Enrolling is Simple.
Just Follow These 3 Easy Steps…

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: (818) 987-5000 fax: 8187769865

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly (by checking account deduction), bi-monthly (every two months) or quarterly (every three months).

Step 3

SEND THE COMPLETED APPLICATION TO:

Oleg Skurskiy

18375 Ventura Blvd. # 226

Tarzana, CA 91356

Please make your check payable to: Health Net

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

If you have questions please contact our office at: (818) 987-5000

Thank you for choosing...

Health Net

Health Net
Life Insurance Company

MEDICARE SUPPLEMENT PLAN APPLICATION
&
STATEMENT OF HEALTH

HERE'S HOW TO APPLY
1. Complete and sign your application.
2. Mail the application in the postage-paid envelope enclosed for your convenience.
3. Please include your first payment. Payment will be returned if your application is denied.
If you have questions about how to enroll, please call us at 1-800-708-7646.

APPLICANT

Name First Middle Initial Last

Address (No P.O. Box address - must be your street address) | E-mail Address

City State ZIP | County | Broker ID

Date of Birth Month Day Year / / | Sex ☐ Male ☐ Female | Telephone number ( )

Are you enrolled in Medicare Hospital Part A? ☐ Yes ☐ No Effective date _____(MUST be included)
Are you enrolled in Medicare Medical Part B? ☐ Yes ☐ No Effective date _____(MUST be included)
You must have both Medicare Part A and Part B to participate in this plan.
Please review your Medicare card to verify these effective dates.
If you are not enrolled in Medicare Hospital Part A or Medical Part B, enter date when you will be enrolled _____

Social Security Number | Your Medicare # (from red, white and blue Medicare card)

Indicate which plan you are applying for: ☐ A ☐ C ☐ E ☐ F ☐ H ☐ I

If applying for, but not accepted for Health Net Medicare supplement plans H or I, I would like to be enrolled in plan: ☐ A ☐ C ☐ E ☐ F

Are you currently a member of Health Net? ☐ Yes ☐ No
If you answered yes, you may need to disenroll from your current plan before enrolling in the Medicare supplement. To request a disenrollment form, please call Member Services at 1-800-926-4178.
Were you ever enrolled in Health Net's Medicare supplement plan before? ☐ Yes ☐ No

To the best of your knowledge:
1. Do you have any other Medicare supplement insurance coverage, including an HMO contract? ☐ Yes ☐ No
   If so, with what company? _____
2. Do you have any other health or disability insurance coverage? ☐ Yes ☐ No
   If so, what company? _____
   What kind of policy? _____
   Would the benefits duplicate the benefits in this Medicare supplement policy? _____
3. Do you intend to replace any health or disability insurance coverage with this policy? ☐ Yes ☐ No
4. Are you eligible for or receiving benefits from Medi-Cal? ☐ Yes ☐ No

1. Are you currently hospitalized, confined to a nursing facility, had any amputation caused by a disease, or have you been hospitalized two or more times in the past 12 months? ☐ Yes ☐ No
2. Within the past year, have you had or been treated for internal cancer? ☐ Yes ☐ No
3. Within the past year, have you been advised to have surgery for joint replacement or for a heart condition? ☐ Yes ☐ No
4. Within the past two years, have you had heart valve surgery, a cerebral vascular accident (stroke), cirrhosis of the liver or been advised to have kidney dialysis? ☐ Yes ☐ No
5. Have you been diagnosed with End Stage Renal Disease? ☐ Yes ☐ No
6. Are you currently taking any medication prescribed by a physician? ☐ Yes ☐ No
   If yes, please provide the following information:

Medication	Dosage	Frequency

If you need more space for additional medications, please attach a list including prescribed medication, dosage and frequency.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

You are entitled to a copy of this signed authorization for your files if requested.

X _____
Signature Date

I understand that my signature on this enrollment form certifies that I have read and understand the information contained on both sides of this application.

Agent/Broker Name	Agent/Broker ID	Agent/Broker Phone #
Oleg Skurskiy	.	(818) 987-5000

1. You do not need more than one Medicare supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages. If you elect only to be covered by this plan, you need to disenroll from your existing health coverage.
3. You may be eligible for benefits under Medi-Cal and may not need a Medicare supplement policy.
4. The benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medi-Cal for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal. If you are no longer entitled to Medi-Cal, your policy will be reinstituted if requested within 90 days of losing Medi-Cal eligibility.
5. Counseling services are available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the Medi-Cal program, including benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB). If you want to discuss buying Medicare supplement insurance with a trained insurance counselor, call the California Department of Insurance toll-free telephone number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Insurance consumer toll-free telephone number (1-800-927-HELP), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free number (1-800-434-0222), or by accessing the Department of Insurance Internet web site (www.insurance.ca.gov).

I have read or have had read to me this Application and Statement of Health and realize that any false statement or misrepresentation herein will be cause for disenrollment. I declare to the best of my knowledge and belief that all the information provided herein is complete and true. I understand that in the event a controversy between myself and Health Net Life, which arises out of or related to coverage under this Policy, but not as to professional negligence (Medical malpractice), the same shall be settled by neutral, binding arbitration. I acknowledge receipt of the attached Guide to Health Insurance for People with Medicare and Health Net Life Medicare Supplement Outline of Coverage. I understand that Health Net Life receipt of my money or cashing of my check with this application does not create Health Net Life coverage. Coverage will come in effect only if this application is approved by Health Net Life and written notice of same is provided to me.

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION

I authorize the United States Department of Health and Human Services, the Centers for Medicare & Medicaid Services, any health care provider, hospital or medical facility to furnish to any agent, designee, employee or representative of Health Net Life any and all records pertaining to claims payment or rejections, medical history, services rendered, or treatment given to myself for purposes of review, investigation or evaluation of this application or a claim. I also authorize Health Net Life and its employees, participating providers, agents and representatives to disclose to any health care provider, health care service plan, insurer or self-insurer any such medical information obtained if such disclosure is necessary to allow the processing of a claim or if requested pursuant to legal process. This authorization shall become effective immediately and shall remain in effect for the term of coverage under the Policy.

Mail to: Health Net Life Medicare Supplement Plan • P.O. Box 10420 • Van Nuys, CA 91410-0420 • (800) 944-7287

QUESTIONS ABOUT MEDICARE? For answers to questions about our Medicare plan, call our Medicare Sales Department at **1-800-944-7287** or our Member Services Department at **1-800-926-4178**.