Health Net Health Plan of Oregon, Inc. (Health Net)

State Continuation Election Form

NOTICE TO MEMBER:

To elect Oregon State Continuation Coverage, complete this election form and return it to your employer.

You must request state continuation coverage within either ten days after the event that triggered your loss of eligibility for coverage or ten days after the date you were provided the State Continuation Notice from Health Net Health Plan of Oregon, Inc. (Health Net), whichever is later. If you do not submit a completed election form within the required time period, you may lose your right to continuation coverage.

1. Employee personal information

Employer name *(print)*:	Group number:
Employee name *(print)*:	Social Security number:

2. Eligible dependents information (attach additional sheets if necessary)

List all dependents to be covered with the employee and/or dependent-only applicants, as allowed. *(Required)*

Oregon domestic partners are eligible for state continuation coverage under an Oregon group employer plan.

☐ Spouse ☐ Domestic partner Dependent name:	Social Security number:
Dependent name:	Social Security number:
Dependent name:	Social Security number:
Dependent name:	Social Security number:

3. Loss of coverage

Loss of coverage reason: ☐ A reduction of hours ☐ The employee's termination of employment ☐ The employee's dependents lose coverage because of employee's death ☐ The employee's dependent spouse or domestic partner loses coverage due to divorce or termination of domestic partnership ☐ The employee is now eligible for Medicare ☐ The dependent child is no longer eligible for coverage under the group policy	Date of event: _____

(continued)

4. Acceptance or declination of coverage (signature required)

I understand that I am eligible to self-pay my present Health Net Health Plan of Oregon, Inc. group medical coverage for up to nine months if I have been covered under the group contract, or similar predecessor contract, for at least three consecutive months.

☐ Yes, I want to continue my group medical insurance through Oregon State Continuation.

1. I am not eligible for Medicare. I will notify the subscriber group if I become eligible for Medicare.
2. I am not eligible for any other group medical insurance coverage. I will notify the subscriber group if I become eligible for any other group medical insurance coverage.
3. I understand I must pay any owed premium to my subscriber group administrator each month in advance of the coverage effective date. Premium for the first month is included with this form.
4. I understand that ACA-compliant individual plans through the Federal Health Insurance Marketplace, Health Net and other carriers are available to me and my eligible dependents.
5. I wish to remain insured by my present group coverage:

   ☐ Self only ☐ Self and currently covered family members ☐ Currently covered dependents

Signature: _____ Date: _____

☐ No, I am not interested in continuing my group medical insurance through Oregon State Continuation.

Signature: _____ Date: _____

Employer Use Only

Return this form to Health Net via email or mail it to the address below. Keep a copy for your files.

Mail: Health Net Health Plan of Oregon, Inc.
Attn: Membership Accounting
PO Box 9103
Van Nuys, CA 91409

Email: HNOregon_Enrollment@healthnet.com