs (Prostate, Testicles [Cysts, Nodules, Lump, Infection], Impotence)
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>2.</b> Back, Neck, Disc, Scoliosis, Lower Back	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>17.</b> Fractures (Bone: _____ Surgery, Pins / Plates / Screws (Present/ Removed) Cast only (circle answers)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>30.</b> Manic Depressive Disorder, Depression, Anxiety/Panic Attacks, Attention Deficit, Hyperactivity, Schizophrenia, OCD
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>3.</b> Birth / Congenital / Physical (Defect, Deformity, Disease, Disorder)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>18.</b> Gallbladder, Intestinal / Stomach (Colitis, Crohn's Disease, Irritable Bowel Syndrome, Hemorrhoids, Acid Reflux)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>31.</b> Muscular System (Chronic Fatigue, Fibromyalgia, Muscular Dystrophy)
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>4.</b> Blood, Bleeding Disorders (Anemia, ITP)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>19.</b> Headaches (Migraines, Stress, Muscle Tension)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>32.</b> Nervous System (Parkinson's Disease, Tremors, Multiple Sclerosis, Paralysis, Numbness, Weakness)
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>5.</b> Blood Vessels / Circulation Disorders (Varicose / Spider Veins, Arteries, Lymph System, Edema / Swelling)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>20.</b> Heart Conditions of any kind, Chest Pain / Bypass, Pacemaker, Heart Murmur, Arrhythmia (Irregular Heart Beat), Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>33.</b> Prosthetic Implants or Devices (Breast, Joint, Eye, Tendon)
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>6.</b> Bone, Joint [Knee, Shoulder, Hip] (Arthritis, Bursitis, Tendonitis TMJ, Carpal Tunnel Syndrome)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>21.</b> Hernia [circle type] (Hiatal, Umbilical, Inguinal, Ventral)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>34.</b> Psychiatric or Psychological Treatment or Counseling
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>7.</b> Brain / Head (Concussion, Injury, Tumor)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>22.</b> High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>35.</b> Reconstructive Surgery (Plastic, Cosmetic, Restorative)
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>8.</b> Breast [Male or Female] (Fibrocystic, Lumps, Nodules, Discharge, Abnormal Mammogram)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>23.</b> Hormonal / Endocrine (Thyroid: Hypo, Hyper, [Nodule / Goiter], Pituitary, Adrenal Gland)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>36.</b> Sexually Transmitted Diseases (HPV/Genital Warts, Genital Herpes, Chlamydia, Gonorrhea)
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>9.</b> Elevated Cholesterol, Triglycerides	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>24.</b> Illicit Drug Use or Abuse / Other Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>37.</b> Skin (Lesions, Discoloration, Lumps, Scleroderma, Psoriasis, Cancer [Melanoma, Basal Cell, Squamous Cell])
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>10.</b> Convulsions (Epilepsy, Seizure Disorder, Febrile Seizure)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>25.</b> Immune System / Inflammatory Disorder (Lupus Erythematosus, Gamma Globulin Deficiency, Gout)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>38.</b> Steroid Use (Anabolic, Prednisone, Decadron, Cortisone Injection)
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>11.</b> Developmental / Cognitive / Motor / Speech Delay	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>26.</b> Liver (Cirrhosis, Hepatitis state type: _____, Elevated Liver Enzymes)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>39.</b> Stroke / Transient Ischemic Attacks (TIA)
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>12.</b> Diabetes, Abnormal Glucose (High or Low)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>27.</b> Lungs (Asthma, Bronchitis, Emphysema/COPD, Valley Fever, Pneumonia, Reactive Airway, Disease, Recurrent Cough Wheeze, Sleep Apnea, Tuberculosis)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>40.</b> Benign Tumors, Cysts, Polyps, Growths, Plantar Warts
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>13.</b> Ear, Nose, Throat (Otitis, Tubes, Hearing Problems, Tonsillitis, Deviated Nasal Septum)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>28.</b> Kidney / Urinary Tract / Bladder (Stones, Infection, Blood in Urine, Incontinence)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>41.</b> Ulcers (Skin, Stomach, Intestine, Eye)
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>14.</b> Eating Disorders (Anorexia, Bulimia)			<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>42.</b> Weight Problems, Gastric Bypass, Recent Weight Loss or Gain
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>15.</b> Eyes (Cataracts, Lens Implants, Glaucoma, Lazy Eyes, Retinal Conditions)				
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>43.</b> Has surgery (major or minor, cosmetic or non-cosmetic, inpatient or outpatient) been performed on any applicant in the past 10 years?				
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>44.</b> In the past 10 years, has any applicant been advised to have surgery (major or minor, cosmetic or non-cosmetic, inpatient or outpatient) that has not yet been performed?				
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>45.</b> In the past 10 years, has any applicant been diagnosed, treated, evaluated for, experienced or been aware of symptoms related to alcoholism, use or abuse of alcohol, or conditions which may be related to alcohol use or abuse (cirrhosis, hepatitis, cardiac disease, delirium tremens, blackouts)?				
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>46.</b> In the past 10 years, has any applicant discussed his/her level of alcohol consumption with a health care professional and/or been advised to either decrease his/her intake of alcohol or stop drinking completely?				
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>47.</b> In the past 10 years, has any applicant been arrested or convicted for DUI/DWI? If yes, please provide Name: _____ How many times: _____ What States: _____ Dates: _____				
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>48.</b> Has any applicant <b>EVER</b> been aware of, evaluated, advised, tested (other than routine screenings), diagnosed or treated for cancer or malignant neoplasms (e.g. tumors, leukemia, Hodgkin's or melanoma)?				
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>49.</b> Has any applicant <b>EVER</b> been diagnosed or treated for AIDS (Acquired Immune Deficiency Syndrome) or AIDS-related conditions or tested positive for the presence of antibodies to the AIDS virus (HIV)?				
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>50.</b> To the best of your knowledge, are you, your spouse or any dependent now pregnant?				
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>51.</b> Is any person not named on this enrollment application currently pregnant by any person to be insured?				

**IF EITHER 50 OR 51 IS ANSWERED "YES", MEDICAL COVERAGE CANNOT BE ISSUED.**

**All questions must be answered.**

**52. FEMALE APPLICANTS** (Attach a separate page if necessary to list additional females.)

NAME	DO YOU MENSTRUATE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, HAVE YOU HAD A NORMAL PERIOD IN THE LAST 30 DAYS? <input type="checkbox"/> YES <input type="checkbox"/> NO	PLEASE PROVIDE DATES MONTH / DAY / YEAR			IF YOU DO NOT MENSTRUATE, PLEASE EXPLAIN
			LAST PERIOD	LAST PAP SMEAR	RESULTS	
	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	/ /	/ /	<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	
	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	/ /	/ /	<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	

Yes  No **53. Has any applicant experienced a weight change greater than 10 lbs. in the past year?**

NAME	WEIGHT CHANGE DURING THE PAST YEAR	CAUSE OF WEIGHT CHANGE
	<input type="checkbox"/> Gained _____ <input type="checkbox"/> Lost _____	<input type="checkbox"/> Diet (self) <input type="checkbox"/> Diet (Dr. recommended) <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____ <input type="checkbox"/> Medication _____
	<input type="checkbox"/> Gained _____ <input type="checkbox"/> Lost _____	<input type="checkbox"/> Diet (self) <input type="checkbox"/> Diet (Dr. recommended) <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____ <input type="checkbox"/> Medication _____

Yes  No **54. Has any applicant ever used tobacco products?**  Cigarettes  Cigars  Other \_\_\_\_\_  
If yes, who? \_\_\_\_\_ How much tobacco use per day? \_\_\_\_\_

For how many years? (indicate start date month/year and end date month/year) \_\_\_\_\_

Yes  No Has the person quit? If yes, who \_\_\_\_\_ When? \_\_\_\_\_

**If you answered "YES" to any parts of questions 1 through 54, please explain below. Attach extra pages if needed.**

QUESTION NO.	PERSON	CONDITION, INJURY, SYMPTOMS OR ILLNESS	DATES	TREATMENT, ADVICE GIVEN, RESULTS AND OTHER DETAILS	NAME, ADDRESS AND PHONE # OF HOSPITALS AND PHYSICIANS

**D. MEDICATION HISTORY (YOU MUST PROVIDE THE FOLLOWING INFORMATION)**

Yes  No **Is any applicant currently taking medications or taken any within the past twelve months?**  
If yes, list below (attach extra pages if needed)

NAME OF APPLICANT	NAME OF MEDICATION	REASON FOR TAKING	DOSAGE AND FREQUENCY	DATE PRESCRIBED	DATE DISCONTINUED	HOW OFTEN REFILLED	NAME OF PRESCRIBING PHYSICIAN

**All questions must be answered.**

**E. INDIVIDUAL TERM LIFE INSURANCE APPLICANT BENEFICIARY INFORMATION**

Please note that life insurance is issued at an additional premium.

APPLICANT'S BENEFICIARY(IES)		RELATIONSHIP	
STREET ADDRESS	CITY	STATE	ZIP
SPOUSE'S BENEFICIARY(IES)		RELATIONSHIP	
STREET ADDRESS	CITY	STATE	ZIP

(If a beneficiary is not indicated and the policy is issued, benefits will be paid in accordance with the provisions of the policy.)

This life insurance is not intended to replace any life insurance for which you are currently insured. Individual Term Life Insurance is underwritten by Health Net Life Insurance Company and available to Primary Applicant and Spouse age 19 and older.

**F. NOTICE TO APPLICANTS WHO HAVE LOST GROUP OR COBRA HEALTH COVERAGE:**

If your group or COBRA health plan (employer provided health coverage) terminated within the past 63 days, you may be eligible for Individual Portability Coverage. This coverage does not require medical underwriting and there is no pre-existing condition waiting period. In order to qualify for this coverage, you must meet specific criteria. Please contact your Broker or Sales Representative for further information. If you are applying for Individual Portability coverage, you'll also need to complete the Individual Portability Questionnaire.

**NOTE:** Not all benefit plans are available for Individual Portability coverage.

BROKER INFORMATION			
Broker's Name	Broker's Signature	Date Signed	Broker's Phone Number
Insurance Agency Name	Health Net Broker Number		Broker's Fax Number
Insurance Agency Address	L.I.D. #		

GENERAL AGENT INFORMATION		
GA Name (If Applicable)	GA Address	GA Number

**G. CREDIT CARD INFORMATION**

If your application for insurance is approved by Health Net's Underwriting Department and you want to pay your first month's premium or 1-1/2 month's premium with a credit card, please complete the following information. **Note: Payment by credit card is only available for first month's or 1-1/2 months' premium.**

CREDIT CARD TYPE: <input type="checkbox"/> VISA <input type="checkbox"/> MASTERCARD			
NAME AS IT APPEARS ON THE CREDIT CARD:			
BILLING ADDRESS	CITY	STATE	ZIP CODE
CREDIT CARD OWNER PHONE NUMBER:	CREDIT CARD NUMBER:		
CREDIT CARD ISSUER NAME OR BANK NAME:	CREDIT CARD EXPIRATION DATE (MONTH AND YEAR):		
E-MAIL ADDRESS:			

I HEREBY authorize Health Net of Arizona or Health Net Life Insurance Company (Health Net) to charge my credit card account for the first month's premium or 1-1/2 month's premium only for my Health Net coverage if my application for coverage is approved by Health Net. I understand that if my application for coverage is approved, the initial first month's premium or 1-1/2 month's premium will be charged to my credit card immediately upon approval by the Health Net Underwriting Department. I further understand that if my application for coverage is approved, premium payment for months following the first month of coverage will not be charged to my credit card and that I am responsible for arranging other methods of payment.\*

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

\* If you are approved for coverage your payment options are monthly billing or Quick Pay. If you would like your premiums deducted from your checking account on a monthly basis, please ask your health insurance representative about Health Net's Quick Pay option.

**H. CONDITIONS OF ENROLLMENT**

**GENERAL CONDITIONS:** Health Net and/or Health Net Life Insurance Company reserve the right to reject any application for enrollment. Health Net and/or Health Net Life Insurance Company may selectively accept the Applicant and any, all or none of applying dependent(s). There is no coverage unless this Application is accepted by Health Net and/or Health Net Life Insurance Company's Underwriting Department and a Notice of Acceptance is issued to the Applicant and Health Net and/or Health Net Life Insurance Company receives first month's premium. No other department, officer, agent or employee of Health Net and/or Health Net Life Insurance Company is authorized to grant enrollment. An insurance agent cannot grant approval, change terms or waive requirements. Health Net and/or Health Net Life Insurance Company may require that you take a medical examination and you will be responsible for payment of any related fees in such event. This Application and any medical information or examination reports shall become a part of the Health Benefit Contract. Any intentional or unintentional non-disclosure, misstatement or omission of fact in application materials that is material to the underwriting decision, including information related to the Subscriber's or Family Member's health status or history, is cause for disenrollment, termination of Coverage AND rescission of the Health Benefit Contract and, in such instance, Health Net and/or Health Net Life Insurance Company may recoup any amounts paid for Covered Services obtained as a result of such non-disclosure or misstatement of fact.

**NOTICE OF INSURANCE INFORMATION PRACTICES:** Pursuant to Arizona law: Health Net and/or Health Net Life Insurance Company may collect personal information about you from sources other than the applicant during the underwriting process. The information collected by Health Net and/or Health Net Life Insurance Company about you may, in certain circumstances, be disclosed to third parties without your authorization. You have the right to review information collected by Health Net and/or Health Net Life Insurance Company and correct erroneous information. A full description of your rights regarding the information collected by Health Net and/or Health Net Life Insurance Company is available from Health Net and/or Health Net Life Insurance Company upon request.

**USE AND DISCLOSURE OF 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. Health Net will 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 as permitted by law.

**IF SOLE APPLICANT IS A MINOR:** If the sole Applicant under this Application is under 18 years of age, Applicant's parent or legal guardian must sign below as such. In such event, the parent or legal guardian does hereby agree to be legally responsible for the accuracy of information in this Application and for premium payment. If such responsible party is not the natural parent of the Applicant, copies of the court papers authorizing guardianship must be submitted with this Application.

**ACKNOWLEDGMENT AND AGREEMENT:** I understand and agree that by enrolling or accepting services under a health plan with Health Net and/or Health Net Life Insurance Company, I am, and any enrolled dependents are, obligated to understand and abide by all terms, conditions and provisions of the Health Benefit Contract. I have read and understand the terms on this Application and my signature below indicates my acceptance of these terms and that the information entered in this Application is complete, true and correct. A photocopy of this is as valid as the original.

In addition, I understand and agree to the following:

- There is no coverage unless an application is approved by Health Net and/or Health Net Life Insurance Company's underwriting department.
- Health Net and/or Health Net Life Insurance Company is not liable for bills incurred before effective date of coverage.
- Health Net and/or Health Net Life Insurance Company will notify me if my application is accepted. My effective date will also be subject to the receipt of my premium by Health Net and/or Health Net Life Insurance Company.
- The broker selling Health Net and/or Health Net Life Insurance Company health coverage does not have the authority to approve my application and can not change any terms of the Agreement or waive any requirements.
- I am responsible for reporting to Health Net and/or Health Net Life Insurance Company any changes in health status that occur before the effective date of the Health Net and/or Health Net Life Insurance Company Plan Agreement. I understand any changes in health status may result in a change of the underwriting decision. This applies to every person listed on the application. I understand that my coverage may be rescinded if I fail to report a change.

**PREMIUM PAYMENT ACKNOWLEDGEMENT:** I understand and agree that in order to process my application, Health Net requires that I submit a payment for the first month's premium or 1-1/2 month's premium and that Health Net will not cash my check or charge my credit card unless coverage is approved by the Underwriting Department. I understand that by collecting the first month or 1-1/2 month's premium, Health Net and/or Health Net Life Insurance Company is not issuing coverage and is not assuming any risk for health coverage for me or any member of my family. I understand that insurance brokers have no authority to approve or bind coverage or to assign effective dates for coverage. I understand that coverage does not become effective immediately. I understand that I may be denied coverage as a result of underwriting. I understand that coverage, if any, is not effective until it is approved by Health Net and/or Health Net Life Insurance Company. I understand that if my application is approved and I or one of my family members chooses not to enroll in the plan, or if one of my family members is not approved for coverage, I will receive a refund for any applicant on this application who chooses not to enroll or who is not approved for coverage by Health Net and/or Health Net Life Insurance Company.

X \_\_\_\_\_  
 APPLICANT'S SIGNATURE (in ink)                      Date signed

X \_\_\_\_\_  
 APPLICANT'S SIGNATURE (in ink)                      Date signed

X \_\_\_\_\_  
 APPLICANT'S SIGNATURE (in ink)                      Date signed

X \_\_\_\_\_  
 APPLICANT'S SIGNATURE (in ink)                      Date signed

X \_\_\_\_\_  
 PARENT or LEGAL GUARDIAN (circle)  
 if sole applicant is under 18 years old                      Date signed

X \_\_\_\_\_  
 SPOUSE'S SIGNATURE (in ink)                      Date signed

**All applicants 18 years and older must sign application.**

**PLEASE BE SURE ALL QUESTIONS ARE ANSWERED AND APPLICATION IS SIGNED AND DATED TO PREVENT APPLICATION FROM BEING RETURNED.**

**PLEASE ATTACH A CHECK TO THE FRONT PAGE OF THIS APPLICATION OR FILL OUT THE CREDIT CARD INFORMATION ON PAGE 5.**

A17740 (9/03)  
 Health Net of Arizona, Inc.  
 is a subsidiary of Health Net, Inc.