



Health Net®
A Better Decision

**NY OUTLOOK EPO ADVANTAGE PLATINUM
ENROLLMENT FORM**

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

**HEALTH NET
CUSTOMER SERVICE
PHONE NUMBER**

Toll-free: 1-800-441-5741

ENROLLEE INFORMATION (please print clearly)	Last Name:		First Name		M.I.	Social Security Number:			
	COMPLETE HOME ADDRESS	Street:		City:	State:	ZIP Code:			
	<input type="checkbox"/> Single (S) <input type="checkbox"/> Married (M) <input type="checkbox"/> Widowed (W) <input type="checkbox"/> Separated (L) <input type="checkbox"/> Divorced (D) <input type="checkbox"/> Other (O)					Home Phone: () ()		Business Phone: () ()	
EMPLOYMENT INFORMATION*	Check box if you are actively employed <input type="checkbox"/>			Union Affiliation:		Average Number of Hours Worked Per Week:			
	Check box if you are retired <input type="checkbox"/>					<input type="checkbox"/> Under 20 Hours <input type="checkbox"/> 20-29 Hours <input type="checkbox"/> 30+ Hours			
OTHER HEALTH COVERAGE INFORMATION	Will you be covered by another health plan when Health Net coverage starts? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, list name and address of other carrier:			Spouse's Social Security Number:			
	Is your spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, list employer's name and address:			Spouse's Daytime Phone Number:			
						Spouse's Date of Birth: MO DAY YR / /			
	Will your spouse be covered by another health plan when Health Net coverage starts? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, list name and address of other carrier:			Policy/Contract #:				
MEDICARE INFORMATION	Are you covered by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicare #:		Effective Dates: Part A Part B				
	Is your spouse covered by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicare #:		Effective Dates: Part A Part B				
	Are other dependents covered by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name(s): Medicare #:		Effective Dates: Part A Part B				
STUDENT INFORMATION	If dependent children listed are age 19 or older, do the attend school on a full-time basis? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, list name of child and school:				If no, is the dependent child disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	

List yourself and any eligible dependents to be covered. **If you or any enrollee had previous health care coverage, enter start and end date of coverage next to name.

	Dates of Prev. Coverage**	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 telephone 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 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: <input type="checkbox"/> New Plan Date of Hire: MO DAY YR <input type="checkbox"/> COBRA Enrollment <input type="checkbox"/> 18 Months <input type="checkbox"/> 36 months Date of Elig: <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Other	Effective Date of Coverage:	Group #:	Subgroup:	Plan Code:
	Company Signature			Date		

Health Net: One Far Mill Crossing, P.O. Box 904, Shelton, CT 06484-0944 White Copy-Health Net • Yellow Copy-Employer • Pink Copy-Subscriber
NY46967 (2/08) 6016101

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