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: 818-654-4548 fax: 818-776-9865

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly, quarterly, or semi-annual.

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: 818-654-4548

Thank you for choosing...

Health Net

Health Net® LIFE INSURANCE COMPANY

California Farm Bureau Federation

California Farm Bureau Health and Life Program Enrollment Application for Association Members and Their Dependents

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

THE APPLICATION MUST BE COMPLETED BY THE APPLICANT. NEITHER BROKER NOR ANY OTHER PERSON MAY COMPLETE THE MEDICAL QUESTIONNAIRE OR SIGN THIS APPLICATION AND AGREEMENT ON BEHALF OF THE APPLICANT(S). (Please see Part VII if Applicant does not read/write English)

Section 1: County Farm Bureau Application For Membership

Residence or Business County	Dues Enclosed ☐ Voting ☐ Sustaining $ A one-time $5.00 Rural Health Fee will be added to each new Farm Bureau membership.	Current/Previous Member# ___ ___ ___ ___ ___ ___ ___

Applicant's Name (Last, First, M.I.) ☐ Mr. ☐ Mrs. ☐ Ms.

Spouse's or Registered Domestic Partner's Name (Last, First, M.I.) ☐ Mr. ☐ Mrs. ☐ Ms.

Business Name (DBA)* Use Business Name as primary membership name? ☐ Yes ☐ *No *Only individual members are eligible for Accidental Death & Dismemberment policy.	Type of Business

Residence Address (Business Address if Under a Business Name)

City	State	Zip Code

Telephone Numbers Home: ( ) Business: ( )	Date of Birth (mo/day/year) Applicant: / / Spouse: / /

Email: _____ May we send you email? ☐ Yes ☐ No

Applicant's Primary Occupation	Spouse's or Registered Domestic Partner's Primary Occupation

Do you expect to earn any income from the growing/raising of an agricultural product? ☐ Yes ☐ No

*If yes, you are a **Voting Member**; if no, you are a **Sustaining Member**.* (See appropriate dues for County Farm Bureau.)

Please indicate next to the following descriptions the category that most closely fits your primary occupation field.

Place an "M" for you (Member) or an "S" for your Spouse/Registered Domestic Partner

01 _____ Own/lease a farm/ranch

02 _____ Own/manage an ag-related business

03 _____ Employee of farm/ranch/ag-related business

04 _____ Retired from farm/ranch/ag-related business

05 _____ Not involved in agriculture

26 _____ Retired, not involved in agriculture

If you checked box 01, would you please let us know the commodity(ies) you grow/raise:

1. _____ 3. _____

2. _____ 4. _____

_____ _____

Applicant's Signature Date

If accepted by the County Farm Bureau above, your annual membership will begin on the first day of the month that your application was signed. Dues payments include a one-year subscription to either Ag Alert® ($2) or California Country® ($1) as well as the County Farm Bureau publication where applicable. Contributions or gifts to Farm Bureau are not deductible as charitable contributions for income tax purposes. However, Farm Bureau dues may be tax deductible as an ordinary and necessary business expense. Please consult your tax advisor.

Approval	Center Code	Recruiter / Agent Name (Please Print)	Agent Number
		Oleg Skurskiy	W771

Applicant Name: _____ Primary Applicant's Social Security Number: _____

Section 2: Application

Part I: Enrollment Reasons + Choices

A. Requested Effective Date

☐ 1st of the month.
Please note date: _____/__01__/_____

☐ Any day of the month, upon approval of my application by underwriting.
For Underwriter's Use: _____/_____/_____

B. Reason for Application

FAMILY TYPE

☐ Self
☐ Self & Spouse/ Domestic Partner*
☐ Self & Child
☐ Self & Children
☐ Self, Spouse/ Domestic Partner and Child*
☐ Self, Spouse/ Domestic Partner and Children*
☐ Child(ren) Only

*Please circle Spouse or Domestic Partner

ENROLLMENT TYPE

☐ New Enrollment
☐ Add Dependent*
☐ Change Plan**

**Member ID Number (listed on your ID card):

_____

C. Billing Options

Please select a billing option for your medical, dental and vision coverage. This billing option does not apply to Term Life, which is billed and administered separately.

FIRST PREMIUM PAYMENT (SELECT ONE)

☐ Automated Bank Draft (Please complete the Simple Payment Option section.)
☐ Pay by Check (Please include completed check and send with application. Amount must match monthly premium.)
☐ Credit Card (Please complete the Credit Card section.)

MONTHLY PREMIUM PAYMENTS (SELECT ONE)
(Includes first month's premium.)

☐ Automated Bank Draft (Please complete the Simple Payment Option section.)
☐ Monthly Bill ($5.00 administrative fee applies.)
☐ Credit Card (Please complete the Credit Card section.)

D. Coverage Choices

Health Net offers the following coverage options:

1. Single Coverage: if you are applying for coverage just for yourself, complete Part II.
2. Family Coverage (applicant plus one or more dependents): for family coverage, you need to fill out both Parts II and III.

With family coverage, you have the option of enrolling in the same plan or choosing different plans for different family members. If you choose different plans for different family members, subscriber-only rates will apply. To specify different plans for different family members be sure to write the plan name you are choosing for each family member in the spaces provided in Part III.

Part II: Primary Applicant

All applicants fill out this section. If you are applying for coverage with a spouse or domestic partner who is younger, indicating him or her as the primary applicant may qualify you for a more favorable rate. If you choose different plans for you and a spouse/domestic partner, subscriber-only rates will apply.

Step 1: Choose your plan

PPO - HEALTH NET LIFE INSURANCE COMPANY:

PPO Choice Saver Select

☐ $1,750 Single Deductible/$3,500 Family Deductible
☐ $2,400 Single Deductible/$4,800 Family Deductible
☐ $3,600 Single Deductible/$7,200 Family Deductible
☐ $4,800 Single Deductible/$9,600 Family Deductible

Lifestyle

☐ $1,750 Deductible ☐ $3,500 Deductible
☐ $2,500 Deductible ☐ $4,500 Deductible

with ☐ Generic Rx or ☐ Three tier Rx

PPO Choice 30

☐ $750 Deductible ☐ $1,500 Deductible
☐ $2,500 Deductible

If you do not meet the underwriting requirements for preferred premiums for the PPO plan for which you applied, Health Net may elect to offer a **Modified Issue PPO** option. The Modified offer may be a plan that will have **a rate that is 20% or 50% higher** than the standard rate for which you applied. You will be automatically enrolled unless otherwise specified. Please check this box if you do not want to be automatically enrolled into the **Modified Issue PPO** option.

☐ **NO, do not enroll me in the Modified Issue PPO option**

CASHNET PLAN (Underwritten by Health Net Life Insurance Company)

Available only to members of a Health Net Farm Bureau PPO Insurance Plan. This product is a supplement to your health coverage and is not a substitute for hospital or medical insurance.

☐ **Yes** ☐ **No**

DENTAL COVERAGE

(Health Net Dental Scheduled Reimbursement Plan is underwritten by SafeHealth Life Insurance Company; Health Net Dental HMO is provided by SafeGuard Health Plans, Inc.)

You must be enrolled in a Health Net medical plan in order to enroll in a dental plan.

☐ Health Net Dental Scheduled Reimbursement Plan (No ortho)
☐ Health Net Dental HMO. Please choose an HMO dentist and list his/her dentist number _____

VISION COVERAGE

(Health Net Vision is underwritten by Fidelity Security Life Insurance Company and serviced by EyeMed Vision Care, LLC)

You must be enrolled in a Health Net medical plan in order to enroll in the Health Net Vision Plan.

☐ **Yes** ☐ **No**

Applicant Name: _____ Primary Applicant's Social Security Number: _____

Step 2: Tell us about yourself

Primary Applicant's Last Name	First Name	MI	☐ Male ☐ Female

Home Address

City	State	ZIP	County applicant resides in

☐ Billing Address (if you want your bill sent to an address different from home address; only your bill will be sent to this address)

City	State	ZIP

Home Phone Number	Work Phone Number	Email Address
( )	( )	

Primary Applicant's Birth Date (mo/day/year)	Primary Applicant's Social Security Number
/ /	– –

Height	Weight (lbs)	Farm Bureau Member No. (if already a Farm Bureau member)

In the past 6 months, have you been a resident of United States?

☐ Yes ☐ No If no, where was your last residence? _____

Type of Business:	Occupation:	Salary Range (optional):
☐ Self Employed/Consultant ☐ Student		☐ $18,000 - 30,000 ☐ $60,001 - 75,000
☐ Professional/Management ☐ Retired		☐ $30,001 - 45,000 ☐ $75,001 - 90,000
☐ Employed (Non-managerial) ☐ Other:_____		☐ $45,001 - 60,000 ☐ $90,001+
☐ Unemployed (between jobs)		

Would you be interested in other Health Net or affiliated entities products and services? ☐ Yes ☐ No

May we contact you by email? ☐ Yes ☐ No
If Yes, a Health Net representative or Authorized Broker may contact you.

How did you hear about Health Net's California Farm Bureau Members' Health Insurance Program?

☐ Radio ☐ Mail ☐ Billboard ☐ Newspaper ☐ Yellow Pages ☐ Broker ☐ Internet ☐ Other_____

Applicant Name: _____ Primary Applicant's Social Security Number: _____

Part III: Family Member(s) to be Enrolled

1. List all eligible family members to be enrolled other than you. If a listed family member's last name is different from yours, please explain on a separate sheet of paper. To be processed under one Subscriber, all family members must enroll in the same plan and reside at the same address.

2. For Domestic Partner coverage all requirements for eligibility, as required by the applicable laws of the State of California, must be met and a joint Declaration of Domestic Partnership must be filed with the California Secretary of State.

3. How to make different plan choices:

   a. If you wish to choose different medical, CashNet, dental and/or vision plan coverage for each family member, please complete the last four (4) columns.*

   b. For dental HMO coverage, please provide the dentist number of the HMO dentist you've chosen. You may choose a different dentist per family member. If you do not select a dental office, one will be selected for you in your area.

   c. Tell us if you'd like all family members on one bill (called a Consolidated Bill): ☐ Yes ☐ No

4. Supplemental term life insurance: to enroll in this optional coverage, please see Part VI.

							Complete these sections only if you wish to choose different medical, CashNet, dental and vision plans for each family member.			
Relation	Last Name First Name MI	Social Security No.	Date of Birth	Height	Weight (lbs)		Medical Plan Choice (write in plan name from list in Part II)	CashNet Plan	Dental Plan Coverage	Vision Coverage
☐ Husband ☐ Wife	Spouse/Domestic Partner	— —	/ /					☐ Yes ☐ No	☐ Scheduled Reimbursement Dental Plan ☐ Dental HMO. Primary Dentist #_____	☐ Yes ☐ No
☐ Son ☐ Daughter	Child 1	— —	/ /					☐ Yes ☐ No	☐ Scheduled Reimbursement Dental Plan ☐ Dental HMO. Primary Dentist #_____	☐ Yes ☐ No
Full time Student? ☐ Yes ☐ No	Units Carried	Name of School								
☐ Son ☐ Daughter	Child 2	— —	/ /					☐ Yes ☐ No	☐ Scheduled Reimbursement Dental Plan ☐ Dental HMO. Primary Dentist #_____	☐ Yes ☐ No
Full time Student? ☐ Yes ☐ No	Units Carried	Name of School								
☐ Son ☐ Daughter	Child 3	— —	/ /					☐ Yes ☐ No	☐ Scheduled Reimbursement Dental Plan ☐ Dental HMO. Primary Dentist #_____	☐ Yes ☐ No
Full time Student? ☐ Yes ☐ No	Units Carried	Name of School								
☐ Son ☐ Daughter	Child 4	— —	/ /					☐ Yes ☐ No	☐ Scheduled Reimbursement Dental Plan ☐ Dental HMO. Primary Dentist #_____	☐ Yes ☐ No
Full time Student? ☐ Yes ☐ No	Units Carried	Name of School								

For additional dependents please attach another sheet with the requested information.
*Subscriber only rates apply when you enroll each family member in different plan(s).

Applicant Name: _____ Primary Applicant's Social Security Number: _____

Part IV: (a) Statement of Health

Please answer all questions. A separate Statement of Health must be completed for each family member applying for coverage. If the three Statement of Health questionnaires included with the application are not enough to enroll your family, please request additional Statement of Health questionnaires by contacting your authorized Health Net Broker or calling Health Net at 1-800-909-3447, option 4. Please answer all questions, "Yes" or "No." IF "YES," PLEASE CIRCLE THE SPECIFIC **CONDITIONS** and complete Part B for the appropriate applicant. For the purposes of this Statement of Health, a health care provider or practitioner is any health care professional capable of rendering any kind of health care service.

NOTICE: You must provide truthful and complete answers to the following questions to the best of your ability. We are relying on the information you provide to determine whether you are eligible for coverage. We have the right to review all of your medical records to verify accuracy of your information during the first 24 months you are covered. Even if you currently have health insurance coverage or had prior coverage with Health Net, you must fully disclose and answer all health history questions. See "Part IX. Conditions of Enrollment" for information regarding rescission of membership.

1A	**Female applicants only:**		
(i)	Are you currently pregnant?	☐ Yes	☐ No
(ii)	During the previous 90 days, have you performed a home pregnancy test, which has reacted positive?	☐ Yes	☐ No
1B	**Male applicants only:**		
(i)	Are you expecting a child with anyone, even if the mother is not listed on this application?	☐ Yes	☐ No
(ii)	Has your spouse, even if not listed on this application, performed a home pregnancy test during the previous 90 days, which has reacted positive?	☐ Yes	☐ No
	ALL APPLICANTS		
2)	During the past 12 months have you seen a health care provider(s) or practitioner(s), had a physical exam, laboratory test(s), EKG, X-ray(s), MRI, CT scan or other diagnostic test(s)?	☐ Yes	☐ No
3)	During the past 5 years, have you consulted a health care provider(s) or practitioner(s), for any condition or symptom(s) for which a diagnosis has not been established, or for which you have not been made aware of the cause or diagnosis, been advised to have diagnostic test(s), treatment(s), surgery or hospitalization, or are you waiting for the results of any diagnostic tests?	☐ Yes	☐ No
4)	During the past 5 years, have you received Medicare benefits or any other disability benefits as a result of disability or chronic illness or condition?	☐ Yes	☐ No
5)	Within the past 2 years, have you consulted a health care provider(s) or practitioner(s), received advice from a health care provider(s) or practitioner(s), sought treatment from a health care provider(s) or practitioner(s), had treatment recommended by a health care provider(s) or practitioner(s), received treatment from a health care provider or practitioner or been hospitalized for any of the following:		
	A. Bursitis, arthritis, gout, muscle or tendon pain?	☐ Yes	☐ No
	B. Chest pain, pneumonia, shortness of breath, pain or difficulty breathing, sleep apnea, or difficult chewing or swallowing?	☐ Yes	☐ No
	C. Acne, rosacea, psoriasis or keratosis, or any other skin disorder?	☐ Yes	☐ No
	D. Jaundice, chronic diarrhea, unintentional or unexplained weight loss?	☐ Yes	☐ No
	E. Dizziness?	☐ Yes	☐ No
	F. Epstein-Barr virus?	☐ Yes	☐ No
	G. Recurrent or chronic pain (including back pain)?	☐ Yes	☐ No
	H. Cataracts, ear infection (otitis), sinusitis, deviated nasal septum, TMJ (temporomadibular joint disorder), tonsillitis, or allergies?	☐ Yes	☐ No
	I. Asthma? If "Yes", have you been hospitalized or been to an emergency room in the past 24 months? If "Yes", have you received any adrenaline or epinephrine injections?	☐ Yes ☐ Yes ☐ Yes	☐ No ☐ No ☐ No
	J. Thyroid disorder?	☐ Yes	☐ No
6)	Within the last 5 years, have you consulted a health care provider(s) or practitioner(s), received advice from a health care provider(s) or practitioner(s), sought treatment from a health care provider(s) or practitioner(s), had treatment recommended by a health care provider(s) or practitioner(s), received treatment from a health care provider(s) or practitioner(s), or been hospitalized for any of the following:		
	A. High or low blood pressure, hypertension, high cholesterol, phlebitis, Raynaud's disease, loss of consciousness, seizure disorder, headaches, anemia, varicose veins, or paralysis?	☐ Yes	☐ No
	B. Pyelonephritis, kidney stones, or any other disorder of the kidney, bladder, or urinary tract?	☐ Yes	☐ No

Applicant Name: _____ Primary Applicant's Social Security Number: _____

	C. Herpes, HPV (Human Papilloma Virus), genital or anal warts, or any other sexually transmitted disease?	☐ Yes	☐ No
	D. Carpal tunnel syndrome, osteopenia, osteoporosis, or any other bone or joint disorder?	☐ Yes	☐ No
	E. Pancreatitis, ulcers, spastic colitis, hemorrhoids, hernia, or any other disorder of the gallbladder, liver, stomach, intestines or esophagus?	☐ Yes	☐ No
	F. Cyst(s), lump(s), or tumor(s) in any part of the body?	☐ Yes	☐ No
	G. Nervous, mental, emotional, behavioral disorder, panic attack(s)?	☐ Yes	☐ No
	H. Anxiety, depression, chronic fatigue syndrome, attention deficit disorder, or ADHD?	☐ Yes	☐ No
	I. Developmental delay, premature birth, club foot, cleft lip or palate?	☐ Yes	☐ No
	J. Glaucoma?	☐ Yes	☐ No
	K. Male reproductive system: disorder of the prostate, infections, impotency, sexual dysfunction, or any other disorder of the male reproductive system?	☐ Yes	☐ No
	L. Female reproductive system: disorder of the breast, fibroid tumors, menstruation disorders, abnormal Pap test, infections, abnormal bleeding, endometriosis, disorder of the ovaries, or any other disorder of the female reproductive system?	☐ Yes	☐ No
7)	Have you ever consulted a health care provider(s) or practitioner(s), received advice from a health care provider(s) or practitioner(s), sought treatment from a health care provider(s) or practitioner(s), had treatment recommended by a health care provider(s) or practitioner(s), received treatment from a health care provider(s) or practitioner(s), or been hospitalized for any of the following:		
	A. Manic depression, bipolar disorder, schizophrenia, obsessive compulsive disorder, suicide attempt, or eating disorder?	☐ Yes	☐ No
	B. Cancer, melanoma, leukemia, bone marrow transplant, Kaposi's sarcoma, Hodgkin's disease, enlarged, lymph nodes, or any other malignancy?	☐ Yes	☐ No
	C. Cerebral palsy, Alzheimer's disease, Parkinson's disease, stroke, or any other disorder of the brain or nervous system?	☐ Yes	☐ No
	D. Heart attack, angina, heart murmur, heart valve replacement, irregular heart beat, palpitations, peripheral vascular disease, blood clot, pacemaker, shunt, heart disease, heart valve disorder, or any other heart, cardiovascular, or circulatory disorder?	☐ Yes	☐ No
	E. Emphysema, chronic obstructive pulmonary disease (COPD), pneumocystis carinii pneumonia, cystic fibrosis, tuberculosis or coughing up blood?	☐ Yes	☐ No
	F. Colitis, ulcerative colitis, Crohn's disease, cirrhosis, liver disease, hepatitis, or gastric bypass surgery?	☐ Yes	☐ No
	G. Infertility?	☐ Yes	☐ No
	H. Ankylosing spondylitis, spondylosis, herniated, ruptured or bulging disc, rheumatoid arthritis, sclerodoma, joint replacement, or fixation device(s) (pins, plates, rods)?	☐ Yes	☐ No
	I. Amyotrophic lateral sclerosis (ALS), multiple sclerosis, muscular dystrophy, Down's syndrome, or any congenital disorder?	☐ Yes	☐ No
	J. Diabetes, adrenal disorder, lupus, endocrine or metabolic disorder?	☐ Yes	☐ No
	K. Alcoholism, alcohol or substance abuse/dependency?	☐ Yes	☐ No
	L. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or antiviral therapy?	☐ Yes	☐ No
	M. Breast implants, reconstructive or cosmetic surgery, or any other prosthesis or implant?	☐ Yes	☐ No
	N. Hemophilia or any other blood or bleeding disorder?	☐ Yes	☐ No
	O. Organ transplant?	☐ Yes	☐ No
8)	During the past 12 months, have you smoked cigarettes, cigars, pipes, or used chewing tobacco?	☐ Yes	☐ No
9)	Within the past two years, have you visited or consulted a physician, psychiatrist, chiropractor, physician assistant, nurse practitioner, physical therapist, or other licensed health care provider or practitioner that has not been disclosed elsewhere on this application?	☐ Yes	☐ No
10)	During the past 12 months, have you had a physical injury or experienced reoccurring pain or symptoms that have not been evaluated by a licensed health care provider or practitioner or for which you plan to have evaluated by a licensed health care provider or practitioner?	☐ Yes	☐ No
11)	Are you currently taking medication? If "Yes", please complete section IV: Medications.	☐ Yes	☐ No
12)	Have you been prescribed or taken any prescription medication during the past 12 months?	☐ Yes	☐ No
13)	Do you consume alcoholic beverages? If "yes", please indicate the number of alcoholic beverages you consume weekly (a beverage is 12 ounces of beer, 6 ounces of wine, 1 ounce of liquor): _____	☐ Yes	☐ No
14)	Have you ever received counseling or been a member of a support group related to alcohol or substance abuse?	☐ Yes	☐ No
15)	Have you ever been convicted of driving under the influence of alcohol or any controlled substance and as a consequence been required to receive counseling or attend a support group or class related to driving under the influence of alcohol or any controlled substance?	☐ Yes	☐ No

Applicant Name: _____ Primary Applicant's Social Security Number: _____

Part IV: (a) Statement of Health (continued)

Female applicants only (applicable to all females listed on the application).

16)	A. Have you had a menstrual period in each of the last six months, including within the last 30 days? If "No", please explain: _____	☐ Yes	☐ No
	B. (i) Have you had a pelvic exam? If yes, date of last pelvic exam (mo/day/year): _____	☐ Yes	☐ No
	(ii) Have you had a pap smear? If yes, date of last pap smear (mo/day/year): _____	☐ Yes	☐ No
	(iii) Were the results of the exam(s) normal? If "No", please explain: _____	☐ Yes	☐ No

Part IV: (b) Statement of Health Details

If you answered "Yes" to any questions in Section IV (a), please identify the question number and explain in FULL DETAIL below. If additional space is necessary, please attach extra pages.

Question Number	Diagnosis, signs or symptoms, condition, treatment, or recommendation?	Still under treatment?	Dates of treatment or Hospitalization (mo/year)		Full name, address & telephone number of every health care provider or practitioner, clinic, hospital or any other medical facility (include ZIP code)
			Began	Ended	
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			

Part IV: Doctor's Visits

Please provide information regarding your last health care provider or practitioner visit or physical examination.

Date of Visit	Reason for Visit	Results of Visit	Full name, address & telephone number of every health care provider or practitioner, clinic, hospital or any other medical facility (include ZIP code)

Part IV: Medications

Please list all medications you are currently taking or which you have taken or been prescribed within the last 12 months.

Condition	Name of Medication	Prescribing Physician	Most Recent Refill Date	Strength (No. of milligrams)	Dosage & Frequency (How many pills & how often take)	Number of refills per year

Applicant Name: _____ Primary Applicant's Social Security Number: _____

Part IV: (a) Statement of Health

Please answer all questions. A separate Statement of Health must be completed for each family member applying for coverage. If the three Statement of Health questionnaires included with the application are not enough to enroll your family, please request additional Statement of Health questionnaires by contacting your authorized Health Net Broker or calling Health Net at 1-800-909-3447, option 4. Please answer all questions, "Yes" or "No." IF "YES," PLEASE CIRCLE THE SPECIFIC **CONDITIONS** and complete Part B for the appropriate applicant. For the purposes of this Statement of Health, a health care provider or practitioner is any health care professional capable of rendering any kind of health care service.

NOTICE: You must provide truthful and complete answers to the following questions to the best of your ability. We are relying on the information you provide to determine whether you are eligible for coverage. We have the right to review all of your medical records to verify accuracy of your information during the first 24 months you are covered. Even if you currently have health insurance coverage or had prior coverage with Health Net, you must fully disclose and answer all health history questions. See "Part IX. Conditions of Enrollment" for information regarding rescission of membership.

1A	**Female applicants only:**		
(i)	Are you currently pregnant?	☐ Yes	☐ No
(ii)	During the previous 90 days, have you performed a home pregnancy test, which has reacted positive?	☐ Yes	☐ No
1B	**Male applicants only:**		
(i)	Are you expecting a child with anyone, even if the mother is not listed on this application?	☐ Yes	☐ No
(ii)	Has your spouse, even if not listed on this application, performed a home pregnancy test during the previous 90 days, which has reacted positive?	☐ Yes	☐ No
	ALL APPLICANTS		
2)	During the past 12 months have you seen a health care provider(s) or practitioner(s), had a physical exam, laboratory test(s), EKG, X-ray(s), MRI, CT scan or other diagnostic test(s)?	☐ Yes	☐ No
3)	During the past 5 years, have you consulted a health care provider(s) or practitioner(s), for any condition or symptom(s) for which a diagnosis has not been established, or for which you have not been made aware of the cause or diagnosis, been advised to have diagnostic test(s), treatment(s), surgery or hospitalization, or are you waiting for the results of any diagnostic tests?	☐ Yes	☐ No
4)	During the past 5 years, have you received Medicare benefits or any other disability benefits as a result of disability or chronic illness or condition?	☐ Yes	☐ No
5)	Within the past 2 years, have you consulted a health care provider(s) or practitioner(s), received advice from a health care provider(s) or practitioner(s), sought treatment from a health care provider(s) or practitioner(s), had treatment recommended by a health care provider(s) or practitioner(s), received treatment from a health care provider or practitioner or been hospitalized for any of the following:		
	A. Bursitis, arthritis, gout, muscle or tendon pain?	☐ Yes	☐ No
	B. Chest pain, pneumonia, shortness of breath, pain or difficulty breathing, sleep apnea, or difficult chewing or swallowing?	☐ Yes	☐ No
	C. Acne, rosacea, psoriasis or keratosis, or any other skin disorder?	☐ Yes	☐ No
	D. Jaundice, chronic diarrhea, unintentional or unexplained weight loss?	☐ Yes	☐ No
	E. Dizziness?	☐ Yes	☐ No
	F. Epstein-Barr virus?	☐ Yes	☐ No
	G. Recurrent or chronic pain (including back pain)?	☐ Yes	☐ No
	H. Cataracts, ear infection (otitis), sinusitis, deviated nasal septum, TMJ (temporomadibular joint disorder), tonsillitis, or allergies?	☐ Yes	☐ No
	I. Asthma? If "Yes", have you been hospitalized or been to an emergency room in the past 24 months? If "Yes", have you received any adrenaline or epinephrine injections?	☐ Yes ☐ Yes ☐ Yes	☐ No ☐ No ☐ No
	J. Thyroid disorder?	☐ Yes	☐ No
6)	Within the last 5 years, have you consulted a health care provider(s) or practitioner(s), received advice from a health care provider(s) or practitioner(s), sought treatment from a health care provider(s) or practitioner(s), had treatment recommended by a health care provider(s) or practitioner(s), received treatment from a health care provider(s) or practitioner(s), or been hospitalized for any of the following:		
	A. High or low blood pressure, hypertension, high cholesterol, phlebitis, Raynaud's disease, loss of consciousness, seizure disorder, headaches, anemia, varicose veins, or paralysis?	☐ Yes	☐ No
	B. Pyelonephritis, kidney stones, or any other disorder of the kidney, bladder, or urinary tract?	☐ Yes	☐ No

Applicant Name: _____ Primary Applicant's Social Security Number: _____

	C. Herpes, HPV (Human Papilloma Virus), genital or anal warts, or any other sexually transmitted disease?	☐ Yes	☐ No
	D. Carpal tunnel syndrome, osteopenia, osteoporosis, or any other bone or joint disorder?	☐ Yes	☐ No
	E. Pancreatitis, ulcers, spastic colitis, hemorrhoids, hernia, or any other disorder of the gallbladder, liver, stomach, intestines or esophagus?	☐ Yes	☐ No
	F. Cyst(s), lump(s), or tumor(s) in any part of the body?	☐ Yes	☐ No
	G. Nervous, mental, emotional, behavioral disorder, panic attack(s)?	☐ Yes	☐ No
	H. Anxiety, depression, chronic fatigue syndrome, attention deficit disorder, or ADHD?	☐ Yes	☐ No
	I. Developmental delay, premature birth, club foot, cleft lip or palate?	☐ Yes	☐ No
	J. Glaucoma?	☐ Yes	☐ No
	K. Male reproductive system: disorder of the prostate, infections, impotency, sexual dysfunction, or any other disorder of the male reproductive system?	☐ Yes	☐ No
	L. Female reproductive system: disorder of the breast, fibroid tumors, menstruation disorders, abnormal Pap test, infections, abnormal bleeding, endometriosis, disorder of the ovaries, or any other disorder of the female reproductive system?	☐ Yes	☐ No
7)	Have you ever consulted a health care provider(s) or practitioner(s), received advice from a health care provider(s) or practitioner(s), sought treatment from a health care provider(s) or practitioner(s), had treatment recommended by a health care provider(s) or practitioner(s), received treatment from a health care provider(s) or practitioner(s), or been hospitalized for any of the following:		
	A. Manic depression, bipolar disorder, schizophrenia, obsessive compulsive disorder, suicide attempt, or eating disorder?	☐ Yes	☐ No
	B. Cancer, melanoma, leukemia, bone marrow transplant, Kaposi's sarcoma, Hodgkin's disease, enlarged, lymph nodes, or any other malignancy?	☐ Yes	☐ No
	C. Cerebral palsy, Alzheimer's disease, Parkinson's disease, stroke, or any other disorder of the brain or nervous system?	☐ Yes	☐ No
	D. Heart attack, angina, heart murmur, heart valve replacement, irregular heart beat, palpitations, peripheral vascular disease, blood clot, pacemaker, shunt, heart disease, heart valve disorder, or any other heart, cardiovascular, or circulatory disorder?	☐ Yes	☐ No
	E. Emphysema, chronic obstructive pulmonary disease (COPD), pneumocystis carinii pneumonia, cystic fibrosis, tuberculosis or coughing up blood?	☐ Yes	☐ No
	F. Colitis, ulcerative colitis, Crohn's disease, cirrhosis, liver disease, hepatitis, or gastric bypass surgery?	☐ Yes	☐ No
	G. Infertility?	☐ Yes	☐ No
	H. Ankylosing spondylitis, spondylosis, herniated, ruptured or bulging disc, rheumatoid arthritis, sclerodoma, joint replacement, or fixation device(s) (pins, plates, rods)?	☐ Yes	☐ No
	I. Amyotrophic lateral sclerosis (ALS), multiple sclerosis, muscular dystrophy, Down's syndrome, or any congenital disorder?	☐ Yes	☐ No
	J. Diabetes, adrenal disorder, lupus, endocrine or metabolic disorder?	☐ Yes	☐ No
	K. Alcoholism, alcohol or substance abuse/dependency?	☐ Yes	☐ No
	L. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or antiviral therapy?	☐ Yes	☐ No
	M. Breast implants, reconstructive or cosmetic surgery, or any other prosthesis or implant?	☐ Yes	☐ No
	N. Hemophilia or any other blood or bleeding disorder?	☐ Yes	☐ No
	O. Organ transplant?	☐ Yes	☐ No
8)	During the past 12 months, have you smoked cigarettes, cigars, pipes, or used chewing tobacco?	☐ Yes	☐ No
9)	Within the past two years, have you visited or consulted a physician, psychiatrist, chiropractor, physician assistant, nurse practitioner, physical therapist, or other licensed health care provider or practitioner that has not been disclosed elsewhere on this application?	☐ Yes	☐ No
10)	During the past 12 months, have you had a physical injury or experienced reoccurring pain or symptoms that have not been evaluated by a licensed health care provider or practitioner or for which you plan to have evaluated by a licensed health care provider or practitioner?	☐ Yes	☐ No
11)	Are you currently taking medication? If "Yes", please complete section IV: Medications.	☐ Yes	☐ No
12)	Have you been prescribed or taken any prescription medication during the past 12 months?	☐ Yes	☐ No
13)	Do you consume alcoholic beverages? If "yes", please indicate the number of alcoholic beverages you consume weekly (a beverage is 12 ounces of beer, 6 ounces of wine, 1 ounce of liquor): _____	☐ Yes	☐ No
14)	Have you ever received counseling or been a member of a support group related to alcohol or substance abuse?	☐ Yes	☐ No
15)	Have you ever been convicted of driving under the influence of alcohol or any controlled substance and as a consequence been required to receive counseling or attend a support group or class related to driving under the influence of alcohol or any controlled substance?	☐ Yes	☐ No

Applicant Name: _____ Primary Applicant's Social Security Number: _____

Part IV: (a) Statement of Health (continued)

Female applicants only (applicable to all females listed on the application).

16)	A. Have you had a menstrual period in each of the last six months, including within the last 30 days? If "No", please explain: _____	☐ Yes	☐ No
	B. (i) Have you had a pelvic exam? If yes, date of last pelvic exam (mo/day/year): _____	☐ Yes	☐ No
	(ii) Have you had a pap smear? If yes, date of last pap smear (mo/day/year): _____	☐ Yes	☐ No
	(iii) Were the results of the exam(s) normal? If "No", please explain: _____	☐ Yes	☐ No

Part IV: (b) Statement of Health Details

If you answered "Yes" to any questions in Section IV (a), please identify the question number and explain in FULL DETAIL below. If additional space is necessary, please attach extra pages.

Question Number	Diagnosis, signs or symptoms, condition, treatment, or recommendation?	Still under treatment?	Dates of treatment or Hospitalization (mo/year)		Full name, address & telephone number of every health care provider or practitioner, clinic, hospital or any other medical facility (include ZIP code)
			Began	Ended	
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			

Part IV: Doctor's Visits

Please provide information regarding your last health care provider or practitioner visit or physical examination.

Date of Visit	Reason for Visit	Results of Visit	Full name, address & telephone number of every health care provider or practitioner, clinic, hospital or any other medical facility (include ZIP code)

Part IV: Medications

Please list all medications you are currently taking or which you have taken or been prescribed within the last 12 months.

Condition	Name of Medication	Prescribing Physician	Most Recent Refill Date	Strength (No. of milligrams)	Dosage & Frequency (How many pills & how often take)	Number of refills per year

Applicant Name: _____ Primary Applicant's Social Security Number: _____

Part IV: (a) Statement of Health

Please answer all questions. A separate Statement of Health must be completed for each family member applying for coverage. If the three Statement of Health questionnaires included with the application are not enough to enroll your family, please request additional Statement of Health questionnaires by contacting your authorized Health Net Broker or calling Health Net at 1-800-909-3447, option 4. Please answer all questions, "Yes" or "No." IF "YES," PLEASE CIRCLE THE SPECIFIC **CONDITIONS** and complete Part B for the appropriate applicant. For the purposes of this Statement of Health, a health care provider or practitioner is any health care professional capable of rendering any kind of health care service.

NOTICE: You must provide truthful and complete answers to the following questions to the best of your ability. We are relying on the information you provide to determine whether you are eligible for coverage. We have the right to review all of your medical records to verify accuracy of your information during the first 24 months you are covered. Even if you currently have health insurance coverage or had prior coverage with Health Net, you must fully disclose and answer all health history questions. See "Part IX. Conditions of Enrollment" for information regarding rescission of membership.

1A	**Female applicants only:**		
(i)	Are you currently pregnant?	☐ Yes	☐ No
(ii)	During the previous 90 days, have you performed a home pregnancy test, which has reacted positive?	☐ Yes	☐ No
1B	**Male applicants only:**		
(i)	Are you expecting a child with anyone, even if the mother is not listed on this application?	☐ Yes	☐ No
(ii)	Has your spouse, even if not listed on this application, performed a home pregnancy test during the previous 90 days, which has reacted positive?	☐ Yes	☐ No
	ALL APPLICANTS		
2)	During the past 12 months have you seen a health care provider(s) or practitioner(s), had a physical exam, laboratory test(s), EKG, X-ray(s), MRI, CT scan or other diagnostic test(s)?	☐ Yes	☐ No
3)	During the past 5 years, have you consulted a health care provider(s) or practitioner(s), for any condition or symptom(s) for which a diagnosis has not been established, or for which you have not been made aware of the cause or diagnosis, been advised to have diagnostic test(s), treatment(s), surgery or hospitalization, or are you waiting for the results of any diagnostic tests?	☐ Yes	☐ No
4)	During the past 5 years, have you received Medicare benefits or any other disability benefits as a result of disability or chronic illness or condition?	☐ Yes	☐ No
5)	Within the past 2 years, have you consulted a health care provider(s) or practitioner(s), received advice from a health care provider(s) or practitioner(s), sought treatment from a health care provider(s) or practitioner(s), had treatment recommended by a health care provider(s) or practitioner(s), received treatment from a health care provider or practitioner or been hospitalized for any of the following:		
	A. Bursitis, arthritis, gout, muscle or tendon pain?	☐ Yes	☐ No
	B. Chest pain, pneumonia, shortness of breath, pain or difficulty breathing, sleep apnea, or difficult chewing or swallowing?	☐ Yes	☐ No
	C. Acne, rosacea, psoriasis or keratosis, or any other skin disorder?	☐ Yes	☐ No
	D. Jaundice, chronic diarrhea, unintentional or unexplained weight loss?	☐ Yes	☐ No
	E. Dizziness?	☐ Yes	☐ No
	F. Epstein-Barr virus?	☐ Yes	☐ No
	G. Recurrent or chronic pain (including back pain)?	☐ Yes	☐ No
	H. Cataracts, ear infection (otitis), sinusitis, deviated nasal septum, TMJ (temporomadibular joint disorder), tonsillitis, or allergies?	☐ Yes	☐ No
	I. Asthma? If "Yes", have you been hospitalized or been to an emergency room in the past 24 months? If "Yes", have you received any adrenaline or epinephrine injections?	☐ Yes ☐ Yes ☐ Yes	☐ No ☐ No ☐ No
	J. Thyroid disorder?	☐ Yes	☐ No
6)	Within the last 5 years, have you consulted a health care provider(s) or practitioner(s), received advice from a health care provider(s) or practitioner(s), sought treatment from a health care provider(s) or practitioner(s), had treatment recommended by a health care provider(s) or practitioner(s), received treatment from a health care provider(s) or practitioner(s), or been hospitalized for any of the following:		
	A. High or low blood pressure, hypertension, high cholesterol, phlebitis, Raynaud's disease, loss of consciousness, seizure disorder, headaches, anemia, varicose veins, or paralysis?	☐ Yes	☐ No
	B. Pyelonephritis, kidney stones, or any other disorder of the kidney, bladder, or urinary tract?	☐ Yes	☐ No

Applicant Name: _____ Primary Applicant's Social Security Number: _____

	C. Herpes, HPV (Human Papilloma Virus), genital or anal warts, or any other sexually transmitted disease?	☐ Yes	☐ No
	D. Carpal tunnel syndrome, osteopenia, osteoporosis, or any other bone or joint disorder?	☐ Yes	☐ No
	E. Pancreatitis, ulcers, spastic colitis, hemorrhoids, hernia, or any other disorder of the gallbladder, liver, stomach, intestines or esophagus?	☐ Yes	☐ No
	F. Cyst(s), lump(s), or tumor(s) in any part of the body?	☐ Yes	☐ No
	G. Nervous, mental, emotional, behavioral disorder, panic attack(s)?	☐ Yes	☐ No
	H. Anxiety, depression, chronic fatigue syndrome, attention deficit disorder, or ADHD?	☐ Yes	☐ No
	I. Developmental delay, premature birth, club foot, cleft lip or palate?	☐ Yes	☐ No
	J. Glaucoma?	☐ Yes	☐ No
	K. Male reproductive system: disorder of the prostate, infections, impotency, sexual dysfunction, or any other disorder of the male reproductive system?	☐ Yes	☐ No
	L. Female reproductive system: disorder of the breast, fibroid tumors, menstruation disorders, abnormal Pap test, infections, abnormal bleeding, endometriosis, disorder of the ovaries, or any other disorder of the female reproductive system?	☐ Yes	☐ No
7)	Have you ever consulted a health care provider(s) or practitioner(s), received advice from a health care provider(s) or practitioner(s), sought treatment from a health care provider(s) or practitioner(s), had treatment recommended by a health care provider(s) or practitioner(s), received treatment from a health care provider(s) or practitioner(s), or been hospitalized for any of the following:		
	A. Manic depression, bipolar disorder, schizophrenia, obsessive compulsive disorder, suicide attempt, or eating disorder?	☐ Yes	☐ No
	B. Cancer, melanoma, leukemia, bone marrow transplant, Kaposi's sarcoma, Hodgkin's disease, enlarged, lymph nodes, or any other malignancy?	☐ Yes	☐ No
	C. Cerebral palsy, Alzheimer's disease, Parkinson's disease, stroke, or any other disorder of the brain or nervous system?	☐ Yes	☐ No
	D. Heart attack, angina, heart murmur, heart valve replacement, irregular heart beat, palpitations, peripheral vascular disease, blood clot, pacemaker, shunt, heart disease, heart valve disorder, or any other heart, cardiovascular, or circulatory disorder?	☐ Yes	☐ No
	E. Emphysema, chronic obstructive pulmonary disease (COPD), pneumocystis carinii pneumonia, cystic fibrosis, tuberculosis or coughing up blood?	☐ Yes	☐ No
	F. Colitis, ulcerative colitis, Crohn's disease, cirrhosis, liver disease, hepatitis, or gastric bypass surgery?	☐ Yes	☐ No
	G. Infertility?	☐ Yes	☐ No
	H. Ankylosing spondylitis, spondylosis, herniated, ruptured or bulging disc, rheumatoid arthritis, sclerodoma, joint replacement, or fixation device(s) (pins, plates, rods)?	☐ Yes	☐ No
	I. Amyotrophic lateral sclerosis (ALS), multiple sclerosis, muscular dystrophy, Down's syndrome, or any congenital disorder?	☐ Yes	☐ No
	J. Diabetes, adrenal disorder, lupus, endocrine or metabolic disorder?	☐ Yes	☐ No
	K. Alcoholism, alcohol or substance abuse/dependency?	☐ Yes	☐ No
	L. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or antiviral therapy?	☐ Yes	☐ No
	M. Breast implants, reconstructive or cosmetic surgery, or any other prosthesis or implant?	☐ Yes	☐ No
	N. Hemophilia or any other blood or bleeding disorder?	☐ Yes	☐ No
	O. Organ transplant?	☐ Yes	☐ No
8)	During the past 12 months, have you smoked cigarettes, cigars, pipes, or used chewing tobacco?	☐ Yes	☐ No
9)	Within the past two years, have you visited or consulted a physician, psychiatrist, chiropractor, physician assistant, nurse practitioner, physical therapist, or other licensed health care provider or practitioner that has not been disclosed elsewhere on this application?	☐ Yes	☐ No
10)	During the past 12 months, have you had a physical injury or experienced reoccurring pain or symptoms that have not been evaluated by a licensed health care provider or practitioner or for which you plan to have evaluated by a licensed health care provider or practitioner?	☐ Yes	☐ No
11)	Are you currently taking medication? If "Yes", please complete section IV: Medications.	☐ Yes	☐ No
12)	Have you been prescribed or taken any prescription medication during the past 12 months?	☐ Yes	☐ No
13)	Do you consume alcoholic beverages? If "yes", please indicate the number of alcoholic beverages you consume weekly (a beverage is 12 ounces of beer, 6 ounces of wine, 1 ounce of liquor): _____	☐ Yes	☐ No
14)	Have you ever received counseling or been a member of a support group related to alcohol or substance abuse?	☐ Yes	☐ No
15)	Have you ever been convicted of driving under the influence of alcohol or any controlled substance and as a consequence been required to receive counseling or attend a support group or class related to driving under the influence of alcohol or any controlled substance?	☐ Yes	☐ No

Applicant Name: _____ Primary Applicant's Social Security Number: _____

Part IV: (a) Statement of Health (continued)

Female applicants only (applicable to all females listed on the application).

16)	A. Have you had a menstrual period in each of the last six months, including within the last 30 days? If "No", please explain: _____	☐ Yes	☐ No
	B. (i) Have you had a pelvic exam? If yes, date of last pelvic exam (mo/day/year): _____	☐ Yes	☐ No
	(ii) Have you had a pap smear? If yes, date of last pap smear (mo/day/year): _____	☐ Yes	☐ No
	(iii) Were the results of the exam(s) normal? If "No", please explain: _____	☐ Yes	☐ No

Part IV: (b) Statement of Health Details

If you answered "Yes" to any questions in Section IV (a), please identify the question number and explain in FULL DETAIL below. If additional space is necessary, please attach extra pages.

Question Number	Diagnosis, signs or symptoms, condition, treatment, or recommendation?	Still under treatment?	Dates of treatment or Hospitalization (mo/year)		Full name, address & telephone number of every health care provider or practitioner, clinic, hospital or any other medical facility (include ZIP code)
			Began	Ended	
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			

Part IV: Doctor's Visits

Please provide information regarding your last health care provider or practitioner visit or physical examination.

Date of Visit	Reason for Visit	Results of Visit	Full name, address & telephone number of every health care provider or practitioner, clinic, hospital or any other medical facility (include ZIP code)

Part IV: Medications

Please list all medications you are currently taking or which you have taken or been prescribed within the last 12 months.

Condition	Name of Medication	Prescribing Physician	Most Recent Refill Date	Strength (No. of milligrams)	Dosage & Frequency (How many pills & how often take)	Number of refills per year

Applicant Name: _____ Primary Applicant's Social Security Number: _____

Part V: Prior Health Coverage

A. **During the previous 63 days, have you been covered by health insurance?** ☐ Yes ☐ No

If "Yes", Current Carrier:_____ Effective Date: _____ Expected Termination date: _____

☐ Individual & Family HMO ☐ Group HMO ☐ Disability, Short Term or Interim

☐ Individual & Family PPO ☐ Group PPO ☐ Other: _____

B. Has anyone on this application been a Health Net or Foundation Health Member in the last five years? ☐ Yes ☐ No

If "Yes," former Health Net or Foundation Health Member name: _____

Group Number (listed on your ID card): _____

Member ID Number (listed on your ID card): _____

C. **HIPAA Guaranteed Issue Coverage**

If you do not qualify for the coverage under a Farm Bureau PPO plan, you may be considered for coverage under the HIPAA Guaranteed Issue plans. The HIPAA Guaranteed Issue plans do not require medical underwriting and the rates are higher compared to the other Individual Plans. If you qualify for coverage under the HIPAA Guaranteed Issue plans please request the complete benefit details and rates for those plans. To be eligible for HIPAA Guaranteed Issue coverage, you must meet every condition below.

1. Have you had a total of at least 18 months of health care coverage (including COBRA or Cal-COBRA, if applicable) without more than a 63-day break (excluding any employer imposed waiting periods) in coverage? ☐ Yes ☐ No

2. Was your most recent coverage through a group health plan (COBRA and Cal-COBRA are considered group coverage)? ☐ Yes ☐ No

3. Currently are you eligible for coverage under a group health plan, Medicare or Medicaid? ☐ Yes ☐ No
   (If yes, you are not eligible for HIPAA coverage)

4. Was your most recent coverage terminated because of nonpayment or fraud? ☐ Yes ☐ No

5. Were you eligible under COBRA or Cal-COBRA? ☐ Yes ☐ No
   If Yes, start date _____End Date: _____
   If Yes, did you accept and use up all benefits that were available? ☐ Yes ☐ No

   If No, please explain:_____

Applicant Name: _____ Primary Applicant's Social Security Number: _____

Part VI: Term Life Insurance - underwritten by Health Net Life Insurance Company

I. Required Life and AD&D Coverage

A. The Primary Applicant approved for a Health Net PPO medical plan will be required to purchase $5,000 Life and AD&D coverage at $3.00 per month. If your spouse is covered under the same certificate, he/she will receive $2,500 Life and AD&D coverage.

B. Primary Applicants and Spouses who enroll under separate certificates are both required to purchase $5,000 Life and AD&D coverage at $3.00 per month.

Please list the Beneficiary Name and Relationship for this coverage.

Primary Applicant:

Beneficiary Name	Beneficiary Relationship	Percentage*
(1)		
(2)		
(3)		

Spouse:

Beneficiary Name	Beneficiary Relationship	Percentage*
(1)		
(2)		
(3)		

* The percentage for all beneficiaries must total 100%

II. Supplemental Term Life Insurance Coverage

The Primary Applicant and/or any dependents that are approved for a Health Net PPO medical plan will also qualify for Term Life coverage. Coverage is optional and can be purchased at an additional charge. Applicants under the age of one year and Applicants being offered Modified Issue plans are ineligible for Life Insurance. This coverage does not replace the required $5,000 Life and AD&D coverage at $3.00 per month as outlined in section I above. This insurance also is not intended to replace any Life Insurance Policy currently in force.

Premium for life insurance coverage is not required before enrollment. Once enrolled, Health Net will bill you for the applicable life insurance premium.

If you would like supplemental coverage:

1. Please list all family members applying for Term Life Insurance Coverage (available for ages 1-64).
2. Life insurance requires an additional premium. You will be billed for the premium after enrollment is confirmed by Health Net.
3. Complete the beneficiary information. You can have one or more beneficiaries. If you have more than one, the percentages must add up to 100%.

Name of Family Member/Full Name	Relationship to Primary Applicant	Birthdate (mo/day/year)	Amount
	Self		☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000

Beneficiary Name	Beneficiary Relationship	Percentage*
(1)		
(2)		
(3)		

Signature of Applicant	Date

* The percentage for all beneficiaries must total 100%

Applicant Name: ______________________________ Primary Applicant's Social Security Number: ____________________

Name of Family Member/Full Name	Relationship to Primary Applicant	Birthdate (mo/day/year)	Amount
	Spouse/Domestic Partner		☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000

Beneficiary Name	Beneficiary Relationship	Percentage*
(1)		
(2)		
(3)		

Signature of Spouse/Domestic Partner	Date

Name of Family Member/Full Name	Relationship to Primary Applicant	Birthdate (mo/day/year)	Amount
	Child		☐ $10,000

Beneficiary Name	Beneficiary Relationship	Percentage*
(1)		
(2)		
(3)		

Signature of Child if over 18 years of age	Date

Name of Family Member/Full Name	Relationship to Primary Applicant	Birthdate (mo/day/year)	Amount
	Child		☐ $10,000

Beneficiary Name	Beneficiary Relationship	Percentage*
(1)		
(2)		
(3)		

Signature of Child if over 18 years of age	Date

Name of Family Member/Full Name	Relationship to Primary Applicant	Birthdate (mo/day/year)	Amount
	Child		☐ $10,000

Beneficiary Name	Beneficiary Relationship	Percentage*
(1)		
(2)		
(3)		

Signature of Child if over 18 years of age	Date

* The percentage for all beneficiaries must total 100%

Applicant Name: _____ Primary Applicant's Social Security Number: _____

Part VII: California Farm Bureau Plans Exception to Standard Enrollment — Statement of Accountability

Instructions for Part VII: The following form is to be used when the Applicant cannot complete the application because of the reason(s) indicated below. The applicant must complete the appropriate section that applies to their enrollment. This form must be submitted with the California Farm Bureau Enrollment Application when applicable.

I, _____ personally read and completed the California Farm Bureau Enrollment Application for the Applicant named above because:

☐ Applicant does not read English ☐ Applicant does not speak English ☐ Applicant does not write English

☐ Other (explain) _____

Under the penalty of perjury I attest that, I translated/read to the applicant the contents of the California Farm Bureau Enrollment Application, including Part IX "Conditions of Enrollment" and Part X "Important Provisions" of the California Farm Bureau Enrollment Application. I accurately listed all the requested personal and medical history disclosed by:

_____(Name of applicant)

Signature and date *(required in ink)*

SIGNATURE of APPLICANT		Today's Date
SIGNATURE of TRANSLATOR		Today's Date
TRANSLATOR'S/READER'S NAME (PRINT)		TRANSLATOR'S/READER'S PHONE NUMBER
TRANSLATOR'S/READER'S ADDRESS		
TRANSLATOR'S/READER'S CITY	STATE	ZIP

Part VIII: Applicant's Agent/Broker Information

Complete agent/broker name and address is necessary for correspondence to be sent to the agent/broker.

Instructions for Part VIII: The following form is to be completed by the Applicant's agent/broker (if applicable).

Health Net Broker ID: _____ **Sub-Broker ID:**_____
(Must be completed only if Sub-Broker Agreement is approved)

Name: _____ Phone number: _____

Address: _____ Fax Number: _____

_____ Email address: _____

_____ / / _____

Applicant's Agent/Broker Signature/Number (required) **Date Signed (required)**

Agent/Broker Certification ☐ Yes ☐ No Are you aware of any information not disclosed in this application that might have a bearing on the risk? If "Yes," please explain: _____	Did you personally see the applicant signing the application (includes spouse/ domestic partner, if applying)? ☐ Yes ☐ No

Applicant Name: _____ Primary Applicant's Social Security Number: _____

Part IX: Conditions of Enrollment

GENERAL CONDITIONS: Health Net reserves the right to reject any application for enrollment. Health Net may selectively accept the Applicant or only a dependent(s). There is no coverage unless this Application is accepted by Health Net's Underwriting Department and a Notice of Acceptance is issued to the Applicant even though you paid money to Health Net for the first month's premium. Cashing your check does not mean your application is approved. If rejected, your money will be returned to you. No other department, officer, agent or employee of Health Net is authorized to grant enrollment. The Applicant's broker or agent cannot grant approval, change terms or waive requirements of this application. Health Net may require that you take a medical examination and you will be responsible for payment of any related fees in such event. This application and all medical information or examination reports shall become a part of the Insurance Certificate.

Family Members who are covered under a Health Net Individual plan are not eligible for coverage hereunder. Should a Family Member enrolling for coverage, become covered under a Health Net Individual plan at a later date, his or her coverage under this plan will terminate on the effective date of coverage under the Health Net Individual plan.

Health Net Life Insurance Company ("HNL") is an Insurance Company licensed and regulated under the California Insurance Code. Health Net's PPO plans are underwritten by HNL. Any intentional or unintentional nondisclosure or misstatement of fact in application materials is cause for disenrollment and rescission of the Insurance Certificate and HNL may recoup from the Subscriber (or from You or from the applicant) any amounts paid for Covered Services obtained as a result of such nondisclosure or misstatement of fact. In addition, if a Subscriber makes a false statement or omission as to the Subscriber's or Family Member's health status or history on application materials, HNL shall have no liability for the provision of coverage under the Insurance Certificate. By signing this application, you represent that all responses to the Statement of health are true, complete and accurate and that should your application be accepted by HNL, the application will become part of the contract between HNL and yourself. By signing this application you further represent and agree to abide by the terms of the contract. Should the contract be rescinded, HNL will provide a written notice that will explain the basis of the decision and your appeals rights. HNL will refund all amounts paid by you, less any medical expenses that HNL paid.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: I acknowledge and understand that health care providers may disclose health information about me or my dependents to Health Net. Health Net uses and may disclose this information for purposes of treatment, payment and health plan operations, including but not limited to, utilization management, quality improvement, disease or case management programs. Health Net's Notice of Privacy Practices is included in the Insurance Certificate, and that I may also obtain a copy of this Notice on the website at www.healthnet.com or through Health Net Customer Contact Center. Authorization for use and disclosure of protected health information shall be valid for a period of 30 months from the date of my signature below.

IF SOLE APPLICANT IS A MINOR: If the sole Applicant under this application is under 18 years of age, the Applicant's parent or legal guardian must sign as such. By signing, he or she does hereby agree to be legally responsible for the accuracy of information in this Application and for payments of premiums. If such responsible party is not the natural parent of the Applicant, copies of the court papers authorizing guardianship must be submitted with this Application.

IF APPLICANT CANNOT READ ENGLISH: If an Applicant does not read English, the translator and Applicant must sign and submit the **Statement of Accountability** for translating this entire Application (on page 17, PART VII of this Application).

Applicant Name: _____ Primary Applicant's Social Security Number: _____

Part X: Important Provisions

NOTICE: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health care services plans or insurance companies as a condition of obtaining coverage.

ACKNOWLEDGEMENT AND AGREEMENT: I, the applicant, understand and agree that by enrolling with or accepting services from Health Net, I and any enrolled dependents are obligated to understand and abide by the terms, conditions and provisions of the Insurance Certificate. I, the applicant, have read and understand the terms of this Application and my signature below indicates that the information entered in this Application is complete, true and correct, and I accept these terms.

BINDING ARBITRATION: I, the applicant, understand and agree that any and all disputes or disagreements between me (including any of my enrolled family members or heirs or personal representatives) and Health Net regarding the construction, interpretation, performance or breach of the Health Net Insurance Certificate, or regarding other matters relating to or arising out of my Health Net membership, whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or employees, are also involved, must be submitted to final and binding arbitration in lieu of a jury or court trial. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties, including Health Net, are giving up their constitutional right to the extent permitted by law to have their dispute decided in a court of law before a jury. I also understand that disputes that I may have with Health Net involving claims or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) are also subject to final and binding arbitration. A more detailed arbitration provision is included in the Insurance Certificate. My signature below indicates that I understand the terms of this Binding Arbitration Clause and agree to submit disputes to binding arbitration.

APPLICANT or PARENT OR LEGAL GUARDIAN'S SIGNATURE IF APPLICANT IS UNDER 18 YEARS OLD	Date Signed
SPOUSE/DOMESTIC PARTNER'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

Signatures: The Application and this Arbitration clause must be signed in ink by the Applicant. For this Application to be considered, neither Broker nor any other person may sign this Application and Agreement.

Make personal check payable to "Health Net." Return Completed Application to:

Health Net Individual and Family Enrollment
Post Office Box 1150
Rancho Cordova, California 95741–1150

You may submit a photocopy or facsimile of the Application and Authorizations.
Health Net recommends that you retain a copy of this Application and Authorizations for your records.

All references to "Health Net" herein include the affiliates and subsidiaries of Health Net which underwrite or administer the coverage to which this Enrollment Application applies. " "Insurance Certificate" refers to Health Net Life Insurance Company Explanation of Your Insurance Plan, Health Net PPO Certificate. SafeGuard Health Plans, Inc., SafeHealth Life Insurance Company, Fidelity Security Life Insurance Company and EyeMed Vision Care, LLC are not affiliated with Health Net Life Insurance Company. Obligations under dental and vision plans are not obligations of, and are not guaranteed by, Health Net Life Insurance Company."

Health Net®

Primary Applicant's Social Security Number: _____

Health Net's Pay Option – Monthly Automatic Payment for CA Farm Bureau Members' Health Insurance Program

SIMPLE PAYMENT OPTION (Automatic Bank Draft) ☐ First month's payment ☐ Monthly premium payment (includes first month's premium)

Monthly premium charge can be withdrawn directly from your personal checking or savings account. The premium will be withdrawn from your bank account about ten days in advance of the due date. Please select your account type: ☐ Checking ☐ Savings

Account Holder's Social Security Number	Transit Routing Number	Account Number

Bank Name	State

As a convenience, I request and authorize Health Net to pay and charge to the above account drafts drawn on that account by and payable to the order of "**Health Net**" provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the Premium withdrawn from my account will be for the future bill period plus any past due balances and my first month's withdraw maybe for multiple periods if I did not submit a binder check or due to the timing of the set up. I agree that Health Net's rights in respect to each such draft 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 draft. *(Note: A 30-day notice is required to discontinue this service due to the time required to initiate this change with your bank.)*

Automatic Bank Draft (ABD) transmissions are submitted to the bank approximately the 20th of every month, for the following month's premium.

Your initial premium will be deducted on the day your application is approved by Underwriting.

I further agree that if any such draft be dishonored, with or without cause and whether intentionally or inadvertently, I will be charged a $25 service charge for each occurrence. I understand Health Net shall be under no liability whatsoever even though such dishonor may result in the forfeiture of health coverage.

SIGNATURE of ACCOUNT HOLDER (Required to Process).	Date

CREDIT CARD ☐ First month's payment ☐ Monthly premium payment (includes first month's premium)

Monthly premium charge can be charged directly to your credit card account. The premium will be charged to your credit card account approximately ten days in advance of the due date. Your card will be charged for the first month's premium on the day your application is approved by Underwriting.

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 (mo/year)	***Signature Panel Code**	Cardholder's email address

Billing Address	City	State	**ZIP**[1]

Signature Panel Code can be found on the back of your credit card. This 3 digit code is usually the last three digits located in the signature panel. This information is required in order for the credit card to be processed.

As a convenience, I request and authorize Health Net Life Insurance Company ("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 $25 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