SMALL BUSINESS APPLICATION FOR GROUP SERVICE AGREEMENT/GROUP POLICY

☐ **New Sales**
☐ **Renewal**

1 HEALTH PLAN INFORMATION

PPO
Standard
☐PPO 10
☐PPO 20
☐PPO 30
☐PPO 40
Value
☐PPO 10
☐PPO 20
☐PPO 30
☐PPO 40

HSA
Standard
☐HSA 2000
☐HSA 3000
☐HSA 4000
Value
☐HSA 1500
☐HSA 2500
☐HSA 3500
☐HSA 4500

POS
☐POS 10
☐POS 20

HMO
Standard
☐HMO 10
☐HMO 20
☐HMO 30
☐HMO 40
Value
☐HMO 10
☐HMO 20
☐HMO 30
☐HMO 40

HMO SILVER NETWORK
Standard
☐HMO 10
☐HMO 20
☐HMO 30
☐HMO 40
Value
☐HMO 10
☐HMO 20
☐HMO 30
☐HMO 40

EOA
Standard
☐EOA 10
☐EOA 20
☐EOA 30
☐EOA 40
Value
☐EOA 10
☐EOA 20
☐EOA 30
☐EOA 40

Hn OPTIONS
☐Options PPO 250
☐Options PPO 500
☐Options PPO 1500
☐Options PPO 1750
☐Options PPO 3000 *(HSA compatible)*
☐Options PPO 4000 *(HSA compatible)*
☐Options HMO 25
☐Options HMO 35
☐Options HMO 25 Silver
☐Options HMO 35 Silver
☐Options EOA 25
☐Options EOA 35

SALUD CON HEALTH NET
Salud HMO y Más[1]
☐Salud HMO y Más 15
☐Salud HMO y Más 25
☐Salud PPO[2]
☐Salud EPO[2]
☐Salud Mexico[3]

FLEX NET
☐Indemnity *(Out of service area only)*

[1]Available in Los Angeles, Orange and select ZIP codes of Riverside and San Bernardino counties.
[2]Available in Los Angeles, Orange and Ventura counties.
[3]Available in San Diego and Imperial counties.

ENHANCED CHOICE
☐(Allows all medical plans except Silver Network)

☐ **SILVER CHOICE**
☐ **Hn OPTIONS**
☐ **Hn OPTIONS SILVER**

DENTAL
DHMO
☐HN Value Plan ☐HN Plus Plan
_____ _____

DENTAL
DPPO
☐Preferred Value Plan
_____
☐Plus Plan ☐Value Plan
_____ _____

VISION
PPO
☐Preferred 1025-2
☐Preferred 1025-3
☐Value 10-2

OPTIONAL RIDER
☐Chiropractic
☐Acupuncture
☐Combined (all riders for HMO, Salud HMO, EOA and POS only)

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 HMO plans are provided by Dental Benefit Providers of California, Inc. and dental PPO and Indemnity insurance plans are underwritten by Unimerica Insurance Company (together, the "DBP Entities"). Vision plans are provided by Fidelity Security Life Insurance Company and serviced by Eyemed Vision Care LLC (together, the "Fidelity Entities").

Neither the DBP 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 Service Agreement/Group Policy provided by the Health Net Entities, the DBP 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 DBP 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 & 13.)

Company Name	DBA	Group #	SIC Code

Type of Business	Type of entity (corporation, sole prop, LLC, partnership)	How Long in Business	Effective Date / (Renewal Date)

Company Contact	Telephone #	Fax #

Mailing Address (if P.O. Box, please provide physical address)	City	State	Zip

Billing Address (if Different)	City	State	Zip

E-mail Address (print clearly)

(continued on back)

3 EMPLOYER CONTRIBUTION (Note: Employer contribution for health is a minimum of 50%[4] and for life is 100% (2-9) Enrollees and 25% (10-50 Enrollees)

Employee Health: _____% or, $_____[5] Employee Life: _____% Employee Dental: _____% Employee Vision: _____%

Dependent Health: _____% or, $_____[5] Dependent Life: _____% Dependent Dental: _____% Dependent Vision: _____%

NOTE: Dental HMO and Vision PPO can be either voluntary or employer sponsored. If employer sponsored, you must complete the employee contribution. If you select Dental and/or HMO Vision with no contribution, indicate "0."

[4]Enhanced Choice, Silver Choice, H^n Options and H^n Options Silver require 50% of the lowest cost plan (excluding Salud), or $100 minimum.
[5]Flat dollar contribution applies to Enhanced Choice, Silver Choice, H^n Options and H^n Options Silver only.

4 ELIGIBILITY INFORMATION

1. Probationary Period for New Hires/Rehires - First of the month following: ☐ Date of hire ☐ 1 mo. ☐ 2 mos. ☐ 3 mos. ☐ __mos. (6 max)
2. Do you want to waive the Probationary Period for all enrollees at initial enrollment? ☐ YES ☐ NO
3. Number of hours worked per week required to be eligible for medical insurance coverage: ☐ 20 ☐ 30

	MEDICAL	LIFE	DENTAL	VISION
4. Number of Eligible Employees (include eligible owner(s))	_____	_____	_____	_____
5. Total Number of Health Net Enrollees (excluding COBRA enrollees)	_____	_____	_____	_____
6. Number of Health Net COBRA Enrollees (applying for health coverage)	_____	_____	_____	_____
7. Number of Waivers (Please include an enrollment form with Section 7 "Declination of Coverage" indicated.)	_____	_____	_____	_____

8. What type of COBRA[6] are you subject to: ☐ Federal COBRA ☐ Cal-COBRA
   If Federal COBRA, how would you like your COBRA enrollees to be billed: ☐ Group Billed ☐ Member Billed
9. Within the last 12 months, has the employer held a Health Net contract? ☐ YES ☐ NO
10. Do the eligible enrollees represent a carve-out either by class, location or union affiliation? ☐ YES ☐ NO
11. Does the group file a DE-6? ☐ YES ☐ NO[7]

[6]Note: 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.
[7]If 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 Health Net be the only carrier? ☐ 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 are there any current pregnancies or recent hospitalization for any employee, dependent of an employee, or person covered? ☐ Yes ☐ No
4. 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
5. 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) – Email address required in Section 2

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 WHERE WOULD YOU WANT YOUR ID CARDS MAILED?

☐ Member ☐ Employer

11 WHERE WOULD YOU LIKE YOUR ADMINISTRATION KIT MAILED?

☐ Broker ☐ Employer

12 UNDERWRITING CRITERIA

General Conditions

The issuance of coverage and a Group Service Agreement/Group Policy is subject to Underwriting review and approval by the Health Net Entities, the DBP 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 DBP 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 DBP Entities and/or the Fidelity Entities as appropriate within specified time requirements.

13 ARBITRATION AGREEMENT AND OTHER IMPORTANT TERMS

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/Group Policy is subject to review and approval by Health Net Entities, the DBP 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 DBP 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 DBP 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 Group Service Agreement/Group Policy and to forward such amounts in advance of the due date to the Health Net Entities, the DBP 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/GROUP POLICY" and any attached Addendum together with the Health Net Entities, the DBP 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 care services plans or insurance companies as a condition of obtaining 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 DBP Entities and/or the Fidelity Entities regarding the construction, interpretation, performance or breach of the Health Net Entities, the DBP Entities and/or the Fidelity Entities Group Policies, or regarding other matters relating to or arising out of the Health Net Entities, the DBP 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 DBP 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 DBP 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 DBP 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 DBP Entities and/or the Fidelity Entities to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by Health Net Entities, the DBP 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 DBP 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

14 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 #

Account Executive Name	Date

15 FOR HEALTH NET USE ONLY				
Underwriter Signature	Date	Approved: ☐ Medical ☐ Dental ☐ Vision Declined: ☐ Medical ☐ Dental ☐ 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.
Unimerica Insurance Company offers the following product: Dental PPO and Dental Indemnity.
Dental Benefit Providers of California, Inc. offers the following product: Dental HMO.
Fidelity Security Life Insurance Company offers the following product serviced by EyeMed Vision Care, LLC: Vision PPO.

Small Business Group submission checklist

To ensure prompt processing, please make sure to include the following documents.

Groups applying for a 1st of the month effective date must be submitted to Health Net by the 5th of the month. Paperwork must be completed by the 20th of the month, otherwise the group will be rolled to the following month.

☐ A signed original application for Group Service Agreement (GSA)/Group Policy

☐ A complete employee application for each eligible employee, enrolling/waiving coverage

☐ A check or a Check-by-Fax form for the first month's premium drawn from the group account

☐ A Health Questionnaire is required for:

- All groups of 6-9 employees enrolling
- Groups of 1-5 enrolling employees that are eligible for an industry discount
- Any employee referenced on the GSA with a known medical condition
- Non-guarantee issue groups
- All carve-out groups

☐ The latest quarter DE-6, reconciled

- If the group has not been in business long enough to have a DE-6, six weeks of payroll, including withholdings, may be submitted
- 2 weeks payroll required for all employees that don't appear on the current DE-6
- For wages exceeding a part-time and wages below full-time status, payroll will be required
- To reconcile the DE-6, please indicate next to each employee's name one of the following

  T – Terminated (including termination date)

  E – Eligible and enrolling

  W – Eligible and waiving coverage

  S – Seasonal

  WP – Waiting Period (include date of hire for those in waiting period)

  TEMP – Temporary employees

  PT – Part time

  Covered by another carrier – add carrier name.

☐ Ownership paperwork (required if owner/partners names do not appear on the DE-6 or payroll records). Must list each person's first and last name. Paperwork must be filed with the state or county. Documentation may include:

For Sole Proprietor:

- California Business License
- Fictitious Business Name Statement
- Schedule C Tax Form

For Partnership:

- California Business License (showing both names)
- Fictitious Business Name Statement (showing both names)
- Schedule K Tax Form (for all eligible owners)
- Tax certificate (showing both names)

For Corporation

- Articles of Incorporation
- Statement of Information
- Tax Form 1120

Note: Please consult your sales representative for acceptable ownership documentation for other business structures.

FOR PPO PLANS:

☐ Prior Creditable Coverage Certificate or up to 6 months of prior carrier bills for waiving the Pre-Existing Conditions Clause

☐ Copies of EOBs for employees requesting Deductible Credit from prior carrier

☐ An Employer Acknowledgment Form must be completed if the group is enrolling in an HSA compatible plan or a high-deductible plan

☐ Groups enrolling in the HSA EZAccess Program:

- Completed Bank of America Employer Enrollment Forms
  - – Health Net Authorization Form (1 page)
  - – Bank of America Employer Group Set Up Form (2 pages)
  - – Bank of America Services Agreement (3 pages)

Employees can easily enroll online for The HSA for Life from Bank of America by following these simple steps:

1. Visit www.bankofamerica.com/benefitslogin.[8]
2. Under *New User*, select *Yes*, and click *Continue*
3. Enter the Group ID provided to them by the employer.
4. Follow the prompts to complete and submit the application.

[8]If the employees do not have online access, contact your authorized Health Net agent or broker.