Large Group

2025 Enrollment and Change Application

Application must be typed or completed in blue or black ink.

Medical insurance plans are provided by Health Net Health Plan of Oregon, Inc. (Health Net). Life and AD&D plans are underwritten by Health Net Life Insurance Company. Dental PPO insurance plans are underwritten by Health Net Health Plan of Oregon, Inc. and administered by Dental Benefit Providers, Inc. (DBP). Vision plans are underwritten by Health Net Health Plan of Oregon, Inc. and serviced by Centene Vision Services. Health Net Health Plan of Oregon, Inc., Health Net Life Insurance Company and Centene Vision Services are subsidiaries of Centene Corporation.

Welcome to Health Net

Simple steps for completing the form:

1. Review the materials enclosed in your enrollment packet. Be sure that you understand the coverage options that are available to you by your employer.

2a. **If you are *declining* coverage** for yourself and/or your dependents, section 6 is required. Do not fill out any other sections.

2b. **If you are *accepting* coverage** for yourself and/or your dependents, sections 1, 2, 3, 5, and 7 are required.

The Affordable Care Act (ACA) requires Health Net to provide to the IRS confirmation of health care coverage for yourself, as the subscriber, and your covered dependents. The IRS uses this information to confirm each member has minimum essential coverage. Please ensure that the Social Security number (SSN) is accurate for yourself and each dependent you are enrolling. For more information about the individual shared responsibility payment provision, go to http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision.

3. If you choose to enroll in the EPO, POS or CommunityCare plans, **you must select your primary care physician (PCP).** Be sure to fill in the names and 10-digit enrollment ID numbers as they appear in Health Net's online ProviderSearch tool. **Note:** If you do not select a PCP, one will be selected for you.
4. If you choose to enroll in a PPO insurance plan, you are not required to select a PCP to enroll.
5. Make a copy of the completed application for your records. **If a correction is needed, cross out and initial each correction. Please do not use a white-out product.**

For employer use only:

Existing Group	**New Group**
Submit to Membership Accounting: Email: HNOregon_Enrollment@healthnet.com Fax: 1-855-607-0982	Please send all completed paperwork to your designated account executive or broker.

health net

To be completed by employer	
Employer name:	Administrative Email:
Requested effective date: _____	Employer group number (medical):
Employee eligibility date: ☐ Same as hire date ☐ Other: _____	

Important: Please print all sections in black ink. You are entitled to see a Summary of Benefits and Coverage (SBC) before you choose a plan. Please contact your employer if you do not have the SBC for the plan you have selected.

1. Health plan information - All medical plans include alternative care benefits.

(Please select your coverage and print the plan name in the space provided.)

Medical

☐ PPO: _____
☐ CommunityCare 1T[1]: _____
☐ CommunityCare 3T[1]: _____
☐ Other: _____

Dental

☐ Plus: _____
☐ Value: _____
☐ Preferred Value: _____
☐ Preferred Plus: _____
☐ Essentials

Vision

☐ Elite 1010-1
☐ Supreme 010-2
☐ Preferred 1025-2
☐ Preferred 1025-3
☐ Plus 20-1
☐ Preferred Value 10-3
☐ Exam Only

2. Reason for application

☐ Plan change
☐ Change address/name
☐ Delete dependent (list names below)
☐ Other:
_____

☐ New hire ☐ Rehire ☐ Open Enrollment

Special Enrollment Period

Qualifying event date: _____

Add dependent:
☐ Marriage/Domestic Partnership
☐ Newborn/Adoption/Legal guardianship/Court order/Assumption of parent-child relationship
☐ Loss of prior coverage ☐ Other (specify): _____

☐ **COBRA**
Effective date: _____
Qualifying event: _____
Qualifying event date: _____

3. Employee personal information

Last name:	First name:	MI:	☐ Male ☐ Female
Residence address:	City:	State:	ZIP:

Date of birth *(mm/dd/yyyy)*:	Social Security #/Tax ID #:	Marital status: ☐ Single ☐ Married ☐ Domestic partner
Telephone #:	Work phone #:	Email address:

Date of hire:	Dept. #:	Job title:	☐ Salary ☐ Hourly ☐ Retired

Entering eligible class? ☐ Part-time to full-time ☐ Temporary to permanent ☐ Hourly to salaried

If available, I would prefer to receive communication and plan information in Spanish: ☐ Yes ☐ No

Primary care physician *(For EPO, POS, CommunityCare plans only)*:

PCP enrollment ID # *(10-digit PCP number)*:	Is this your current PCP? ☐ Yes ☐ No

[1]Available to employer groups located in Multnomah, Clackamas, Washington, Clatsop, Columbia, and Tillamook counties. Available to employees in Multnomah, Clackamas, Washington, Clatsop, Columbia, and Tillamook counties, and Clark County, WA.

Employee name: ____________________________

4. Family information – please list all eligible family members to be enrolled
(Attach additional sheets if necessary.)

Spouse/Domestic partner ☐ M ☐ F	Last name:	First name:		MI:
Residence address: ☐ Check here if same as subscriber		City:	State:	ZIP:
Date of birth *(mm/dd/yyyy)*:		Social Security #/Tax ID #:		
Primary care physician *(For EPO, POS, CommunityCare plans only)*:		PCP enrollment ID # *(10-digit PCP number)*:		
Is this your current PCP? ☐ Yes ☐ No				

☐ Son ☐ Daughter	Last name:	First name:		MI:
Residence address: ☐ Check here if same as subscriber		City:	State:	ZIP:
Date of birth *(mm/dd/yyyy)*:		Social Security #/Tax ID #:		
Primary care physician *(For EPO, POS, CommunityCare plans only)*:		PCP enrollment ID # *(10-digit PCP number)*:		
Is this your current PCP? ☐ Yes ☐ No				

☐ Son ☐ Daughter	Last name:	First name:		MI:
Residence address: ☐ Check here if same as subscriber		City:	State:	ZIP:
Date of birth *(mm/dd/yyyy)*:		Social Security #/Tax ID #:		
Primary care physician *(For EPO, POS, CommunityCare plans only)*:		PCP enrollment ID # *(10-digit PCP number)*:		
Is this your current PCP? ☐ Yes ☐ No				

☐ Son ☐ Daughter	Last name:	First name:		MI:
Residence address: ☐ Check here if same as subscriber		City:	State:	ZIP:
Date of birth *(mm/dd/yyyy)*:		Social Security #/Tax ID #:		
Primary care physician *(For EPO, POS, CommunityCare plans only)*:		PCP enrollment ID # *(10-digit PCP number)*:		
Is this your current PCP? ☐ Yes ☐ No				

Employee name: ______________________________

5. Do you or your dependents have other health care coverage (including Medicare)?

☐ Yes, if "Yes," please complete this section.
☐ No, If "No," please proceed to Section 6.

☐ Self	Name:	Name of other insurance carrier:	Prior coverage start date *(mm/dd/yy)*:		
Prior coverage end date *(mm/dd/yy)*:	Reason for ending coverage:	Group #/Policy ID #:	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:

☐ Spouse ☐ Domestic partner	Name:		Name of other insurance carrier:		Prior coverage start date *(mm/dd/yy)*:	
Prior coverage end date (mm/dd/yy):	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? ☐ Yes ☐ No	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:

☐ Son ☐ Daughter	Name:		Name of other insurance carrier:		Prior coverage start date *(mm/dd/yy)*:	
Prior coverage end date (mm/dd/yy):	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? ☐ Yes ☐ No	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:

☐ Son ☐ Daughter	Name:		Name of other insurance carrier:		Prior coverage start date *(mm/dd/yy)*:	
Prior coverage end date (mm/dd/yy):	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? ☐ Yes ☐ No	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:

☐ Son ☐ Daughter	Name:		Name of other insurance carrier:		Prior coverage start date *(mm/dd/yy)*:	
Prior coverage end date (mm/dd/yy):	Reason for ending coverage:	Group #/ Policy ID #:	Is this your dependent's primary coverage? ☐ Yes ☐ No	Does it cover? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No	Medicare: ☐ Part A ☐ Part B	Medicare claim/ HICN #:

Employee name: _____

6. Declination of coverage

(Complete this section if any coverage is being declined by you or your eligible dependents.)

Waiving coverage for:	Person(s) waiving coverage (First, MI, Last Name):
☐ Medical ☐ Dental ☐ Vision	Employee: Reason for waiver: ☐ Individual ☐ Employer group ☐ Medicare ☐ Other: _____
☐ Medical ☐ Dental ☐ Vision	Spouse/Domestic Partner:
☐ Medical ☐ Dental ☐ Vision	Dependent Child:
☐ Medical ☐ Dental ☐ Vision	Dependent Child:
☐ Medical ☐ Dental ☐ Vision	Dependent Child:

IF YOU ARE DECLINING COVERAGE – STOP AND READ CAREFULLY

I have decided to decline coverage for myself and/or my dependent(s). I acknowledge that my dependents and I may have to wait to be enrolled until the next annual Open Enrollment Period or Special Enrollment Period due to a qualifying event. The available coverages have been explained to me by my employer, and I have been given the chance to apply for the available coverages. Additionally, by signing below, I certify, to the best of my knowledge or belief, that the reason I am declining coverage is accurate as indicated by the check marks above.

Employee signature: _____ **Date:** _____
(Sign only if declining coverage. If signed in error, please cross out and initial.)

7. Acceptance of coverage (Signature required.)

By completing this enrollment form, I confirm that I have provided accurate and complete information to the best of my knowledge. I also affirm that all individuals I am seeking enrollment for are eligible for coverage.

As the applicant (employee), I agree that if any health care benefits provided by Health Net become the primary responsibility of Medicare, work-related injury or illness coverage, or any third party due to injury, illness, condition, or damage, I will promptly notify Health Net. I am also willing to execute any necessary documents, such as assignments or liens, to enable Health Net to recover the value of the services provided.

Furthermore, should I, a dependent, or any of my family members receive benefits, damages, or reimbursement from Medicare or any other third party related to injury, illness, condition, or damage, I will reimburse Health Net fully for the services provided in accordance with the group plan contract.

I also commit to adhere to all terms and conditions outlined in the group plan contract, including any amendments made in the future. I authorize my employer to deduct from my earnings any necessary amount to cover my portion of the premiums or prepayment fees under the group contract.

I acknowledge that I have chosen a Primary Care Physician/Provider from the current Health Net participating provider network (for Exclusive Provider Organization (EPO), Triple Option/POS, and CommunityCare plans). I understand that this list is based on the providers available at the time of publication and may change. Health Net and its representatives do not guarantee the availability of any specific participating provider.

I recognize that Health Net's benefits are only accessible when obtained in compliance with all the provisions outlined in the group plan contract. I also acknowledge that participating providers operate as independent contractors and are not employees, agents, or controlled by Health Net. These providers are responsible for delivering or arranging all medical services for me and my dependents, and Health Net is not liable for their actions or omissions, whether deliberate or negligent.

Employee signature: _____ **Date:** _____
(Sign only if accepting coverage. If signed in error, please cross out and initial.)

Please contact the Health Net Customer Contact Center at the toll-free number below if you need assistance in completing this form or if you have questions about your coverage:

Medical: 1-888-802-7001

If you have questions about your Behavioral Health, Dental, Vision or Life coverage, please call:

Behavioral Health:	1-800-977-8216
Dental:	1-877-410-0176
Vision:	1-866-392-6058
Life:	1-800-865-6288

You can print a temporary ID card to use until you receive your permanent ID card. To print a temporary ID card, create a Member Portal Account at www.healthnetoregon.com by selecting "Members" and "Register."

Emergency and urgently needed care:

- If your situation is life-threatening or an emergency: Call 911 or go to the nearest hospital.
- If your situation is not so severe: If you cannot call your primary care physician or physician group, or you need medical care right away, go to the nearest hospital or urgent care center.
- If you are outside your physician group's service area: Go to the nearest hospital or medical center, or call 911. In all cases, contact your primary care physician or participating physician group as soon as possible to inform them about your condition.
- Call the number on your ID card within 48 hours of being admitted, or as soon as possible.

Prior authorization:

You, the member, are responsible for obtaining prior authorization for certain services. Please check your plan certificate for a list of services requiring prior authorization.

For prior authorization, please call 1-888-802-7001.

Declination of coverage:

If you are declining enrollment for yourself or your Dependents (including your spouse or Domestic Partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this plan if you or your Dependents lose eligibility for the other coverage (or if your employer stops contributing toward your or your Dependents' other coverage). However, you must request enrollment within 30 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, guardianship, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 30 days after the marriage, birth, guardianship, adoption, or placement for adoption.

If you previously declined enrollment in this plan for yourself or your Dependents because of coverage under a Medicaid plan or CHIP plan, you can enroll within 60 days of loss of such coverage. If you become eligible for premium assistance under a Medicaid plan or CHIP plan, you or your Dependents can enroll in this plan within 60 days of becoming eligible for premium assistance.