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 Life

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

California Farm Bureau Federation Members' Medicare Supplement plans

Application for Medicare

Please follow the instructions so that we can process your application quickly.

ELIGIBILITY REQUIREMENTS

TO BE ELIGIBLE FOR A HEALTH NET LIFE INSURANCE COMPANY (HNL) MEDICARE SUPPLEMENT PLAN, PROPOSED INSUREDS MUST SATISFY THE FOLLOWING REQUIREMENTS*:

- Be eligible under Medicare and have applied for Medicare Parts A and B; and
- Be a member of a County Farm Bureau of the California Farm Bureau Federation and its Rural Health Department; and
- Not be concurrently insured under any other California Farm Bureau Federation service to member health insurance program; and
- Be an individual age 65 or older who, on the effective date of a Medicare Supplement Plan, is not insured under HNL's Master Group Policy No. AC0601, or be an individual under age 65 who is disabled and has Medicare Parts A & B.

*Coverage is subject to HNL's approval of this Application.

NOTICE

IN ACCORDANCE WITH FEDERAL REGULATIONS, PROPOSED INSUREDS CANNOT, EVEN IF OTHERWISE ELIGIBLE, APPLY FOR A MEDICARE SUPPLEMENT PLAN IF THEY HAVE ANY OTHER MEDICARE SUPPLEMENT COVERAGE, AND DO NOT INTEND TO REPLACE SUCH COVERAGE WITH ONE OF HNL'S MEDICARE SUPPLEMENT PLANS.

Health Net®
LIFE INSURANCE COMPANY

County Farm Bureau Application For Membership

Residence or Business County	Dues Enclosed	Current/Previous Member#
	$ ❑ Voting ❑ Sustaining	___ ___ ___ ___ ___ ___ ___

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

Address

City	State	Zip Code

Telephone Numbers

Home: ( ) _____ Business: ( ) _____

Date of Birth (mm /dd / yy)

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

Health Net®
LIFE INSURANCE COMPANY

Medicare Supplement Plan Application

Underwritten by Health Net Life Insurance Company

Home Office Use: Date Received

HNL USE ONLY

_____ Approved by | _____ Date | _____ Plan Effective Date | _____ Certificate No.

A. AS A MEMBER OF THE CALIFORNIA FARM BUREAU FEDERATION, I APPLY FOR MEDICARE SUPPLEMENT INSURANCE BASED ON THE FOLLOWING REPRESENTATIONS:

Applicant(s) (Please Print):

Primary Name _____ Sex: M ☐ F ☐

Spouse/Registered Domestic Partner(RDP) Name _____ Sex: M ☐ F ☐

Mailing Address _____

Billing Address (If Different) _____

Member Social Security # _____-_____-_____ Spouse/RDP Social Security # _____-_____-_____

Telephone Number _____

Proposed Insureds:

Primary _____ D.O.B. _____/_____/_____

Spouse/RDP _____ D.O.B. _____/_____/_____

Date First enrolled in:	
Medicare Part "B"	Medicare Part "D"
_____/_____/_____	_____/_____/_____
_____/_____/_____	_____/_____/_____

B. PLEASE COMPLETE THE MEDICARE INFORMATION:

Prior or Current HNL Certificate Number (if any): _____

C.F.B.F. Membership Number: _____ County: _____

Primary Medicare # _____ Spouse Medicare # _____

(# from your Medicare Card. Include alpha letters)

Plan: ☐ A ☐ C ☐ F ☐ F+ (High Ded.) ☐ J*

Effective Date Requested: _____/ 01 /_____

C. PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

- You may not have more than one Medicare Supplement plan.
- If you are age 65 or older, you may be eligible for benefits under Medi-Cal or Medicaid and may not need a Medicare Supplement plan.
- Benefits and premiums under your Medicare Supplement plan may be suspended during your entitlement to Medi-Cal or Medicaid for up to 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal or Medicaid. Once you are no longer eligible for Medi-Cal or Medicaid your Medicare Supplement plan will be reinstated without evidence of insurability, if requested within 90 days after losing Medi-Cal or Medicaid eligibility.
- Counseling services are available with a trained insurance counselor. Call Health Insurance Counseling and Advocacy Program (HICAP) office at 800-434-0222. HICAP is a service provided free of charge by the State of California.

D. PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE

1. Do you have any other Medicare Supplement policy or certificate in force? ☐ Yes ☐ No
   a) If Yes, is it with a Preferred Provider Organization (PPO)? Which plan? _____ ☐ Yes ☐ No
   b) If Yes, is it with a Health Maintenance Organization (HMO)? ☐ Yes ☐ No
   c) If Yes, with which company? (d) Effective Date:
2. Do you have any other health insurance policies that provide benefits which this Medicare Supplement plan would duplicate? ☐ Yes ☐ No
   a) If Yes, with which company? (b) What kind of policy?
3. **If the answer to questions 1 or 2 is Yes**, do you intend to replace any of your medical or health insurance coverage policies / certificates with this plan? **(Agent: If Yes, include enclosed form 6014635.)** ☐ Yes ☐ No
4. Are you eligible for or receiving benefits from Medi-Cal or Medicaid? ☐ Yes ☐ No

E. STATEMENT OF HEALTH

NOTE: YOU DO NOT HAVE TO COMPLETE SECTION E IF YOU HAVE FIRST ENROLLED IN PART B OF MEDICARE WITHIN THE PAST 6 MONTHS OR ARE ELIGIBLE UNDER MEDICARE GUARANTEED ISSUE (SEE PAGE 5 AND 6). IF YOU QUALIFY FOR GUARANTEED ISSUE YOU DO NOT NEED TO SIGN THE FORM REQUIRED BY THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996.

1. Applicant's: Height _____ Weight _____ Spouse/RDP (if applying): Height _____ Weight _____

2. Have you been prescribed or taken prescription medication in the last 12 months? ☐ Yes ☐ No
   If Yes, names of medications/drugs you have been prescribed, as well as all medications/drugs you have taken and provide the reason they are taken:

   _____

   _____

   _____

3. Have you, within the past five years,
   - Received medical advice or treatment, or
   - Taken or been prescribed prescription medication, or
   - Been confined for treatment,related to any of the following conditions:

   a. Multiple Sclerosis, Parkinson's, Huntington's Chorea, Alzheimer's, Paralysis, Stroke, Rheumatoid/Psoriatic Arthritis, Bone or Joint Disorders or Replacements, Seizures. ☐ Yes ☐ No

   b. Heart Trouble, High Blood Pressure, Blood Clot/Blood Disorders, Circulation Problems, Leukemia, Irregular Heartbeat. ☐ Yes ☐ No

   c. Liver Disorders, Hepatitis, Ulcerative Colitis. ☐ Yes ☐ No

   d. Kidney Disease or Failure, Chronic Lung Disease, Emphysema. ☐ Yes ☐ No

   e. Diabetes, AIDS or ARC (AIDS Related Complex), Lupus. ☐ Yes ☐ No

   f. Cancer or Malignant Tumors. ☐ Yes ☐ No

   g. Alcoholism or Drug Dependency. ☐ Yes ☐ No

   h. Severe Depression, Schizophrenia, Suicide Attempt, Bipolar Disorder. ☐ Yes ☐ No

4. Have you ever had a pacemaker, or any type of transplant surgery or any type of heart surgery, such as angioplasty or bypass? ☐ Yes ☐ No

5. Have you been bed-ridden, confined to a hospital, nursing home, convalescent hospital or other institution in the past two years? ☐ Yes ☐ No

6. Have you been advised to enter a hospital, nursing home, convalescent hospital or other institution, but have not done so yet? ☐ Yes ☐ No

7. Has a medical professional recommended surgery, diagnostic testing, or medical treatment, but has not yet been done? ☐ Yes ☐ No

Please explain below any "Yes" answers to the above questions.
(If application is being made for more than one person, indicate name of person to whom "Yes" answers apply)

Quest. No.	Person (Name)	Diagnosis and type of treatment/surgery	Name of Doctor, phone #, and complete address

Provide complete name, telephone number and address of personal Doctor for:

Applicant:_____

Spouse/RDP (if applying):_____

F. ACKNOWLEDGEMENT

I [Proposed Insured(s) signing below] hereby apply for a Medicare Supplement Plan, and certify that I have received the "Outline of Medicare Supplement Coverage" and "Guide to Health Insurance for People with Medicare" booklets; and, that I have read, understand and satisfy all of the Eligibility Requirements set forth on the front of this Application.

I understand that:

(1) the insurance applied for will become effective on the effective date of the Certificate of Insurance only if (a) this application is approved by HNL and (b) the full first premium is paid, but not to exceed one month's premium if paid on a monthly basis. I understand that HNL has no obligation on account of this application, although I may have paid premiums thereon, unless a certificate is issued and received by me; and

(2) a copy of this Application will be included with my Certificate of Insurance; and

(3) if this Application is not approved, HNL will promptly refund all premium enclosed with the Application.

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

Signed At (City, State): _____

Applicant Signature	Date	Signature of Spouse (if applying)	Date

Agent Signature	Date	Name of Agent (Print)	Agent No.
		Oleg Skurskiy	W771

Agent Telephone No. 818-654-4548 Agent FAX No. 818-776-9865 E-Mail: oleg@askoleg.c

Send Certificate of Insurance to: ☐ Agent for Delivery ☐ Certificateholder

G. AGENT STATEMENT

I certify that the following list represents all disability (health) policies that I (or my agency) have sold to the Proposed Insureds shown in Section A of this Application. (If None, so state.)

Policies presently in force:	Policies sold in the last 5 years which are no longer in force:

Agent's Signature _____ Date _____

H. AGENT COMMENTS

I. PREMIUM PAYMENT MODE

☐ Monthly by Check.
Please make checks payable to Health Net Life.

☐ Monthly by EFT (Please complete EFT Authorization form below.)

☐ Monthly by Repetitive Credit Card (Fill out credit card information below.)

Monthly Repetitive Credit Card Authorization - By signing below, I request and authorize Health Net to charge my card for monthly recurring premiums on each due date. I understand that the amount may vary as a result of changes I make, such as, but not limited to, adding and deleting dependents, or moving to a new location. The amount may also change as outlined in my Certificate of Insurance. This authorization is to remain in effect until revoked by me by providing Health Net a 30-day written notice. I agree that Health Net shall be fully protected in honoring such card payments. I further agree if any such payment is dishonored, whether with or without cause and whether intentionally or inadvertently, Health Net shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage.

☐ Quarterly by Check.

☐ Semi-annual by Check.

☐ Please charge the total quarterly or semi-annual premium to my credit card including the annual Farm Bureau membership dues.

☐ Please charge only one month's premium to my credit card including the annual Farm Bureau membership dues and bill me the difference for the quarterly or semi-annual premium mode I selected.

J. PREMIUM CALCULATION

Premium - Per Mode $ _____

One-Time Rural Health Department Fee $ 5.00

Total: $ _____

Annual Farm Bureau Dues $ _____

Total Amount Enclosed: $ _____

Make one check payable to Health Net
OR complete the credit card or EFT section below.

Credit Card Information

Credit Card: ☐ VISA ☐ MasterCard

Card No. | | | | | | | | | | | | | | | | |

V-Code | | | | (Last 3 numbers located on the backside of your card in the signature panel.)

Expiration Date: _____

Cardholder's Name (As it appears on the credit card.)

PRINT NAME | DATE

x

Authorized Signature (As it appears on the credit card.)

SIGNATURE | DATE

x

Cardholder's Billing Address

ADDRESS

CITY STATE ZIP

K. AUTHORIZATION FOR ELECTRONIC FUND TRANSFER (EFT) PREMIUM PAYMENT

I authorize HNL to send checks or electronic fund transfer (EFT) notices to my bank or other financial institution each month and charge them against my account. I understand these account charges will pay premiums for the health certificate being applied for, if the certificate is issued. Insurance will become effective only upon approval by HNL and only upon the effective date of the certificate following that approval and acceptance.

I agree that: (a) each such charge shall constitute notice of premiums becoming due the first day of the following month for each charge; and (b) this payment method may be terminated by you or me on 30 days written notice in either case, or immediately by you if a charge is not honored for any reason.

I agree that: my premium will be drafted the 1st business day of each month.

I agree that: (a) my financial institution's rights with respect to each charge shall be the same as if it were personally signed by me; and (b) if any such charge is not honored, whether with or without cause and whether intentionally or inadvertently, my financial institution shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

X_____
DEPOSITOR"S NAME (PRINT)

_____ X_____ X_____
DATE SIGNATURE OF DEPOSITOR (AS SHOWN ON RECORD FOR THE ACCOUNT TO WHICH THIS AUTHORIZATION APPLIES) OTHER SIGNATURE (IF JOINT ACCOUNT)

The initial premium payment authorized by EFT or credit card will occur upon approval of the application. If a monthly payment mode was chosen, then the initial premium charged may be up to two months to bring the account current with the requested billing cycle.

Bank Information: Bank name: _____

Account number: _____

Routing number: _____

Choose one: ☐ Checking ☐ Savings

MEDICARE GUARANTEED ISSUE GUIDE

HNL

Effective January 1, 2007

SCENARIO	OPTIONS	TIME FRAME
Newly Enrolled in Medicare Part B Applicant has Medicare Part A and is newly enrolled or notified retroactively in Part B.	Plans A, C, F, F+ & J*	Application must be received **no later than six (6) months (123 days)** after the date Part B coverage took effect.
Non-Medigap Coverage Termination Applicant enrolled in a Medicare SELECT Plan, a Medicare Advantage Plan or a PACE provider, but coverage was terminated for permitted circumstances, such as: • The carrier lost its' CMS contract, or • The carrier discontinued offering the Plan.	Plans A, C, F, F+ & J*	Application must be received **within 123 days** of the date they lost coverage under any of these plans; however, they may enroll immediately by submitting an application upon receipt of notice of termination from any of these plans.
Employer Plan Termination Applicant is age 65 or older and enrolled in Medicare Part B, and: • received a notice of termination or has been terminated from an employer-sponsored health plan or employer-sponsored retiree health plan. • received notice of termination or loss of eligibility due to divorce or death of a spouse.	Plans A, C, F, F+ & J*	Application must be received **within six (6) months (123 days)** of the date they lost their health coverage under any of these plans.
Moved out of Service Area Applicant was enrolled in a Medicare Supplement Plan, a Medicare Advantage Plan or a PACE provider, and coverage was terminated because they moved outside the plan's service area.	Plans A, C, F, F+ & J*	Application must be received **within six (6) months (123 days)** of the date they lost their health coverage under any of these plans.
Military Base Closure Applicant was a Medicare-eligible military retiree or dependent age 65 or older and coverage terminated due to: • base closure • lost access to coverage because it is no longer offered	Plans A, C, F, F+ & J*	Application must be received **within six (6) months (123 days)** of the date they lost their health coverage.
Termination from a Medicare Advantage Plan Applicant was terminated from Medicare Advantage Plan.	Plans A, C, F, F+ & J*	Application must be received **within six (6) months (123 days)** of the date they lost their health coverage.
HMO Disenrollment in first 12 months Applicant is enrolled in a Medicare Advantage Plan after either: • First becoming eligible for benefits under Medicare Part A at age 65, or • Postponing enrollment in Medicare Part A or Part B after turning age 65 because they were eligible for eligible for employer-sponsored coverage, And then they disenrolled from that Medicare Advantage Plan by not later than 12 months after the effective date of enrollment.	Plans A, C, F, F+ & J*	Application must be received **within 63 days** of the date they canceled any of these plans.
Medigap Disenrollment in first 12 months Applicant disenrolled from a Medicare Supplement Plan to enroll for the first time in a Medicare SELECT, Medicare Advantage Plan or a PACE Provider, and then voluntarily disenrolled within 12 months of coverage.	May re-enroll in either • Plans A, C, F, F+ & J* Or • The Medicare Supplement Plan they had previously, if it is still offered for sale.	Application must be received **within 63 days** of the date they canceled any of these plans.

Employer Plan Change Applicant was enrolled in an employer group health plan that provided health benefits that supplement the benefits under Medicare, but • the employer stopped providing some, all or substantially all plan benefits, and • the employer no longer provides the individual with insurance that covers all of the payment for the Part B 20% coinsurance.	Plans A, C, F, F+ & J*	Application must be received **within 63 days** of the date they lost their coverage.
Medicare Supplement Plan – Coverage Ended Applicant was enrolled in a Medicare Supplement Plan but coverage stopped because: • The company filed for bankruptcy or insolvency, or • The company involuntarily terminated coverage, (does not include termination for fraud or non-payment of premium) or • The company violated a material provision of the plan, or • The company, or an agent acting on its behalf, materially misrepresented a provision of the plan.	Plans A, C, F, F+ & J*	Application must be received **within 63 days** of the date they lost their Medicare Supplement Plan coverage; however, they may enroll immediately by submitting an application upon receipt of notice of termination from the Medicare Supplement Plan.
Benefits Reduced or Cost Sharing Increased Applicant was enrolled in a Medicare Select or a Medicare Advantage provider but: • Benefits were reduced, or • Cost-sharing was increase.	Plans A, C, F, F+ & J*	Application must be received **within 63 days** of the date benefits were reduced or cost-sharing was increased.
Birthday Rule Applicant currently has a **Medicare Supplement Plan**, and the requested effective date with HNL is no later than 30 days after their last birthday.	Plan of equal or lesser benefit than their current plan.	Application must be received **no later than 30 days** after their last birthday.

ALL SCENARIOS APPLY TO UNDER AGE 65 DISABLED APPLICANTS
DISABLED APPLICANTS TURNING AGE 65 START OVER WITH THE GUARANTEED ISSUE RULES

Definitions

- Medicare Supplement is health insurance that private insurance companies sell to help fill in the gaps that the original Medicare Plan may not cover.
- **Medigap** is Medicare Supplement Insurance
- By law, individuals have the right to purchase a Medigap plan if they lose certain types of health care coverages.
- Type of Medigap plans available: Plans A, B, C, F, F+, H, I or J is available to eligible individuals regardless of age. Plans H, I & J no longer include a prescription drug benefit. Plan F+ includes an annual deductible. **HNL PLANS INCLUDE A, C, F, F+ & J**
- **Medicare SELECT** is another type of Medigap policy, available only in some states. The standardized plans are offered but with limitation on hospitals and, in some cases, doctors (except emergency)
- **Medicare Advantage** is an HMO plan

HEALTH INSURANCE DISCLOSURE NOTICES

The coverage you and your dependents, if any, are applying for under the California Farm Bureau Federation Members' Health Insurance Program (Members' Program) Medicare Supplement Plan is underwritten by Health Net Life Insurance Company. The Members' Program is not an employee group insurance plan and does not replace any such existing, or previously in-force, group coverage provided by your employer. HNL is not responsible for compliance with any state or federal laws involving employee group health insurance such as the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) and the Employee Retirement Income Security Act (ERISA). (Consult HNL for further information.)

NOTICE OF HEALTH INFORMATION PRACTICES

To provide insurance coverage, we need to obtain health information about you and any other persons proposed for insurance. Some of that information will come from you and some will come from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization.

In certain circumstances, Health Net Life Insurance Company or its reinsurer(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

NOTICE TO APPLICANT OF PERSONAL INFORMATION PRACTICES

Personal non-health information may be collected from persons other than you or other individuals proposed for coverage. Any information which we may have or may obtain about you or any other individuals proposed for coverage will be treated as confidential. However, personal or privileged information collected by us or our agents may, in certain circumstances, be disclosed to third parties like the California Department of Insurance or our affiliates for claims handling, servicing, underwriting or insurance marketing.

You have the right to see any personal information collected by us and can request correction of any inaccuracies. If you would like a description of our information practices and your rights regarding information we collect, please write us at the following address: Health Net Life, P.O. Box 31040, Tampa, FL 33631.

FAIR CREDIT REPORTING NOTICE

If we use an independent reporting agency for a report, you have the right to be personally interviewed by them. If you wish to be interviewed, please tell us how the agency can contact you and every effort will be made to interview you. Even if you are not interviewed, you have the further right to request that the reporting agency provide you with a copy of the report it makes. Write us at the address shown below and we'll give you the name and address of any agency we have used to prepare a report on you so that you can contact them directly to find out more about that report.

If you want a more detailed explanation of our information practices or a copy of our Health Net Life Health Information Privacy Practices Notice, please write to us at:
Health Net Life, P.O. Box 31040, Tampa, FL 33631

BINDING ARBITRATION AND WAIVER OF JURY TRIAL

Any controversy, dispute or claim of any nature, and for any type of damages, arising out of, in connection with, or in relation to this coverage or breach thereof, including, but not limited to any claim based upon contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the California Small Claims Court. Actions for medical malpractice between You and Your provider are not affected by this provision.

Any dispute regarding a claim for damages within the jurisdictional limits of the California Small Claims Court will be resolved in such court.

Every Covered Person and Health Net Life agree to be bound by this arbitration provision and acknowledge that they are each giving up the right to a trial by a court or jury.

The arbitration is begun by the Covered Person making written demand on Health Net Life. The arbitration will be conducted by the American Arbitration Association according to its commercial rules of arbitration. The arbitration shall be held in the state of California.

No arbitrator shall have the power to alter, amend, modify or change any of the terms of this coverage. The arbitration findings and result will be final and binding except to the extent that California law provides for the judicial review of arbitration proceedings.

APPLICANT, PLEASE RETAIN FOR YOUR RECORDS.

PREMIUM RATES

Premium rates for health insurance provided under the Certificate are adjusted for changes in Your and Your spouse's (if any) ages. Adjustments are effective as of the first of the month following Your and/or Your spouse's (if any) birthday if the age change moves the individual in to a new age bracket. Should a change in premium rates be made for any other reason, you will be notified of the effective date which will be at least 30 days from the date of the notice. The change will be made only after at least 30 days' prior notice to You and the Policyholder. Premium adjustments will be reflected in Your premium statements due on or next following the effective date of a rate change.

Health Net®

LIFE INSURANCE COMPANY

Underwritten By Health Net Life Insurance Company

6014633 [10/07]