Application Submission Instructions

Please complete the attached application and send to Health Plan One either via fax or mail:
(must submit by mail if enclosing a check or money order)

Health Plan One
1000 Bridgeport Ave. 4th FL
Shelton, CT 06484

Fax (Toll Free): 888.342.1612

Any questions? Please call Health Plan One at 1-877.567.5267. Thank you!

Health Net Health Plan of Oregon, Inc.
Oregon Standard Health Statement
Individual & Family Plan Application

PLEASE COMPLETE IN INK

I am applying to Health Net Health Plan of Oregon, Inc. for an individual medical-surgical-hospital policy, with benefits selected as follows:

Participating Provider Policy requested: (Mark policy **and** deductible)

Diamond 15 (80% / 50%)	**Pearl HMO 25**	**Crystal HDHP** (HSA-Qualified)	**Optional Benefits**
☐ $250 Deductible ☐ $500 Deductible ☐ $1,000 Deductible ☐ $2,500 Deductible ☐ $5,000 Deductible ☐ $7,500 Deductible Preventive care included **Emerald 40** (70% / 50%) ☐ $1,000 Deductible ☐ $2,500 Deductible ☐ $5,000 Deductible ☐ $7,500 Deductible ☐ $10,000 Deductible Preventive care included	☐ HMO 25 Preventive care included (Note: HMO 25 is only available in Clackamas, Multnomah & Washington counties)	**80% Plans** *Individual / Family Choices* ☐ $1,500 Deductible / $3,000 Deductible ☐ $2,500 Deductible / $5,000 Deductible ☐ $3,500 Deductible / $7,000 Deductible Preventive care included **100% Plans** *Individual / Family Choices* ☐ $2,000 Deductible / $4,000 Deductible ☐ $5,000 Deductible / $10,000 Deductible Preventive care included	☐ Alcohol Treatment ☐ Dental/Vision

You may choose an effective date of the 1st or 15th of the month. If the application approval process is completed after the requested effective date, your effective date will be automatically changed to the next available effective date after approval. Requested Effective Date is: _____

☐ My initial payment equal to one month's premium of $_____ is enclosed. If my coverage is effective the 15th of the month, my next billing statement may show a prorated premium.

☐ Bill me for my initial premium upon acceptance. **Note:** Premium must be received before your coverage will become effective.

Future payment choice for plans: ☐ Mail-in premium payment ☐ Simple Pay Option (automatic premium withdrawal) or Credit Card. Monthly Automatic Payment Form is attached.

GENERAL – The oldest family member to be enrolled must be the applicant and will be the policy Subscriber.

Applicant's Name _____ Social Security # _____

Residence Address _____ City _____ State _____ Zip _____ County _____

P.O. Box (if applicable) _____ City _____ State _____ Zip _____

Home Telephone Number ( ) -	Sex M/F	Height	Weight	Birth Date	Primary Care Provider (Last, First Name)(HMO Plan Enrollees Only)

COMPLETE SPOUSE/REGISTERED DP*/DEPENDENT SECTION ONLY IF THEY ARE TO BE COVERED.
Dependent children must be under 23 years old and unmarried

All HMO Plan enrollees must designate a Primary Care Provider (PCP). Each family member may choose a different PCP.

Spouse/Registered DP's Full Name (Last, First, Initial) / Social Security#	Sex M/F	Height	Weight	Birth Date	Primary Care Provider (HMO Plan)	Current Patient Y/N
Dependent's Full Name (Last, First, Initial) / Social Security#	M/F	Height	Weight	Birth Date	Primary Care Provider (HMO Plan)	Y/N
	M/F					Y/N
	M/F					Y/N
If last name of a dependent differs from yours, explain relationship:						

If any of the persons listed above are entitled to Creditable Coverage toward the exclusion periods for pre-existing conditions, other specified conditions and transplant exclusion periods, indicate the period of Creditable Coverage. (See last page for definition.) Include additional sheets if necessary. Please include a copy of your Certificate of Prior Coverage. You will not receive Pre-existing credit until we receive this document.

Prior Carrier Name _____ Telephone # _____

Applicant's Name _____ Creditable Coverage from _____ to _____

Applicant's Name _____ Creditable Coverage from _____ to _____

How did you hear about Health Net Health Plan of Oregon, Inc.? Please check the box that best describes how you heard about us.
☐ **Radio** ☐ **Mail** ☐ **Billboard** ☐ **Newspaper** ☐ **Yellow Pages** ☐ **Broker** ☐ **Internet** ☐ **Other**

* Domestic Partner

HEALTH HISTORY STATEMENT

Please mark either "Yes" or "No" for each item listed for yourself and any family members requesting coverage. **Provide details on page four to any questions answered "Yes."** For the purposes of these questions, chronic means persistent, continuous, or periodic, or a combination of any of these terms.

Within the last **five** years, has anyone listed on this application had any medical advice, diagnosis, care, or treatment, including prescribed medications, recommended or received from a licensed health care professional or had any illness, ailment, injury, health problem, symptoms, physical impairment, surgery or hospital confinement related to any of the following conditions:

1.	AIDS, ARC, HIV positive……	☐ Yes	☐ No
2.	Alcohol/Chemical/Drug abuse/habit…	☐ Yes	☐ No
3.	Anemia/Chronic fatigue ……	☐ Yes	☐ No
4.	Appendicitis/chronic abdominal pain…	☐ Yes	☐ No
5.	Back/Neck/Spine……	☐ Yes	☐ No
6.	Birth defect/Congenital deformities…	☐ Yes	☐ No
7.	Bladder/Urinary tract……	☐ Yes	☐ No
8.	Blood/Circulatory……	☐ Yes	☐ No
9.	Bone/Orthopedic……	☐ Yes	☐ No
10.	Brain disease or injury/concussion ……	☐ Yes	☐ No
11.	Breast (lumps or masses) ……	☐ Yes	☐ No
12.	Cancer……..	☐ Yes	☐ No
13.	Chemotherapy/Radiation treatment….	☐ Yes	☐ No
14. A	Colon/Rectum/Intestinal/Bowel……	☐ Yes	☐ No
14. B	Blood in stool ……	☐ Yes	☐ No
15.	Convulsion/Seizures/Epilepsy……	☐ Yes	☐ No
16.	Diabetes/Sugar in urine……	☐ Yes	☐ No
17.	Chronic ear/Nose/Throat/Tonsil condition/Disease/Disorder……	☐ Yes	☐ No
18.	Eating disorders such as, but not limited to, Anorexia or Bulimia……..	☐ Yes	☐ No
19.	Emphysema/Asthma/Chronic lung disease (COPD) ……	☐ Yes	☐ No
20.	Endocrine/Gland/Hormone system……	☐ Yes	☐ No
21.	Disease or injury of Eye/Cataract/Glaucoma ……	☐ Yes	☐ No
22.	Gallbladder/Pancreatic disease ……	☐ Yes	☐ No
23.	Chronic headaches/Migraines ……	☐ Yes	☐ No
24.	Heart/Chest pain/Angina……	☐ Yes	☐ No
25.	Hernia……	☐ Yes	☐ No
26.	High cholesterol …… If "Yes", current reading …….	☐ Yes	☐ No
27.	High blood pressure…… If "Yes", current reading _____/_____	☐ Yes	☐ No
28.	Kidney/Kidney stones ……	☐ Yes	☐ No
29.	Knee/Shoulder/Hip/Other joints ……	☐ Yes	☐ No
30.	Liver condition /Hepatitis ……	☐ Yes	☐ No
31.	Lupus, chronic muscle pain, muscle injury or disease, or fibromyalgia ……	☐ Yes	☐ No
32. A.	Mental/Emotional condition/ Depression……..	☐ Yes	☐ No
32. B.	Therapy/Counseling within last 5 years (if "Yes", record date of last session on page 3) ……	☐ Yes	☐ No
33.	Neurological condition/Disease/Injury…	☐ Yes	☐ No
34.	Phlebitis/Blood clot……	☐ Yes	☐ No
35.	Osteoarthritis/Osteoporosis/ Osteopenia	☐ Yes	☐ No
36.	Prostate/Elevated PSA/Prostatitis……	☐ Yes	☐ No
37.	Reproductive system disorder/ Infertility…….	☐ Yes	☐ No
38.	Chronic respiratory/Lung condition…	☐ Yes	☐ No
39.	Rheumatoid Arthritis……	☐ Yes	☐ No
40.	Sexually transmitted disease(s)……	☐ Yes	☐ No
41.	Skin condition, abnormal or cancerous moles or eczema/cysts/cancer……	☐ Yes	☐ No
42.	Sleep apnea/Chronic sleep disorder …	☐ Yes	☐ No
43.	Stomach disorders/Ulcer/Acid Reflux…	☐ Yes	☐ No
44.	Stroke/Paralysis/Seizures……	☐ Yes	☐ No
45.	Tumors ……	☐ Yes	☐ No
46.	TMJ/Jaw joint……	☐ Yes	☐ No
47.	Weight fluctuation (+/- 20 lbs.)……	☐ Yes	☐ No
48.	Cosmetic surgery/Implants, use of prosthetic devices/Limbs ……	☐ Yes	☐ No

49. Has any person on this application used tobacco products in any form within the last 5 years? ☐ Yes ☐ No
If Yes:

Name :	Type of product:
Name :	Type of product:
Name :	Type of product:

50. Please provide the following information for each **female** on this application:

Family member	Name:	Name:	Name:	Name:
a. Initial menstrual cycle began?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b. Date of last menstrual period.				
c. If (b) is more than 35 days ago, please explain:				
d. Excessive or absent menstrual bleeding?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e. If (d) is yes, please explain:				
Date of last DEPO Provera shot?				
Abnormal Pap smears? If "Yes", please explain detail on page 4.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Prior Cesarean section or miscarriage?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

51. Is any person on this application now pregnant? ☐ Yes ☐ No

If yes, name _____ Due Date ____/____/____

52. Is any person on this application, including **male** applicants and dependent males or females, responsible for a current pregnancy? ☐ Yes ☐ No

If yes, name _____ Due Date ____/____/____

53. Please provide the following information for each person on this application. Within the last five years, has any person on this application:

a. Had any medical advice, diagnosis, care, or treatment, including prescribed medications, recommended or received from a licensed health care professional, or had any illness, ailment, injury, health problem, symptoms, physical impairment, surgery or hospital confinement not listed above? ☐ Yes ☐ No

b. Been advised to have or contemplated having an operation or medical procedure not yet performed? ☐ Yes ☐ No

c. Taken any prescription medication on a regular basis? ☐ Yes ☐ No

54. List all medications currently being taken by any person on this application:

Name	Medications	Prescribed by (name/address/telephone)	Date Prescribed

Provide details for any questions answered "Yes" on page 2 and 3. Incomplete applications will be returned.

Name	Question Number	Start to end dates	Condition	Treatment Including medications	Final Result **Ongoing or Resolved** Please check	Attending physician/health care provider or hospital (name/address/telephone)
					Ongoing ☐ Resolved ☐	
					Ongoing ☐ Resolved ☐	
					Ongoing ☐ Resolved ☐	
					Ongoing ☐ Resolved ☐	
					Ongoing ☐ Resolved ☐	

Attach additional pages if necessary. ☐ I have attached _____ page(s).

Name, address, and telephone number of medical provider with current medical records/history:

CURRENT OR FORMER HEALTH NET COVERAGE

Member Name	Group Number	State	Last Date of Coverage

Continuation of Present Health Coverage: If you have other health coverage now, will you continue the coverage in addition to the Health Net of Oregon coverage you are applying for? ☐ Yes ☐ No

Name of Company _____ Address _____ Telephone No. _____

Is any person listed on the application receiving or eligible to receive Medicare or Social Security Disability benefits?

☐ Yes ☐ No If Yes, give name:_____Medicare Effective Dates: Part A _____Part B_____

Medicare Identification number:_____

Information Practices: Information about you or an enrolling family member may be obtained from medical records as indicated in the medical information release portion of the application form. Other than from medical records, personal information will not be collected from any sources other than the applicant or individuals proposed for coverage.

BE SURE TO COMPLETE THE HEALTH HISTORY STATEMENT AND SIGN AND DATE THE BACK PAGE

FOR UNDERWRITING USE ONLY

Definition: **"Creditable Coverage"** means any of the following coverages: Group coverage (including FEHBP and Peace Corps); Individual coverage (including student health plans); Medicaid; Medicare; CHAMPUS; Indian Health Service or tribal organization coverage; state high risk pool coverage; and public health plans. Creditable coverage does not include coverage only for a specified disease or illness or hospital indemnity (income) insurance. Coverage is Creditable only if there has not been a gap in coverage exceeding 63 days.

CERTIFICATION AND AUTHORIZATION

CERTIFICATION OF COMPLETION AND CORRECTNESS

I affirm that the answers given in this "Oregon Standard Health Statement" are complete and correct. I have provided these answers as part of the application procedure required by Health Net Health Plan of Oregon, Inc. to enroll in the insurance coverage. I understand that if this application contains any material misstatements or omissions, Health Net may, within the first two years of coverage, deny coverage, modify or cancel the contract, or take other legal action. I will promptly inform Health Net in writing if anything happens before my coverage takes effect that makes this incomplete or incorrect. I understand and agree that no coverage shall be in force until approved by Health Net. If approved, coverage will be in force as of the effective date determined by Health Net. Health Net may contact me to clarify answers on this application. As the applicant, I understand I have the right to inspect the information in my file.

CONDITIONAL AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

To any physician; health care provider, including OHSU; hospital, including OHSU; insurance or reinsurance company; the Medical Information Bureau, Inc. (MIB), or other insurance information exchange:

Each of us authorizes you to give Health Net Health Plan of Oregon, Inc. or its representatives any medical record information (including alcohol, chemical dependency, mental treatment, or HIV treatment) you have about me or my family members. Such information may be used for processing application for coverage, for prior authorizing services or processing claims for benefits, or for purposes of health care provider credentialing, quality assurance, utilization review, case management, peer review, and audit. A photocopy of this authorization is as valid as the original. I understand that I may receive a copy of this authorization upon request.

This authorization takes effect on the date signed and it remains in effect as follows:

- For information used to process this application – 30 months
- For information used for all the other reasons listed above – as long as coverage is in effect or until the completion of processing any claim, whichever is longer.

I affirm that I received a disclosure statement and outline of coverage from Health Net of Oregon or its authorized agent. I understand that a PPO policy will not pay benefits for any loss incurred during the first six months after the effective date on account of a disease or physical condition which I now have or have had in the past. Creditable coverage applies. I understand that if my application for coverage is accepted, I will have ten days after receiving notice of acceptance during which I may cancel the policy for a full refund. I affirm that my employer is not paying the premium for this coverage.

I understand that if I/we are declined for the plan requested on this application, I/we may be offered an alternate plan(s) for which I/we would be accepted.

Be sure to sign and date the application. Spouse's signature is required if applicable. Signature applies to both "Certification of Completeness and Correctness" and "Authorization for Release of Information".

Incomplete applications will be returned. The effective date will be delayed until the completed application has been received.

SIGNATURE OF APPLICANT (PARENT OR LEGAL GUARDIAN IF APPLICANT IS UNER 18 YEARS OF AGE OR LEGALLY INCOMPETENT)	RELATIONSHIP	DATE
PRINT NAME OF APPLICANT (PARENT OR LEGAL GUARDIAN IF APPLICANT IS UNER 18 YEARS OF AGE OR LEGALLY INCOMPETENT)		DATE
SIGNATURE OF APPLICANT'S LEGAL SPOUSE (IF APPLYING FOR COVERAGE)		DATE
SIGNATURE OF APPLICANTS/DEPENDENTS 18 YEARS OF AGE OR OLDER		DATE

INSURANCE PRODUCER USE ONLY

I certify that the information supplied by the applicant(s) has been truly and accurately recorded and that I have made no representation about benefits, condition, or limitation of the policy except through written material furnished by Health Net Health Plan of Oregon, Inc.

Insurance Producer's Signature _____ Date _____

Insurance Producer's Name (please print) _____ Insurance Producer's Number _____

Agency Name HEALTH PLAN ONE Insurance Producer's Phone Number 877-567-5267

Agency Address 1000 Bridgeport Ave., 4th FL City Shelton State CT Zip 06484

Producer Email sales@healthplanone.com

Health Net®

Authorization for Use or Disclosure of Information for Enrollment

This authorization for use or disclosure of personal health information is being requested by Health Net to comply with the terms of federal HIPAA Privacy Rules. A copy of this form is as valid as the original.

THIS AUTHORIZATION FORM MUST BE COMPLETED IN ORDER TO ENABLE HEALTH NET TO UNDERWRITE YOUR COVERAGE. THE ENROLLMENT PROCESS CANNOT BE COMPLETED WITHOUT YOUR EXPRESS AUTHORIZATION WHICH IS MORE FULLY DESCRIBED BELOW. THIS FORM MUST BE SIGNED BY THE APPLICANT AND EACH ADULT FAMILY MEMBER APPLYING FOR COVERAGE (including dependents age 18 and over).

Applicant and Family Members Requesting Enrollment:

Applicant Name	**Social Security Number:**
Spouse Name	**Social Security Number:**
Dependent (age 18 or older)	**Social Security Number:**
Dependent (age 18 or older)	**Social Security Number:**

I, _____, _____,
(applicant print name) (spouse print name)

_____, _____,
(adult dependent print name) (adult dependent print name)

hereby authorize the use or disclosure of personal health information as described below. Additional adult dependents may be listed below.

As the (applicant) parent, I, (print name) _____, authorize the use or disclosure of personal health information about my minor dependent(s), age 17 and under, as described below:

_____, _____, _____,
(print dependent'(s) name)

_____, _____, _____.

1. Person(s) or group of persons authorized to disclose the information to Health Net include:
   - Any medical professional, hospital, or other healthcare facility, clinic, pharmacy, insurer or health benefit plan administrator, Medicare or Medicaid, or any other health care provider or health plan that has medical information about me or my dependent(s);
   - Health care providers or health plans indicated in my application for coverage or on my dependents' applications for coverage, or identified by me during a health history interview in regard to myself or my dependent(s), or identified by me or my dependent(s) to my agent, or any other healthcare provider or health plan referred to in my medical records or my dependent(s) medical records. Medical records include information concerning treatment for alcohol abuse, substance abuse, mental or emotional disorders (excluding psychotherapy notes), AIDs (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex).

2. I authorize the following person(s) or group of persons to receive the information disclosed by one of the persons or organizations listed in paragraph 1 above, and to use that information and the information included on my application for coverage to underwrite and rate the health plan coverage for which I have applied:
   - Health Net and its affiliates including, but not limited to, its agents, underwriting operations, claims operations, legal representatives, its Medical Director or his/her designees, and its sales and marketing operations. I understand that Health Net may condition my or my dependents' enrollment in the health plan on my **signing this Authorization and initialing this paragraph 2**.

     Applicant ____ Spouse ____ Dependent ____ Dependent ____

All references to "Health Net" herein include the affiliates and subsidiaries of Health Net, Inc. which underwrite or administer the coverage to which the Enrollment Application applies.

3. Description of the information that may be used or disclosed includes:
   All health information pertaining to me or my minor dependent(s), if applicable, related to the diagnosis, treatment or prognosis with respect to any physical, accident, illness, medical or mental condition, including but not limited to, substance abuse, mental or emotional disorders, AIDS (Acquired Immune Deficiency Syndrome), or ARC (AIDS-Related Complex), except psychotherapy notes, and any other related information, including but not limited to, the information provided on my application.

4. I understand that if this Authorization is for disclosures to someone other than Health Net, personal health information disclosed may be subject to re-disclosure by the recipient, in which case it would no longer be protected by federal Privacy Rules. However, Health Net is subject to federal Privacy Rules and any information Health Net receives is protected by these Rules.

5. I understand that my enrollment in Health Net's health plan may be conditioned on my signing this Authorization and initialing paragraph 2. I understand that I may refuse to initial paragraph 2 of this Authorization, and that such refusal could affect my enrollment in the health plan or eligibility for benefits under the health plan.

6. If the person completing this Authorization is the personal representative of the applicant or dependent, describe your authority to act on this person's behalf.

   _____

   _____

7. As described in the "Notice of Privacy Practices", I understand that I may revoke this Authorization in writing at any time, except to the extent that action has been taken by Health Net and it's subsidiaries and affiliates in reliance on this Authorization. I may send a written and dated revocation to Health Net to: Health Net Privacy Office, 21650 Oxnard Street, Ste. 2125, Woodland Hills, CA 91367. Health Net's "Notice of Privacy Practices" is available on the Health Net website at www.healthnet.com or will be provided to me in writing upon request.

8. I understand that either I am, or my personal representative is, entitled to receive a copy of my signed Authorization and by my signature below, I acknowledge that I have been provided with a copy.

9. This authorization will remain valid for thirty (30) months from the date the authorization form is signed as to Health Net's determination on enrollment.

Signatures *(required in ink)*

APPLICANT'S SIGNATURE	Date Signed
SPOUSE'S SIGNATURE	Date Signed
SIGNATURE OF APPLICANT'S DEPENDENT (age 18 or older)	Date Signed
SIGNATURE OF APPLICANT'S DEPENDENT (age 18 or older)	Date Signed
PERSONAL REPRESENTATIVE'S NAME, IF APPLICABLE (Print)	
PERSONAL REPRESENTATIVE'S SIGNATURE	Date Signed

Health Net Health Plan of Oregon, Inc.
Individual & Family PPO/HMO Plan
Disclosure Statement

This disclosure statement answers questions consumers often ask about health insurance coverage and costs. It highlights some of the important issues that frequently affect consumers. It is intended for your use whether you are purchasing health insurance for the first time or whether you are replacing or adding to your existing coverage.

General Questions and Answers

1. Does the insurer have a list of doctors or hospitals, or both, under contract that are considered "preferred" or "participating"? **Yes**.

2a. May I use doctors or hospitals that are not on the list under my IFP PPO Plan? **Yes**.

2b. May I use doctors or hospitals that are not on the list under my IFP HMO Plan? **No,** except for Urgent and Emergency Care.

3. Will I save money by using the doctors or hospitals on the list instead of others? **Yes**.

4. Will doctors and hospitals on the list accept benefits paid under the policy as full payment and not bill me for the balance (other than for deductibles and copayments)? **Yes**.

5. Pregnancy Benefits (if the coverage offered is comprehensive major medical):

   a. What are the policy's benefits and limitations with respect to pregnancy? **Pregnancy benefits apply to any covered member and are subject to the 6-month Pre-existing Condition requirements.**

   b. Will the offered policy cover a pregnancy without complications if the pregnancy is in existence at the time of the policy's issuance? **No. Applicants who are currently pregnant would not be issued a policy.**

Are You Replacing Coverage?

6. If I replace my current policy with another and there is no lapse or gap in coverage, will my enrollment under the old policy count toward meeting any pre-existing conditions provisions? **Yes, creditable coverage applies toward the benefit exclusion periods for pre-existing conditions, as well as toward the 12-month exclusion period for specified conditions, and the 24-month waiting period for transplant benefits.**

7. Will expenses I incurred under my current policy during the current policy year be credited to the new policy's deductibles? **No, unless you are transferring from another Health Net of Oregon plan to this plan.**

8. If I have a health condition existing when the offered policy is issued, will that condition be covered as of the date of issuance? **No. Pre-existing health conditions will be covered after a 6-month preexisting conditions period. Covered transplant benefits will be paid after a 24-month exclusion period. There is also a 12-month exclusion period for specified conditions.**

9. Does the policy contain any dollar limitation on specific benefits? Are there any limits on specific benefits such as hospitalization? **Yes. Refer to the attached benefit summary for a list of benefits that have limitations.**

Are You Adding Coverage to Your Current Policy?

10. If my coverage under the new policy duplicates coverage under my current policy, will the new policy pay if my current policy also pays? (You should ask the agent or company representative who sold you your current policy whether your current policy will pay if the new policy pays.) **No. The only time that the benefits of the new policy will be paid without regard to other coverage is in the case of another individual policy with an effective date after this policy.**

Oregon Individual Health Insurance Policy Disclosure Statement

Are You Considering Replacing Current Coverage?

Before you replace your current policy with another, you should review both policies in order to determine whether replacement is in your best interests. The new coverage may be different in important respects. You should be aware of these differences and whether they are temporary or permanent. If you obtained your current policy from another agent or a representative of another company, be sure to ask that agent or representative any questions you may have about that policy.

Are You Considering Adding to Your Current Coverage?

Before you add new coverage to your current coverage, you should review both policies to ensure that you are not purchasing unnecessary coverage. If you obtained your current policy from another agent or a representative of another company, be sure to ask that agent or representative any questions you may have about that policy and the need for additional coverage.

Questions? Ask for Help.

If you have any questions that are not answered by this disclosure statement, be sure to ask you agent or insurer representative.

Read Your Policy!

If you purchase the offered policy, read it carefully as soon as you receive it. Because it is an individual policy, you will have an opportunity to send it back and obtain a premium refund.

Fill Out Your Application Carefully!

Be sure to fill out all portions of your application completely and truthfully. If misstatements are made or information about your health is omitted from the application, the insurer may void the policy or deny your claims. We hope this disclosure statement will help you with your insurance purchase. However, please note that the statement is not intended to be a part of the policy and that only the language of the policy issued by the insurer is final and binding.

_____

(Agent's or insurance company representative)

_____

(Address)

Completed this statement on for _____ for _____

(Date) (Applicant)

The policy is underwritten by:

Health Net Health Plan of Oregon, Inc.

(Insurance company or health care service contractor)

13221 SW 68th Parkway, Suite 200, Tigard, Oregon 97223

(Address)

888-802-7001
www.healthnet.com

Health Net

Subscriber ID / Reference #

Health Net's Pay Option – Monthly Automatic Payment for Individual and Family Plans

☐ **SIMPLE PAYMENT OPTION (Automatic Bank Draft)**
Monthly premium charge can be withdrawn directly from your personal checking account. The premium will be deducted on approximately the fifth day of each month. Your premium payments will be clearly identified on your monthly bank statement. **Mail to: Health Net, Individual and Family Enrollment, 13221 SW 68th Parkway, Suite 200, Tigard, Oregon 97223.**

*****VOIDED CHECK MUST BE ATTACHED TO THIS FORM*****

Account Holder's Social Security Number	Transit Routing Number	Account Number		
Bank Name	Bank Address	City	State	Zip
Name of Health Net Member				

As a convenience, I request and authorize Health Net Health Plan of Oregon, Inc. to pay and charge to the above account checks drawn on that account by and payable to the order of **"Health Net Health Plan of Oregon, Inc."** provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that Health Net's rights in respect to each such check shall be the same as if it were a check written to Health Net and signed personally by me. This authority is to remain in effect until revoked by me in writing and until Health Net actually receives such notice, I agree that Health Net shall be fully protected in honoring any such check.

I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, Health Net shall be under no liability whatsoever even though such dishonor may result in the forfeiture of health coverage.

I further agree that I may terminate the plan Agreement with Health Net Health Plan of Oregon, Inc. upon 30 days written notice. In such event, termination will be effective on the first day of the month following expiration of the 30-day notice period. All returned bank items are subject to a $15.00 fee. (Note: A 30-day notice is required to discontinue this service due to the time required to initiate this change with your bank.)

Signature of Account Holder **Date**

☐ **CREDIT CARD** ☐ **First Month's payment** ☐ **Monthly Premium payment**
Monthly premium charge can be charged directly to your credit card account. The premium will be charged to your credit card account approximately 10 days in advance of the due date.

First Name (as on card)	Middle (as on card)	Last Name (as on card)	Card Type □ Visa □ MasterCard
Account Number 16-digits(complete)	Expiration Date (mm/yyyy)	Cardholder's email address	
Billing Address	City	State	**Zip[1]**

As a convenience, I request and authorize Health Net Health Plan of Oregon, Inc. ("Health Net") to charge my credit card account identified above for the payment of my initial premium and/or my monthly premium. I understand that the premium charged to my account will be for the future bill period plus any past due balances and that my first month's withdraw / charge may be for multiple periods depending upon date of approval and the bill period. This authority is to remain in effect until revoked by me in writing and until Health Net actually receives such notice, I agree that Health Net shall be fully protected in honoring any such charge. (Note: A 30-day notice is required to discontinue this service due to the time required to initiate this change with your credit card company.) I further agree that if my credit card is declined for payment, whether with or without cause and whether intentionally or inadvertently, I will be charged a $15 service charge for each occurrence. Credit card transmissions are submitted to the bank approximately the 20th of every month, for the following month's premium.

[1] The zip code must match the cardholder's address otherwise the credit card cannot be processed.

Signature of Credit Card Account Holder (Required to process) **Date**