Health Net of California only

3 Easy Steps… Enrolling…to Health Net Orange

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK.
Be sure you follow the instructions on the application carefully.
1. Print all pages of the application including instructions.
2. Complete all questions.
If you have any questions, or you are not sure how to answer a question, simply contact us:
Tel. **(818) 987-5000 fax: (818) 776-9865**

Step 2

SELECT THE TYPE OF BILLING YOU WANT

Step 3

SEND THE COMPLETED APPLICATION TO:

Oleg Skurskiy
18375 Ventura Blvd. # 226
Tarzana, CA 91356
Or
To Fax compete application: 1-818-776-9865 (fastest way)

When you fax the application to us make sure you include void check if you select "deduct from my checking account".

If you have questions please contact us:

Oleg Skurskiy
Authorized Independent Agent
Tel.: 1-818-987-5000
Fax: 1-818-776-9865
oleg@askoleg.com

Thank you for choosing... Health Net

Health Net
A Better Decision

HEALTH NET ORANGE
MEDICARE PRESCRIPTION DRUG PLAN
INDIVIDUAL ENROLLMENT FORM

Health Net
MEDICARE PROGRAMS

To Enroll In Health Net Orange, Please Provide The Following Information:			
Please check which plan you want to enroll in: ❑ Two-Tier = $17.65 per month ❑ Three-Tier = $21.99 per month			
LAST Name: **FIRST Name:** **Middle Initial:**			**❑ Mr. ❑ Mrs. ❑ Ms.**
Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	**Sex:** ❑ M ❑ F	**Social Security Number:** *(providing this information is optional)*	**Home Phone Number:** ( )
Permanent Residence Street Address:			
City:		**State:**	**ZIP Code:**
Mailing Address: (only if different from your Permanent Residence Address) Street Address: City: State: ZIP Code:			
Emergency contact: (Optional field) _____ **Phone Number:** (Optional field) _____ **Relationship to You:** (Optional field) _____			
E-mail Address: (Optional field)			

Please Provide Your Medicare Insurance Information:	
Please take out your Medicare Card to complete this section. • Please fill in these blanks so they match your red, white and blue Medicare card - OR - • Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board. **You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.**	MEDICARE HEALTH INSURANCE SAMPLE ONLY Name:_____ Medicare Claim Number Sex ___ — — — - — — - — — — — — Is Entitled To Effective Date **HOSPITAL (Part A)** _____ **MEDICAL (Part B)** _____

Your Plan Premium Payment Option:

You can have the monthly premium for this Medicare drug plan automatically deducted from your Social Security check. If you don't choose this option, we will send you a bill each month, which you can pay by mail or by Electronic Funds Transfer (EFT). Generally, you must stay with the option you choose for the rest of the year.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. Please choose if you want the remaining premium, if there is any, deducted from your monthly check.

Would you like the premium for this plan deducted from your SSA monthly benefit check? ❑ Yes ❑ No

Please Answer The Following Questions To Help Medicare Coordinate Your Benefits:

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal Employee Health Benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to Health Net Orange? ❑ Yes ❑ No
If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage: _____

2. Are you a resident in a long-term care facility, such as a nursing home? ❑ Yes ❑ No
If yes, please provide the following information:

Name of Institution: _____

Address & Phone Number of Institution (number & street): _____

_____

Please Read This Important Information:

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have a prescription drug benefit from your Medicare Advantage Plan that will meet your needs. By joining Health Net Orange, your membership in your Medicare Advantage Plan may end. This will affect both your doctor and hospital coverage, as well as your prescription drug benefits. Read the information that your Medicare Advantage Plan sends you, and if you have questions, contact your Medicare Advantage Plan.

If you currently have health coverage from an employer or union, joining Health Net Orange could affect your employer or union health benefits. If you have health coverage from an employer or union, joining Health Net Orange may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please Read And Sign Below:

By completing this enrollment application, I agree to the following:

Health Net Orange is a Medicare drug plan and is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare coverage. It is my responsibility to inform Health Net Orange of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to Health Net Orange or by calling 1-800-Medicare. TTY users should call 1-877-486-2048.

Health Net Orange serves a specific service area. If I move out of the area that Health Net Orange serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Health Net Orange, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Health Net Orange when I receive it to know which rules I must follow in order to receive coverage with this Medicare drug plan.

Release of Information:

By joining this Medicare prescription drug plan, I acknowledge that Health Net Orange will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Health Net Orange or by Medicare.

Your Signature:	**Today's Date:**

If you are the authorized representative, you must provide the following information:

Name: _____

Address: _____

Phone Number: (_____) _____- _____

Relationship to Enrollee _____

Medicare Prescription Drug Plan Use Only:

Plan ID #:_____

Effective Date of Coverage: _____ IEP: _____ AEP: _____ SEP (type): _____

Plan Representative Signature:_____

White – Enrollment Canary - HNCA Pink – Writing Agent Goldenrod – Member

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