Health Net®
A Better Decision

NY OUTLOOK POS 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:	
	❑ Single (S) ❑ Married (M) ❑ Widowed (W) ❑ Separated (L) ❑ Divorced (D) ❑ Other (O) _____	Home Phone: ( )	Business Phone: ( )
EMPLOYMENT INFORMATION*	Check box if you are actively employed ❑ Check box if you are retired ❑	Union Affiliation:	Average Number of Hours Worked Per Week: ❑ Under 20 Hours ❑ 20-29 Hours ☑ 30+ Hours
OTHER HEALTH COVERAGE INFORMATION	Will you be covered by another health plan when Health Net coverage starts? ❑ Yes ❑ No	If yes, list name and address of other carrier:	Spouse's Social Security Number
	Is your spouse employed? ❑ Yes ❑ 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? ❑ Yes ❑ 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? ❑ Yes ❑ No	If yes, list name and address of other carrier:	Policy/Contract #: djdkd
MEDICARE INFORMATION	Are you covered by Medicare? ❑ Yes ❑ No	Medicare #:	Effective Dates: Part A Part B
	Is your spouse covered by Medicare? ❑ Yes ❑ No	Medicare #:	Effective Dates: Part A Part B
	Are other dependents covered by Medicare? ❑ Yes ❑ 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? ❑ Yes ❑ No	If yes, list the name of child and school	If no, is this dependent child disabled? ❑ Yes ❑ 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 five thousand dollars and the stated value of the claim for each such violation.

AGREEMENT (please sign and date): Your Evidence of Coverage and Certificate of coverage, respectively, are herein after, collectively referred to as your "Health Net contracts." I understand that in New York, coverage under the In-network portion of the Point-of-Service Plan is provided by Health net of New York, Inc.. The out-of-network coverage for the Point-of-Service Plan is underwritten by Health Net Insurance of New York, Inc.

I understand the Health Net benefits and coverage as summarized in the Health Net plan materials and that these benefits are administered strictly as specified in the Health Net Group Subscriber Contract. 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) or me and my family member(s) to furnish such records as may be requested by Health Net of the Northeast, 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 understand that Health Net is not liable to provide coverage to ineligible dependants. If I am required to contribute, I authorize my employer to deduct from any compensation the amount required the amount required for the coverage selected. I certify that all information above is correct to the best of my knowledge.

_____ 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: ❑ New Plan ❑ COBRA Enrollment ❑ 18 Months ❑ 36 months ❑ Open Enrollment ❑ Other Date of Hire: MO / DAY / YR	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
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Coverage is provided by subsidiaries of Health Net of the Northeast, Inc. and Health Net Life Insurance Co. Coverage may be provided by Health Net of New York, Inc. or Health Net Insurance of New York, Inc. in New York; Health Net of New Jersey, Inc. or Health Net Life Insurance Co. in New Jersey; and Health Net of Connecticut, Inc. or Health Net Life Insurance Co. in Connecticut. Health Net® is a registered service mark of Health Net, Inc. All rights reserved.