

# CA Small Manufacturing Health & Welfare Trust Fund

## Application for Employee Benefits

### Effective 6/1/2024 - 5/31/2025 (Rev. 4/3/2024)

**IMPORTANT INSTRUCTIONS:**

Use the attached application for first-time enrollments or changes to medical, dental, and vision benefits. All changes and enrollments outside of Open Enrollment require a Qualifying Life Event. A list of those events is located [HERE](#).

When complete, please email **all pages** of the application to **Vanessa\_Jones@rpadmin.com**

**INSTRUCCIONES IMPORTANTES:**

*Utilice la solicitud adjunta para inscripciones por primera vez o cambios en los beneficios médicos, dentales y de la vista. Todos los cambios e inscripciones fuera de Open Enrollment requieren un Evento de vida calificado. Una lista de esos eventos se encuentra [AQUÍ](#).*

*Cuando esté completo, envíe por correo electrónico las páginas de la solicitud a **AMBAS** direcciones a continuación **Vanessa\_Jones@rpadmin.com***

# CA Small Manufacturing Health & Welfare Trust Fund

Purchaser ID / Company Name:	Enrollment Unit:	Benefit Effective Date:
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## PERSONAL INFORMATION

Last Name:	First Name:	MI:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Address:	Apt #:	City:	State:	Zip:
Date of Hire: (MM/DD/YY)	Home PH#:	Work PH#:	E-Mail Address:	
Date of Birth (MM/DD/YY):	Social Security #:	Job Title:	Salary:	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner	If available, I would prefer to receive plan information and communication in Spanish: <input type="checkbox"/> Yes <input type="checkbox"/> No			

### Reason for Application:

<input type="checkbox"/> New Hire	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Loss of prior coverage Date: _____
<input type="checkbox"/> Re-Hire Date: _____	<input type="checkbox"/> Part-time to Full-Time Employment Date: _____	
<input type="checkbox"/> Family Addition/ Change: _____	Qualifying Event: _____	Qualifying event date: _____
<input type="checkbox"/> COBRA: <input type="checkbox"/> 18 Months <input type="checkbox"/> 29 Months <input type="checkbox"/> 36 Months		
Start Date: _____	End Date: _____	COBRA Event: _____ COBRA Event Date: _____

**If there is other Health Coverage, please list family member, carrier name/group number and effective date**

**PRIOR COVERAGE (PPO PLANS ONLY):** fill out the following information to receive proper credit for previous coverage.

## DEPENDENT INFORMATION

Relation	Coverage <input type="checkbox"/> Medical	NAME (Last, First MI)	SSN	Gender	Date of Birth	Medical HMO: PPG/PCP#	Medical HMO: Current PCP	Dental HMO: Provider #	If children are age 26 or over you must check the appropriate boxes below
Self	<input type="checkbox"/> Dental <input type="checkbox"/> Vision	Same as above	Same as above	Same as above	Same as above		<input type="checkbox"/> Yes <input type="checkbox"/> No		If children are age 26 or over you must check the appropriate boxes below
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			<input type="checkbox"/> Female <input type="checkbox"/> Male			<input type="checkbox"/> Yes <input type="checkbox"/> No		Is Dependent disabled? <small>(documentation required)</small>
Child	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			<input type="checkbox"/> Female <input type="checkbox"/> Male			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Child	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			<input type="checkbox"/> Female <input type="checkbox"/> Male			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Child	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			<input type="checkbox"/> Female <input type="checkbox"/> Male			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Child	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			<input type="checkbox"/> Female <input type="checkbox"/> Male			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

Employee Name: \_\_\_\_\_

SSN \_\_\_\_\_

**MEDICAL ELECTIONS** Enroll Decline

HealthNet	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
HMO Full Network <b>KJI</b> (was JN1)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO Full Network <b>KJL</b> (was JN4)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO ExcelCare <b>KH7</b> (was JPS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO ExcelCare <b>KHG</b> (was JPY)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO ExcelCare <b>KHI</b> (was JQ0)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO ExcelCare <b>KHM</b> (was JQ4)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO Salud Y Mas - <b>KDN</b> (was JON)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO Salud Y Mas - <b>KE4</b> (was JPB)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO SmartCare <b>KGP</b> (was JLP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO SmartCare <b>KGT</b> (was JLT)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO SmartCare <b>KGZ</b> (was JLY)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO SmartCare <b>KH2</b> (was JM1)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PPO - <b>KFB</b> (was JQL)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PPO - <b>KFC</b> (was JQM)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PPO - HSA <b>KFD</b> (was JQN)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PPO - HSA <b>KFK</b> (was JQT)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have other health care coverage? \_ Yes \_ No If "Yes", complete the following:

Name of insurance carrier: \_\_\_\_\_ Prior coverage start date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**THE 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, DBP and/or Fidelity. Health Net, DBP and/or Fidelity use 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 provides members with a Notice of Privacy Practices that describes how it uses and discloses protected health information; the individual's rights to access and to request amendments, restrictions and an accounting of disclosures of protected health information; and the procedures for filing complaints. Health Net's Notice of Privacy Practices is included in the Evidence of Coverage or Certificate of Insurance for coverage underwritten by Health Net. I may also obtain a copy of this notice on the website at [www.healthnet.com](http://www.healthnet.com) or through the Health Net Customer Contact Center.

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

**ACKNOWLEDGMENT AND AGREEMENT:** I understand and agree that by enrolling with or accepting services from Health Net, DBP and/or Fidelity, I and any enrolled dependents are obligated to understand and abide by the terms, conditions and provisions of the Plan Contract or Insurance Policy. I 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 to the best of my information and belief, and I accept these terms.

**BINDING ARBITRATION AGREEMENT:** I, the Applicant, understand and agree that any and all disputes between me (including any of my enrolled family members or heirs or personal representatives) and Health Net must be submitted to final and binding arbitration instead of a jury or court trial. This Agreement to arbitrate includes any disputes arising from or relating to the Evidence of Coverage or Certificate of Insurance or my Health Net membership or coverage, stated under any legal theory. This agreement to arbitrate any disputes applies even if other parties, such as health care providers or their agents or employees, are involved in the dispute. 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 have their dispute decided in a court of law by a jury. I also understand that disputes that I may have with Health Net involving claims for 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. I understand that a more detailed arbitration provision is included in the Evidence of Coverage or Certificate of Insurance. Mandatory Arbitration may not apply to certain disputes if the Employer's

plan is subject to ERISA, 29 U.S.C. §§ 1001-1461. My signature below indicates that I understand and agree with the terms of this Binding Arbitration Agreement and agree to submit any disputes to binding arbitration instead of a court of law.

I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE (THAT IS, AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR CLAIMS SUBJECT TO ERISA, BETWEEN MYSELF AND MY DEPENDENTS ENROLLED IN THE PLAN (INCLUDING ANY HEIRS OR ASSIGNS) AND UNITEDHEALTHCARE OF CALIFORNIA, UNITEDHEALTHCARE OR ANY OF ITS PARENTS, SUBSIDIARIES OR AFFILIATES, SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS THE FEDERAL ARBITRATION ACT PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. ALL PARTIES TO THIS AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHTS TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

### **Declination Acknowledgement**

The available coverages have been explained to me. I have been given the chance to apply for the available coverages. I have decided not to enroll myself and/o my dependent(s) in the following coverage:

	<b>Medical</b>
Employee	<input type="checkbox"/>
Spouse	<input type="checkbox"/>
Child(ren)	<input type="checkbox"/>

**By declining coverage, I acknowledge that my dependents and I may have to wait to be enrolled until the next Open Enrollment Period or qualifying event.**

Employee Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Employee Name: \_\_\_\_\_

SSN \_\_\_\_\_

**DENTAL PPO ELECTIONS**

Enroll

Decline

MetLife	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
PPO - High Option	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PPO - Low Option	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**DENTAL DHMO ELECTIONS**

Enroll

Decline

MetLife	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
HMO High Option (MET 85)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO Low Option (MET 185)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Declination Acknowledgement**

The available coverages have been explained to me. I have been given the chance to apply for the available coverages. I have decided not to enroll myself and/or my dependent(s) in the following coverage:

	Dental
Employee	<input type="checkbox"/>
Spouse	<input type="checkbox"/>
Child(ren)	<input type="checkbox"/>

By declining coverage, I acknowledge that my dependents and I may have to wait to be enrolled until the next Open Enrollment Period or qualifying event.

Employee Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Employee Name: \_\_\_\_\_ SSN \_\_\_\_\_

**VISION ELECTIONS**

**Enroll**

**Decline**

MetLife (VSP)	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
MetLife (VSP) High Option	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MetLife (VSP) Low Option	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Declination Acknowledgement**

The available coverages have been explained to me. I have been given the chance to apply for the available coverages. I have decided not to enroll myself and/or my dependent(s) in the following coverage:

	Vision
Employee	<input type="checkbox"/>
Spouse	<input type="checkbox"/>
Child(ren)	<input type="checkbox"/>

By declining coverage, I acknowledge that my dependents and I may have to wait to be enrolled until the next Open Enrollment Period or qualifying event.

Employee Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

**EMPLOYEE ELECTION CONFIRMATION- SIGNATURE REQUIRED**

**Employee Authorization**

Each person signing below declares that all information given in this enrollment form is true and complete to the best of his/her knowledge and beliefs. Each person understands that this information will be used to determine his/her eligibility.

I understand that these elections cannot be changed during the plan years unless I experience a qualified life event as outlined in employer benefit plan documents. Qualified life events that may change my benefit elections must be reported to the Benefits Administration within 30 days of the event.

Employee Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card, or employer group applicants please call Health Net's Commercial Contact Center at 1-800-522-0088. Individual & Family Plan (IFP) applicants please call 1-877-609-8711. For more help: If you are enrolled in a PPO or EPO insurance policy underwritten by Health Net Life Insurance Company, call the CA Dept. of Insurance at 1-800-927-4357. If you are enrolled in a HMO or HSP plan provided by Health Net of California, Inc., call the DMHC Helpline at 1-888-HMO-2219. Your ID card indicates whether your plan was issued by Health Net Life Insurance Company or Health Net of California, Inc.

**English**

Servicios de Idiomas Sin Costo. Usted puede solicitar un interprete. Puede solicitar que se le lean los documentos y que algunos de ellos se le envíen en su idioma. Para obtener ayuda, llámenos al numero que aparece en su tarjeta de identificación; los solicitantes de grupo de empleadores deben llamar al Centro de Comunicación Comercial de Health Net al 1-800-522-0088. Los solicitantes de Plan Individual y Familiar (por sus siglas en ingles, IFP) deben llamar al 1-877-609-8711. Para obtener mas ayuda: Si esta inscrito en una póliza de seguro PPO o EPO asegurada por Health Net Life Insurance Company, llame al Departamento de Seguros de CA al 1-800-927-4357. Siesta inscrito en un plan HMO o HSP proporcionado por Health Net of California, Inc., llame a la Linea de Ayuda del Departamento de Cuidado Medico (por sus siglas en ingles, DMHC) de California al 1-888-HMO-2219. Su tarjeta de identificación indica si su plan fue emitido por Health Net Life Insurance Company o Health Net of California, Inc.

**Spanish**

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**Chinese**

Djch Vn ngon ngu mien phi. Quy vi c6 the duqc cap thong djch vien va ngubi d9c giup cac tai li u bang ngon ngu cua quy Vi cho quy tj. De duqc trq giup, vui long g9i cho chung toi theo so di n tho<ali ghi tren the hQi vien cua quy tj; nguai ghi danh theo nh6m cua hang SO xin g9i Trung tam Lien l<alc Thuong m<ali cua Health Net theo so 1-800-522-0088. Ngubi ghi danh theo Chuong trinh bao hiem danh cho CA nhan va gia dinh (Individual and Family Plan, IFP) xin g9i so 1-877-609-8711. De duqc trq giup bo tuc: Neu quy Vi ghi danh trong cac hqp dong bao hiem PPO ho c EPO do Health Net Life Insurance Company cam ket tai trq, vui long g9i B9 Bao hiem cua California theo so 1-800-927-4357. Neu quy tj ghi danh trong chuong trinh bao hiem HMO ho c HSP do Health Net of California, Inc. cung cap, xin g9i Dubng day trq giup cua DMHC theo so 1-888-HMO-2219. Tren the hQi vien cua quyvi c6 ghi ro chuong trinh bao hiem cua quyvi la do Health Net Life Insurance Company hay Health Net of California, Inc. cung cap.

**Vietnamese**

£ 2!07 :X:I\$ A-HJl :..... £ N A-HJl :..... Ol el ¥Oli )jl 2J- 2!07.s:'. Al AltJl :..... 4" \$LI Cf.301 .2of6J ¥g g2\_! ID3f.C.: OII 'E 2..I-LHti.2.s:'. 2foH -<?-GJAl.2. ....i -<? :J.J. Jfgj 61 :X:f'a Si2 Health Net gj (Commercial) :...zli AltJl :..... E., 2..I-LHti.2 1-800-522-0088.i:L .s:'. 2foH -<?-GJAl.2. JH2.1 Jf EH (IFP) Jfgj 61 :X:f'ag 2..I-LHti.2 1-877-609-8711ti .s:'. 2foH -<?-GJAl.2. [7 '2,-1-g 301 f?.of Al I:'.! 0 :l1 of Jf Health Net Life Insurance Company Jf 2.14"2J- PPO :f 'E EPO .il.gj cl Al Oli Jfgj of 6J Si2, cl .!Li Of .il.gj (CA Dept. of Insurance), 2..I-LH tti.2 1-800-927-4357ti .s:'.§ of-QJ Al.2. 0 :l1 of Jf Health Net of California, Inc.Oli Al J.:l1 of E HMO :f 'E HSP EH Oli Jfgj of 6J Si2, .il.:z! ti' cl (DMHC) E.2.f 2.1, 2..I-LH tti.2 1-888-HMO-2219ti .s:'.§ of-QJ Al.2. :i:l of ID 3f.C.: Oli :i:l of EH 01 Health Net Life Insurance Company OII Al J.:l1 E:X:l lf 'E Health Net of California, Inc.Oli Al J.:l1 £l 'E:X:l 23 Al £l0, \$LI Cf.

**Korean**

U.u-1\_£u.ir ll,qi-1\_1-141-1-11.i Uu.inu.ijnLfcJjnLUUhp: 'tnq1 4u.irm' h-11 pu.iuu.ii-1\_nr fcJu.ipq.uu.ii <lh-11 phrhl L. lpUIUUIU1fctJ.fcJhr ufcJhpgJl UIUIL .!thr thqi-1\_ni-1\_ : Oq.umfcJjUIU C.u.iuu.ir uhq qu.iuq.u.iC.u.iph-11 9hr ru-111.inLfcJjUIU (ID) u,nuur i-1.ru.i uzi-1\_u.io- C.u.iuu.ipni-1\_ 4u.iu hfCJh q.npo-u.iu.ppi fuupr '1-runrri- h-11, fuu'l-rmLU hu-111-800-522-0088 C.u.iuu.ipni-1\_ qu.iliq.u.iC.u.irhL Health Net-r 2.u.ifu.ifunr'l-r liu.iu.ir lihuu.pnu: U.u.C.u.u,1-1-141-1-11.i L. Cuu,u.iuh4u.iu Upu.iq.rr (Individual and Family Plan/IFP) '1-runr'l-uhppg fuu'l-r-1.mu t qu.iuq.u.iC.u.irhL 1-877-609-8711 C.u.iuu.ipni-1\_ : Lru.igmgrL oq.umfcJjUIU C.u.iuu.ir' 1-800-927-4357 C.u.iuu.ipni-1\_ qu.iuq.u.iC.u.iph-11 liu.itri:>nruru.ilr U.u.iu.iC.ni-1\_u.iq.pnLfcJjUIU P.u.icfu.iuunLU.Jl (CA Dept. of Insurance), hfCJh q.pu.iligi-1\_ht h-11 PPO 4u.iu EPO Uil-ljUIC.ni-1\_u.iq.ru.i4u.ili Uil-ljUIC.ni-1\_u.iq.rr, nrr 4rntJ.U t Health Net Life Insurance Company-u: bfcJh q.pu.iligi-1\_ht h-11 HMO 4u.iu HSP o-pu.iq.pnLU, nrr UUIU1U14u.ipu.ipu t Health Net of California, Inc.- , 1-888-HMO-2219 C.u.iuu.ipni-1\_ qu.iuq.u.iC.u.iph-11 DMHC-r Oq.umfcJjUIU <l\_o-pu: 9hr ru-111.inLfcJjUIU u,nuu uzmu t, fcJh ni-1\_ t felntJ.Ulr4hL 9hr o-pu.iq.rr ' Health Net Life Insurance Company-u, fclh" Health Net of California, Inc.- :

**Armenian**

EecnaTHble ycnynr nepeBop;a. Bbl MO)KeTe BOCnOnb30BaTbCJlycnyraM11 nepeBop;q11Ka,11 BaM MOryT npoq11TaTb p;oKyMeHTbl Ha BallieM J13b1Ke. Ecmr BaM Tpe6yeTCJl noMOII.\b, 3BOHJ1Te HaM no HOMepy TenecoHa, yKa3aHHOMY Ha Balliet: 11p:eHT11<p11KaJl,110HHOH KapTe. YqacTH11K11 nnaHa rpyrnoBoro CTpaxoBaH11JI no MeCTy pa6oTbl MoryT o6paT11TbCJlB KoMMepqek111t: KOHTaKTHb1H 11,eHTp KOMnaH1111 Health Net (Commercial Contact Center) no TenecoHy 1-800-522-0088. YqacTH11K11 nnaHOB 11Hp;11B11p;yanbHOro 11 ceMett:Horo cTpaxoBaH11JI (Individual and Family Plan, IFP), no)Kanyii:CTa, 3BOH11Te no HOMepy 1-877-609-8711. ,D;nJl nonyqeH11JI p;ononH11TenbHOH noMOII;\11: ecn11 y Bae CTpaxoBow non11c OpraH113a11,1111 c npep;noqT11TenbHb1M11 nocTaBII.\11KaM11 ycnpr (Preferred Provider Organization, PPO) 11n11 OpraH113a11,1111c o6J13aTenbHb1M11 nocTaBII.\11KaM11 ycnpr (Exclusive Provider Organization, EPO), KoTOpbrt: npep;ocrnBnJieTcJlJ KOMnaH11eii: Health Net Life Insurance Company, o6pall.\att: Tecb B .D;enapnMeHT CTpaxOBAH11JI liTaTa Kan11cpoH11JI (CA Dept. of Insurance) no TenecoHy 1-800-927-4357. Ecn11 Bbl 3aper11CTp1111poBaHb1 B nnaHe HMO 11n11 HSP, KoTOpbrt: npep;ocTaBneH KOMnaH11eii: Health Net of California, Inc., 3BOH11Te Ha TenecoH fopJieft n11H1111 .D;enapnMeHTa opraH1130BaHHo Mep;1111,11HcKopo 06ncy)K11BaH11JI(DMHC Helpline) no HOMepy 1-888-HMO-2219. Ha Balliew 11p:eHT11<p11KaJl,110HHOH KapTe yia3aHo, 6bm n11Balli nnaH ocpoMneH KOMnaH11eii: Health Net Life Insurance Company 11n11 KOMnaH11eii: Health Net of California, Inc.

**Russian**

1!£f3J(-7) !t-tl- ,.Ao Ss:J:!(7)ifilRiJ,If li:a:!!31m7:f. L \* -t- -ti- ,.a :a =:,Th"(7)771:t, ID JJ- F11ctG(7):m:% \* c'::!3f" j.ïf v-ff <tc v'offl-tflsflf;js:7°7 .,., (7)1JQA:a:t3\$ibJi.(7)7J/i, Health Net(1)B;F"i :...JJ -7 l- •t :.,,JJ-, 1-800-522-0088\* --C:!!3ffi:t<tc v'O -@)J) • %- 7°7:., (IFP),(7)1JQA:a:t3\$Jbj.(7)7J/i, 1-877-609-8711\*--C:t3ffi:§5<tc v'O Gf;:..mj:)JiJ,£, tctmif, Health Net Life Insurance CompanyiJ, [ljl: fo:5! \$t t±c1: ft g PPO\* 1:./iEPO{,jl: §:if; lJ Y-f;: =:JQA,(7)7J/i, 7J lJ7;tJv:..71'1'1{ljl: fo:n\ 1-800-927-4357 \* --C =:':t <tc v'O Health Net of California, Inc.iJ,t'f:f:tT gHMO\* tcf'iHSP7°7 .,.,f;:\_ =:1JQA(7)7Jfi, 7J lJ7;t;v:..71'Wf12s: IT (DMHC) (./)A-Jv:1'7-f:.,., 1-888-HMO-2219\*--C =:':if <tc v'° .:!!3 (7)7°7:.,,(7) 1T-tfiJ,Health Net Life Insurance Company \* tc/iHealth Net of California, Inc.(7)fi:J G --C&> Q7J>'i, IDJJ- )<f;:..13c, ;11,"(1,\* T.

**Japanese**

خدمات یی هزینہ مربوط بہ زبانی می تونید از خدمات یک مترجم شفاهی برخوردار شده و بگوئید تا نوشته ها به زبان خودتان برایتان خوانده شوند. برای دریافت کردن کمک، ما با از طریق شماره تلفنی که روی کارت شناسایی شما قید شده است تماس بگیرید، و یا متقاضیان گروه کارفرمایان لطفاً با مرکز تجاری تماس Health Net به شماره 1-800-522-0088 تماس بگیرید. متقاضیان "طرح افراد و خانواده ها" (IFP) لطفاً به شماره 1-877-609-8711 تلفن کنند. برای دریافت کمک بیشتر: اگر برای یک بیمه نامه PPO یا EPO که توسط Health Net Life Insurance Company تضمین شده است ثبت نام کرده اید، به اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تلفن کنید. اگر در یک طرح HMO یا HSP که توسط Health Net of California, Inc. فراهم شده است ثبت نام میکنید، به خط کمکی DMHC به شماره 1-888-HMO-2219 تلفن کنید. کارت شناسایی تان نشان میدهد که آیا طرح شما توسط Health Net Life Insurance Company صادر شده است یا Health Net of California, Inc.

**Farsi**

Walang Gastusin na Mga Serbisyo sa Wika. Maaari kang kumuha ng interpreter at basahin sa iyong wika ang mga dokumento. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card, o para sa mga aplikante ng pangkat ng employer, mangyaring tawagan ang Commercial Contact Center ng Health Net sa 1-800-522-0088. Para sa mga aplikante ng Individual & Family Plan (IFP), mangyaring tumawag sa 1-877-609-8711. Para sa karagdagang tulong: Kung naka-enroll ka sa isang insurance policy ng PPO o EPO na napapailalim sa Health Net Life Insurance Company, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Kung naka-enroll ka sa isang plano ng HMO o HSP na ipinagkakaloob ng Health Net of California, Inc., tawagan ang DMHC Helpline sa 1-888-HMO-2219. Isinasaad ng iyong ID card kung ang iyong plano ay ibinigay ng Health Net Life Insurance Company o Health Net of California, Inc.

**Tagalog**

Keypab Lus Tsis Muaj Nqi Them. Koj txais tau tus neeg txhais lus thiab muab tau cov ntawv los nyeem rau koj ua koj hom lus. Kom tau keypab, hu rau peb ntawm tus xovtooj sau rau koj daim npav ID, lossis cov tib neeg yuav thov keypab tom chaw haujlwm thov hu rau Health Net Lub Chaw Pab Cov Tib Neeg Siv Cov Key Pab (Customer Contact Center) ntawm 1-800-522-0088. Cov neeg thov keypab hauv pawg Tus Kheej & Tsev Neeg (Individual and Family Plan; IFP) thov hu rau 1-877-609-8711. Yog xav tau keypab ntawv: Yog koj muaj npe nkag nrog PPO lossis EPO cov kev tuav pov hwm los ntawm Health Net Life Insurance Company, hu rau CA Qhov Chaw Saib Xyuas Txog Kev Tuav Pov Hwm (Dept. of Insurance) ntawm 1-800-927-4357. Yog koj muaj npe nkag nrog ib qho kev npaj pab HMO lossis HSP uas los ntawm Health Net of California, Inc., hu rau DMHC Tus Xovtooj Muab Key Pab ntawm 1-888-HMO-2219. Koj daim npav ID yuav qhia tau tias koj qhov kev npaj pab yog los ntawm Health Net Life Insurance Company lossis Health Net of California, Inc.

**Hmong**

Doo Bqah 'Alinígóó Saad Bee 'áka'anida'awo'ígíí. 'Ata' halne'í dóó naaltsoos bee 'éédahozinígíí t'áa ni nizaad bee hadadilyaago nich'í' yidóoltah. 'Áka'a'eyeed biniiyégo, ninaaltsoos nitl'izi bee nééhozinígíí bine'déé' béésh bee haneí biká'ígíí bee nich'í' hodíilnih, doodago ninaalishí bíl hada'dil'ínígíí t'áa shqodí Health Net Commercial Hane' 'Íí'íh Bíl Haz'ánijí' 1-800-522-0088 hodíilnih. Lá' Jizíh dóó Hooghan Haz'áagi Naaltsoos Hadadít'éhígíí (IFP) hada'dile'ígíí t'áa shqodí kohjí' 1-877-609-8711 hodíilnih. T'áa náásgóó 'áka'a'eyeed biniiyégo: PPO doodago EPO béeso 'ách'áqáh naa'nil bíbeé haz'ánii Health Net Life Insurance Company, bich'í' haidíilaagíí bíl ha'dít'éhígíí bíl ha'diléehgo, CA Dept. béeso 'ách'áqáh naa'nil bíl haz'ánígíí bich'í' kohjí' 1-800-927-4357 hodíilnih. Health Net of California, Inc. biyaadóó HMO doodago HSP bíl ha'dít'éhígíí bíl ha'diléehgo, DMHC 'Áka'aná'awo' Bíl Haz'ánígíí kohjí' 1-888-HMO-2219 hodíilnih. Health Net Life Insurance Company doodago Health Net of California, Inc. bíl naaltsoos bíl náha'dít'éhígíí ninaaltsoos nitl'izi bine'déé' bikáá'.

**Navajo**

ਭਾਸ਼ਾ ਦੀਆਂ ਮੁਢਲੀ ਸੇਵਾਵਾਂ। ਤੁਹਾਨੂੰ ਦੁਬਾਰੀਆਂ ਮਿਲ ਸਕਦਾ ਹੈ ਅਤੇ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈ ਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ, ਜਾਂ ਇੰਪਲਾਇਰ ਗਰੁੱਪ ਦੇ ਅਰਜ਼ੀਦਾਰ ਕਿਰਪਾ ਕਰਕੇ Health Net ਦੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ 1-800-522-0088 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਯੋਜਨਾ (IFP) ਵਾਲੇ ਅਰਜ਼ੀਦਾਰ ਕਿਰਪਾ ਕਰਕੇ 1-877-609-8711 ਨੰਬਰ ਤੇ ਸੰਪਰਕ ਕਰੋ। ਹੋਰ ਮਦਦ ਲਈ: ਜੇ ਤੁਸੀਂ Health Net Life Insurance Company ਵਲੋਂ ਜਾਰੀ ਕਿਸੇ PPO ਜਾਂ EPO ਬੀਮਾ ਪਾਲਿਸੀ ਲਈ ਨਾਂ ਲਿਖਵਾਇਆ ਹੈ ਤਾਂ ਕੈਲੀਫੋਰਨੀਆ ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ 1-800-927-4357 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਜੇ ਤੁਸੀਂ Health Net of California, Inc. ਵਲੋਂ ਮੁਹੱਈਆ ਕੀਤੀ ਗਈ ਕਿਸੇ HMO ਜਾਂ HSP ਯੋਜਨਾ ਲਈ ਨਾਂ ਲਿਖਵਾਇਆ ਹੈ ਤਾਂ DMHC ਦੀ ਹੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਤੁਹਾਡੇ ਆਈ ਡੀ ਕਾਰਡ ਤੇ ਦਿਖਾਇਆ ਗਿਆ ਹੈ ਕਿ ਤੁਹਾਡੀ ਯੋਜਨਾ Health Net Life Insurance Company ਵਲੋਂ ਜਾਰੀ ਕੀਤੀ ਗਈ ਸੀ ਜਾਂ Health Net of California, Inc. ਵਲੋਂ।

**Punjabi**

សេវាបង្កើតឡើងសម្រាប់ជនមានជំនួយ។ អ្នកអាចទទួលបានជំនួយសម្រាប់ការស្រាវជ្រាវ និងផ្តល់ជំនួយសម្រាប់ការស្រាវជ្រាវខ្លួនអ្នកជាភាសាខ្មែរបាន។ សំរាប់ព័ត៌មាន សូមទូរស័ព្ទមកលេខ 1-800-522-0088 តាមលេខ 1-800-522-0088។ អ្នកជាប់ការស្រាវជ្រាវសំរាប់ការស្រាវជ្រាវ និងផ្តល់ជំនួយសម្រាប់ការស្រាវជ្រាវខ្លួនអ្នកជាភាសាខ្មែរបាន។ សំរាប់ព័ត៌មានលម្អិត : បើអ្នកមានលេខសម្រាប់ការស្រាវជ្រាវសំរាប់ការស្រាវជ្រាវ PPO ឬ EPO បានជាភាសាខ្មែរសម្រាប់ការស្រាវជ្រាវ Health Net Life Insurance Company ទូរស័ព្ទទៅត្រូវស្តាប់ ជាភាសាខ្មែរសម្រាប់ការស្រាវជ្រាវ HMO ឬ HSP ដែលបានផ្តល់ជំនួយ Health Net of California, Inc.។ ទូរស័ព្ទទៅលេខ 1-800-927-4357។ បើអ្នកមានលេខសម្រាប់ការស្រាវជ្រាវ HMO ឬ HSP ដែលបានផ្តល់ជំនួយ Health Net of California, Inc.។ ទូរស័ព្ទទៅលេខ 1-888-HMO-2219។ ប័ណ្ណ ID របស់អ្នក បញ្ជាក់ពីការស្រាវជ្រាវរបស់អ្នកបានផ្តល់ជំនួយ Health Net Life Insurance Company ឬ Health Net of California, Inc.។

**Khmer**

الخدمات اللغوية المجانية: يمكنك الحصول على مترجم فوري للمساعدة في قراءة مستنداتك باللغة التي تتحدث بها. للحصول على المساعدة يرجى الاتصال بنا على الرقم الموضح على بطاقة التعريف الخاصة بك، أو إذا كنت من مقدمي الطلبات من الموظفين يرجى الاتصال بمركز التواصل مع العملاء لدى Health Net على الرقم 1-800-522-0088. بالنسبة لمقدمي طلبات خطة الفرد والأسرة (IFP)، يرجى الاتصال على الرقم 1-877-609-8711. للحصول على المزيد من المساعدة: إذا كنت مسجلاً في سياسة التأمين بخطة PPO أو EPO التي تكتسبها شركة التأمين على الحياة Health Net Life Insurance Company، يرجى الاتصال بـ CA Dept. of Insurance (وزارة التأمين بولاية كاليفورنيا) على الرقم 1-800-927-4357. إذا كنت مسجلاً في خطة HMO أو HSP التي توفرها شركة Health Net of California, Inc.، يرجى الاتصال بخطة المساعدة لدى DMHC على الرقم 1-888-HMO-2219. توضح بطاقة التعريف الخاصة بك ما إذا كان تم إصدار خطتك عبر شركة التأمين على الحياة Health Net Life Insurance Company أو شركة Health Net of California, Inc.

**Arabic**

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# California Small Manufacturing Health & Welfare Trust

Num. Identificación / Nombre de Empresa:	Unidad:	Fecha de vigencia:
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## Información Personal

Apellido:	Nombre:	MI:	<input type="checkbox"/> M	<input type="checkbox"/> F
Dirección:		Apt #:	Ciudad:	Estado: Código postal:
Fecha de contratación: (MM/DD/AAAA)	Num. de teléfono principal	Num Tel Trabajo#:	Correo Electrónico:	
Fecha de nacimiento (MM/DD/AAAA):	Seguro Social #:	Título:	Salario:	
Estado Civil: <input type="checkbox"/> Soltero <input type="checkbox"/> Casado <input type="checkbox"/> Vive in paraje		Si está disponible, yo preferiría la información en Español: <input type="checkbox"/> Si <input type="checkbox"/> No		

**Tipo de solicitud:**

Inscripción Nueva                       Inscripción Abierta                       Pérdida de cobertura (fecha): \_\_\_\_\_

Fecha de Reconstrucción: \_\_\_\_\_     Fecha de medio tiempo a tiempo completo: \_\_\_\_\_

Agregar Familia/ Cambios: \_\_\_\_\_    Evento calificado: \_\_\_\_\_    Fecha de el evento: \_\_\_\_\_

COBRA:  18 Meses     29 Meses     36 Meses

Fecha de inicio: \_\_\_\_\_    Fecha Final: \_\_\_\_\_    Evento de COBRA: \_\_\_\_\_    Fecha de COBRA: \_\_\_\_\_

**Si hay otra cobertura de salud, favor de escribir el nombre su familia, el nombre y numero de poliza de la compania y fecha**

Nombre	Relación	Nombre de Aseguradora	# de Grupo	Fecha de vigencia	Primario
					<input type="checkbox"/> Si <input type="checkbox"/> No
					<input type="checkbox"/> Si <input type="checkbox"/> No

**Cobertura Anterior (Solo Planes PPO):** Complete la siguiente información para recibir crédito apropiado para la cobertura anterior.

Nombre	Fecha de cobertura	Fecha de Fin de cobertura	Nombre de Aseguradora	Rason por terminar cobertura

## Información de Dependiente

Relación	Cobertura	Nombre (Apellido, Nombre)	SSN	Genero	Fec. De. Nac.	Medico HMO: Proveedor #	Medico HMO: Actual PCP	Dental HMO Proveedor #	Si sus hijos son mayores de 26, debe marcar la casilla apropiada abajo.
<input type="checkbox"/> Medical									
Yo	<input type="checkbox"/> Dental <input type="checkbox"/> Vision	Igual que arriba	Igual que arriba	Igual que arriba	Igual que arriba			<input type="checkbox"/> Si <input type="checkbox"/> No	la casilla apropiada abajo.
<input type="checkbox"/> Cónyuge <input type="checkbox"/> Pareja Domestica	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			<input type="checkbox"/> F <input type="checkbox"/> M				<input type="checkbox"/> Si <input type="checkbox"/> No	
Hijo	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			<input type="checkbox"/> F <input type="checkbox"/> M				<input type="checkbox"/> Si <input type="checkbox"/> No	<input type="checkbox"/> Si <input type="checkbox"/> No
Hijo	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			<input type="checkbox"/> F <input type="checkbox"/> M				<input type="checkbox"/> Si <input type="checkbox"/> No	<input type="checkbox"/> Si <input type="checkbox"/> No
Hijo	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			<input type="checkbox"/> F <input type="checkbox"/> M				<input type="checkbox"/> Si <input type="checkbox"/> No	<input type="checkbox"/> Si <input type="checkbox"/> No
Hijo	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			<input type="checkbox"/> F <input type="checkbox"/> M				<input type="checkbox"/> Si <input type="checkbox"/> No	<input type="checkbox"/> Si <input type="checkbox"/> No

Nombre del Empleado: \_\_\_\_\_

SSN \_\_\_\_\_

**Elecciones Mèdicas**

**Inscribirse**

**Declinar**

HealthNet	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
HMO Full Network <b>JN1</b> (HSS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO Full Network <b>JN4</b> (HSV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO ExcelCare <b>JPS</b> (HVH)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO ExcelCare <b>JPY</b> (HVN)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO ExcelCare <b>JQ0</b> (HVP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO ExcelCare <b>JQ4</b> (HVT)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO Salud Y Mas - <b>JON</b> (HUG)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO Salud Y Mas - <b>JPB</b> (HUV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO SmartCare <b>JLY</b> (HSF)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO SmartCare <b>JM1</b> (HSJ)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO SmartCare <b>JLT</b> (HSC)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO SmartCare <b>JLP</b> (HS8)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PPO - <b>JQL</b> (HX5)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PPO - <b>JQM</b> (HX6)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PPO - HSA <b>JQN</b> (HXL)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PPO - HSA <b>JQT</b> (HXH)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have other health care coverage? \_ Yes \_ No If "Yes", complete the following:

Name of insurance carrier: \_\_\_\_\_ Prior coverage start date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**THE 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, DBP and/or Fidelity. Health Net, DBP and/or Fidelity use 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 provides members with a Notice of Privacy Practices that describes how it uses and discloses protected health information; the individual's rights to access and to request amendments, restrictions and an accounting of disclosures of protected health information; and the procedures for filing complaints. Health Net's Notice of Privacy Practices is included in the Evidence of Coverage or Certificate of Insurance for coverage underwritten by Health Net. I may also obtain a copy of this notice on the website at [www.healthnet.com](http://www.healthnet.com) or through the Health Net Customer Contact Center.

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

**ACKNOWLEDGMENT AND AGREEMENT:** I understand and agree that by enrolling with or accepting services from Health Net, DBP and/or Fidelity, I and any enrolled dependents are obligated to understand and abide by the terms, conditions and provisions of the Plan Contract or Insurance Policy. I 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 to the best of my information and belief, and I accept these terms.

**BINDING ARBITRATION AGREEMENT: I, the Applicant, understand and agree that any and all disputes between me (including any of my enrolled family members or heirs or personal representatives) and Health Net must be submitted to final and binding arbitration instead of a jury or court trial. This Agreement to arbitrate includes any disputes arising from or relating to the Evidence of Coverage or Certificate of Insurance or my Health Net membership or coverage, stated under any legal theory. This agreement to arbitrate any disputes applies even if other parties, such as health care providers or their agents or employees, are involved in the dispute. 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 have their dispute decided in a court of law by a jury. I also understand that disputes that I may have with Health Net involving claims for medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) are**

Nombre del Empleado: \_\_\_\_\_

SSN \_\_\_\_\_

also subject to final and binding arbitration. I understand that a more detailed arbitration provision is included in the Evidence of Coverage or Certificate of Insurance. Mandatory Arbitration may not apply to certain disputes if the Employer's plan is subject to ERISA, 29 U.S.C. §§ 1001-1461. My signature below indicates that I understand and agree with the terms of this Binding Arbitration Agreement and agree to submit any disputes to binding arbitration instead of a court of law.

I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE (THAT IS, AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR CLAIMS SUBJECT TO ERISA, BETWEEN MYSELF AND MY DEPENDENTS ENROLLED IN THE PLAN (INCLUDING ANY HEIRS OR ASSIGNS) AND UNITEDHEALTHCARE OF CALIFORNIA, UNITEDHEALTHCARE OR ANY OF ITS PARENTS, SUBSIDIARIES OR AFFILIATES, SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS THE FEDERAL ARBITRATION ACT PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. ALL PARTIES TO THIS AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHTS TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

### Reconocimiento de Declinación

Las coberturas disponibles han sido explicado. Se me ha dado la oportunidad de solicitar las coberturas disponibles. He decidido no inscribir a mi mismo y/o a mi dependiente(s) en la siguiente cobertura.

	Medico
Empleado	<input type="checkbox"/>
Cònyuge	<input type="checkbox"/>
Hijo(s)	<input type="checkbox"/>

Por la disminuciòn de la cobertura, reconozco que mis dependientes y yo puede que tengan que esperar para inscribirse hasta el pròximo periòdo de inscripciòn abierta o evento calificado.

Firma del Empleado: \_\_\_\_\_

Imprime su Nombre: \_\_\_\_\_

Fecha: \_\_\_\_\_

Nombre del Empleado: \_\_\_\_\_

SSN \_\_\_\_\_

**Elecciones PPO Dentales**

Inscribirse

Declinar

MetLife	Empleado Solo	Empleado + Cónyuge	Empleado + Hijo(s)	Empleado + Familia
PPO - High Option	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PPO - Low Option	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Elecciones DHMO Dentales**

Inscribirse

Declinar

MetLife	Empleado Solo	Empleado + Cónyuge	Empleado + Hijo(s)	Empleado + Familia
HMO High Option (MET 85)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO Low Option (MET 185)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Reconocimiento de Declinación**

Las coberturas disponibles han sido explicado. Se me ha dado la oportunidad de solicitar las coberturas disponibles. He decidido no inscribir a mi mismo y/o a mi dependiente(s) en la siguiente cobertura.

	Dental
Empleado	<input type="checkbox"/>
Cónyuge	<input type="checkbox"/>
Hijo(s)	<input type="checkbox"/>

Por la disminución de la cobertura, reconozco que mis dependientes y yo puede que tengan que esperar para inscribirse hasta el próximo período de inscripción abierta o evento calificado.

Firma del Empleado: \_\_\_\_\_

Imprime su Nombre: \_\_\_\_\_

Fecha: \_\_\_\_\_

Nombre del Empleado: \_\_\_\_\_ SSN \_\_\_\_\_

**Elecciones Visión**

Inscribirse

Declinar

MetLife (VSP)	Empleado Solo	Empleado + Cónyuge	Empleado + Hijo(s)	Empleado + Familia
MetLife (VSP) High Option	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MetLife (VSP) Low Option	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Reconocimiento de Declinación**

Las coberturas disponibles han sido explicado. Se me ha dado la oportunidad de solicitar las coberturas disponibles. He decidido no inscribir a mi mismo y/o a mi dependiente(s) en la siguiente cobertura.

	Visión
Empleado	<input type="checkbox"/>
Cónyuge	<input type="checkbox"/>
Hijo(s)	<input type="checkbox"/>

Por la disminución de la cobertura, reconozco que mis dependientes y yo puede que tengan que esperar para inscribirse hasta el próximo período de inscripción abierta o evento calificado.

Firma del Empleado: \_\_\_\_\_

Imprima su nombre: \_\_\_\_\_ Fecha: \_\_\_\_\_

**EMPLOYEE ELECTION CONFIRMATION- SIGNATURE REQUIRED**

**Employee Authorization**

Each person signing below declares that all information given in this enrollment form is true and complete to the best of his/her knowledge and beliefs. Each person understands that this information will be used to determine his/her eligibility.

I understand that these elections cannot be changed during the plan years unless I experience a qualified life event as outlined in employer benefit plan documents. Qualified life events that may change my benefit elections must be reported to the Benefits Administration within 30 days of the event.

Employee Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card, or employer group applicants please call HealthNet's Commercial Contact Center at 1-800-522-0088. Individual & Family Plan (IFP) applicants please call 1-877-609-8711. For more help: If you are enrolled in a PPO or EPO insurance policy underwritten by HealthNet Life Insurance Company; call the CA Dept of Insurance at 1-800-927-4357. If you are enrolled in a HMO or HSP plan provided by HealthNet of California, Inc., call the DMHC Helpline at 1-888-HMO-2219. Your ID card indicates whether your plan was issued by HealthNet Life Insurance Company or HealthNet of California, Inc.

**English**

Servicios de Idiomas Sin Costo. Usted puede solicitar un interprete. Puede solicitar que se le lean los documentos y que algunos de ellos se le envíen en su idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación; los solicitantes de grupo de empleadores deben llamar al Centro de Comunicación Comercial de HealthNet al 1-800-522-0088. Los solicitantes del Plan Individual y Familiar (por sus siglas en inglés, IFP) deben llamar al 1-877-609-8711. Para obtener más ayuda: Si está inscrito en una póliza de seguro PPO o EPO asegurada por HealthNet Life Insurance Company, llame al Departamento de Seguros de CA al 1-800-927-4357. Si está inscrito en un plan HMO o HSP proporcionado por HealthNet of California, Inc., llame a la Línea de Ayuda del Departamento de Cuidado Médico (por sus siglas en inglés, DMHC) de California al 1-888-HMO-2219. Su tarjeta de identificación indica si su plan fue emitido por HealthNet Life Insurance Company o HealthNet of California, Inc.

**Spanish**

☞--☞☞☞ 9S ° f☞Pftl-I&l ☞D☞☞☞ 9S ° fJG-fl' ☞Pftl-ffixftf:☞☞☞Mti:a' iliPjtl-ffiffB:B-fl☞n\Gf☞e'gxf☞ts☞M☞☞ ☞ffliihWJ' ☞ J::pfijUB'gg--S☞\*☞☞☞ Jm1:a)!!ft\$ ilJj,A ilJffilHealthNet e'gjLJ☞☞☞:p,t,, ☞1-800-522-0088 ° Individual and Family Plan (IFP) \$i1Jj,A\_i1Jj ffl1-877-609-8711 ° ☞ffl;isl:-ftgmWJ : ☞:W:☞mf\*e'g☞HealthNet Life Insurance Company f\*f'e'g PPO 1?JG EPO f\*☞ft' [ , ilJffilCalifornia Department of Insurance g-§ 1-800-927-4357 ° J<D:W: 1 ☞f'e'g☞Health Net of California, Inc. ☞HMO 1?JG HSP \$fili , ilJffilDMHC mWJ:.w:☞1-888-HMO-2219 ° ☞e'g☞☞-tiftt☞☞ggf☞f☞☞ HealthNet Life Insurance Company 1?JG Health Net of California, Inc. f\*☞

**Chinese**

Djch V1,1 ngon ngu mien phi. Quyvi c6 the duqc cap thong cijch vien va ngu<':li d9c giup cac tai li☞ bang ngon ngu cu.a quyvi cho quyvi, De duqc tr(J giup, vui long gQi cho chung toi theo so di☞n thofu ghi tren the hc,;i vien cu.a quyvi; ngu<':li ghi danh theo nh6m cu.a hang sci :xin gQi Trung tam Lien l☞c Thucmg mfu cu.a Health Net theo so 1-800-522-0088. Nguc:li ghi danh theo Chue1ng trlnh bao hiem danh cho ca nhan va gia dlnh (Individual and Family Plan, IFP) :xin gQi so 1-877-609-8711. De duqc trq giup M rue: Neu quyvi ghi danh trong cac h<Jp dong bao hiem PPO ho☞c EPO do Health Net Life Insurance Company cam ket tai trq, vui long gQi BQ Bao hiem cu.a California theo so 1-800-927-4357. Neu quyvi ghi danh trong chue1ng trlnh bao hiem HMO ho☞c HSP do Health Net of California, Inc. cung cap, :xin gQi Du<':lng day trq giup cu.a DMHC theo so 1-888-HMO-2219. Tren the hc;>i vien cu.a quyvi c6 ghi r6 chudng trlnh bao hiem cu.a quyvi la do Health Net Life Insurance Company hay Health Net of California, Inc. cung cap.

**Vietnamese**

-9-E e: ! OI XI ☞kl:t:ll ☞-9-E ☞QI Af kl:t:ll ☞gJ OI 2.HEOJJ-II !!: et e: ! 01 E kl☞☞☞kl:t:ll ☞☞E!:"☞4' 2J. \$Li Cf. .5: \$01 ☞Hoft. ! J:Eg ☞☞<?:! ID 3f☞☞☞Jj 2J.e e!-LH\!::!2 E ☞1-oH ☞☞AI2.. :ilg☞☞:J. ☞JfgJ 61 ☞Xf'a.<?:! ☞9- HealthNet.<?:! ☞gJ (Commercial) :il2.!! kl t:ll ☞☞E!, e!-LH !::!2 1-800-522-0088\!::!☞☞ ☞2foH ☞☞AI2.. JH ☞gJ Jf☞☞:!! (IFP) JfgJ 61 ☞Xf'a g e!-LH !::!2 1-877-609-8711\!::!☞☞ ☞E!oH ☞☞AI2. [ ☞ Btg .5: \$01 ☞HofAl e! e!-☞☞=ti ofJf HealthNet Life Insurance CompanyJf ☞4'e!- PPO !Ee EPO ☞gt ¥cIAIOJl JfgJ oft. ! ☞9-, ☞2.1 ±t.LI Of ☞ (CA Dept. of Insurance), e!-LH !::!2 1-800-927-4357\!::!☞☞ ☞☞?l of AI2.. e!-☞☞ TlofJf HealthNet of California, Inc.OJl kl ☞☞ofe HMO !Ee H☞ ☞:!!OJl JfgJoft. ! ☞9-, ☞c!☞c.1 ¥ (DMHC) ☞:!.2.f☞ e!-LH !::!2 1-888-HMO-2219\!::!☞☞ ☞<?:.lof AI2.. Tlof.<?:.I ID 3f☞☞☞Jj -=tlof.<?:.I ☞ HealthNet Life Insurance CompanyOJIA☞☞☞:I XI !Ee HealthNet of California, Inc.OJl kl ☞☞:I XI ☞AI5:IOI 2J. \$Li Cf.

**Korean**

Uuil\_fiwr Lbqil\_w☞wu UwnWJMLjJJnLUUbr: 'l-nL☞☞vrn'l. b☞p wpuwil\_nr Fjwr☞.i.iwL c\bn.p pbrL L. i./,wu,nwFF'IFfbr☞☞uFJbr9bi LnWL .2br ibqil\_nil\_: O☞unLjJJwL C.wi.iwr i.ibq qwL☞.wC.wrb☞.2br fiL☞unLjJJWU (ID) Lnni.iufi il.rw L2il\_wa C.wi.iwrnil☞, ☞w.r bjiyb ☞\_nraw,nfirni fui.ipfi '1-fii.inr'l- b☞p, fuu\_rnLLi bu☞p 1-800-522-0088 C.wi.iwrnil. qwu☞.wC.wrbL Health Net-ti l.wnwfunr☞.r l:iwUfr libu,nrrnu: UuC.w,nw☞wu L. (lu,nwub☞wL Urw☞.rr (Individual and Family Plan/IFP) 1J-f!Linr1J-ubrfi9 fuu☞.ril.nLLi t qwu☞.wC.wrbL 1-877-609-8711 C.wi.iwrnil\_: Lrw9nL9fiL o☞unLjJJwL C.wi.iwr 1-800-927-4357 C.wi.iwrnil. qwu☞.wC.wrb☞ liwiti=f-nrurwJr U☞☞wC.nil\_w☞.rnLjJJWU P.wd-wui.inLU☞ (CA Dept. of Insurance), bjiyb ☞.rwu9il\_b☞p PPO ☞w.r EPO W☞☞WC.m\w☞.rw☞wL W☞☞WC.nil\_w☞.rr, nrr ☞n'l.L t Health Net Life Insurance Company-u: bjiyb ☞.rwu9il\_b☞p HMO ☞v.r HSP arw☞.rmi.i, nrr i.iw,nw☞vrwru t Health Net of California, Inc.☞ 1-888-HMO-2219 C.wi.iwrnil. qwu☞.wC.wrb☞ DMHC-ti O☞unLjJJWU q.atiu: .2br fiu☞LnLjJJWU Lnni.iu☞u2nLLi t, jifb nil\_ t Ffn'lwr☞bl .2br arw☞.ri Health Net Life Insurance Company-u, jifb'" Health Net of California, Inc.☞

**Armenian**

BecniaTHble yc1iyn1 TiepeBoy;a. Bbl MO)KeTe BOCTIOJib30BaTbCJl ycnYraMjf nepeBOWJfKa, ir BaM MOryT TipoqJfTaTb μ;oKyMeHTbl Ha BallleM H3blKe. ECJlf BaM Tpe6yeTCJl TIOMOID;b, 3BOHJfTe HaM TIO HOMepy Teneq;oHa, 'Ka.3aHHOMY Ha BallleH lf,D;eHTJfq>lfKan;HOHHOH KapTe. YqacTHJfKH IlJiaHa rpynTIOBOro cTpxoBaHIDI TIO MecTy pa6oThl MOryT o6parnThCJl B KoMMepqecKHH KOHTaKTHBH n;eHTP KOMTiaHlfH Health Net (Commercial Contact Center) TIO Teneq;oHy 1-800-522-0088. YqacTHmrn IlJiaHOB lfH,IlJfBlfpy,y.lJibHoro ir ceMeti:Horo CTpxoBaHIDI (Individual and Family Plan, IFP), nO)KaJIYHCTa, 3BOHJfTe TIO HOMepy 1-877-609-8711 .,il;JH TionyeHIDI ,D;OTIOJlHJfTeJibHOH TIOMOID:jf: eCJlf y Bae CTpxoBOH TIOJlJfC OpraHJf3☞fj| c npey;rrorqnTeJibHblMjf TIOCTaBID:jfKaMjf ycnYr (Preferred Provider Organization, PPO) JfJlf OpraHJf3☞fjf c o6H3aTeJibHblMjf TIOCTaBID:jfKaMjf ycnYr (Exclusive Provider Organization, EPO), KOTopblti: Tipey;ocTaBJIHeTCJl KOMnaHJfe:iI Health Net Life Insurance Company, o6pam;ati:Tech B ,Jl;eTiaPtaMeHT cTpxoBaHIDI IIITaTa KanHq>opHHH (CA Dept. of Insurance) TIO Teneq;OH' 1-800-927-4357. Ecnlf Bbl 3apemcTpHpoBaHbl B IlJiaHe HMO lfJlf HSP, KOTopbi:il Tipey;ocTaBHeH KOMTiaHHe:iI Health Net of California, Inc., 3BOHTe Ha Teneq;OH fopHqeti: JlfHJlf lf;Jl;eTiaPtaMeHTa opraHJf30BaHHoro Me,D;lfD;JfHCkopo o6cny)KHBaHIDI (DMHC Helpline) TIO HOMepy 1-888-HMO-2219. Ha BameTi: Hy;eHTlfq>lfK☞fOHHOH KapTe ycicaaHo, 6brn Jlfj Balll TlJiaH oqioPMjeH KOMTiaHJfe:iI Health Net Life Insurance Company JfJlf KOMTiaHJfe:iI Health Net of California, Inc.

**Russian**

1\|tf-(f-O) is\$ ffi☞1☞:-- 7-a S ,f>:ffiO)JffifRij>il=ffi☞to☞j. L\*Ta ☞1☞:-- 7-☞☞:--'ffi"☞☞)jfi, IDj- FW'ct(tO)::li-|}\*\*'l'.torb☞'if:bit <t-c. ☞☞\_a Jij=I=lrffif\*:1'7☞:,☞☞fjDA☞td\$☞7j.O)jffj:, HealthNetO)☞fllj☞:r☞:,27☞:7 l- t☞:,27-, 1-800-522-0088\*1'.td'1:ffi< t-c☞☞\_a -ffifilA \*☞77☞, (IFP)☞fjOA☞td\$☞7j.O)jffj:, 1-877-609-8711 \*1'.td'1:ffi< t-c☞☞\_a ☞G 1c.mWJtj>&' ,Jl'.ft☞?i-, HealthNet lE Insurance Companyj>1\*☞51☞☞±c: ftOPPO\*f.:fj:EPO-f\*☞☞Jl 1/- f☞:☞fjAO)JfJf: .:fj 1J 7;t:Jv:= 71-i'l'f\*☞fi\ 1-800-927-4357 \*1'.☞:☞\_il☞ t-c☞☞\_a HealthNet of California, Inc.j>☞☞QHMO\*f.c.fj:HSP:l'7☞:,☞:☞fjAO)JfJf: .:fj 1J 7;t:v:= 71'i'f!!!☞IR)T (DMHC) O)☞v:1'7,{☞:,☞, 1-888-HMO-2219\*1'. "Jl☞< t-c☞☞\_o :td\$☞☞)7'7 ☞:,☞)5efi:j!fi)>HealthNet Life Insurance Company \*t..lJ:HealthNet of California, Inc.O☞:l G \*1'ilr; Q ij>lj; , IDj- FICW'ct(\☞n-n\*Ta

**Japanese**

خدمات یی هزینہ مربوط بہ زبان می توایند از خدمات یک مترجم شفاهی برخوردار شده و بگویند تا نوشته ها به زبان خودتان برایتان خوانده شوند. برای دریافت کردن کمک، ما با از طریق شماره تلفنی که روی کارت شناسایی شما قید شده است تماس بگیرید، و یا متقاضیان گروه کارفرمایان لطفاً با مرکز تجاری تماس Health Net به شماره 1-800-522-0088 تماس بگیرید. متقاضیان "طرح افراد و خانواده ها" (IFP) لطفاً به شماره 1-877-609-8711 تلفن کنند. برای دریافت کمک بیشتر: اگر برای یک بیمه نامه PPO یا EPO که توسط Health Net Life Insurance Company تضمین شده است ثبت نام کرده اید، به اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تلفن کنید. اگر در یک طرح HMO یا HSP که توسط Health Net of California, Inc. فراهم شده است ثبت نام میکنید، به خط کمکی DMHC به شماره 1-888-HMO-2219 تلفن کنید. کارت شناسایی تان نشان میدهد که آیا طرح شما توسط Health Net Life Insurance Company صادر شده است یا Health Net of California, Inc.

**Farsi**

Walang Gastusin na Mga Serbisyo sa Wika. Maaari kang kumuha ng interpreter at basahin sa iyong wika ang mga dokumento. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card, o para sa mga aplikante ng pangkat ng employer, mangyaring tawagan ang Commercial Contact Center ng Health Net sa 1-800-522-0088. Para sa mga aplikante ng Individual & Family Plan (IFP), mangyaring tumawag sa 1-877-609-8711. Para sa karagdagang tulong: Kung naka-enroll ka sa isang insurance policy ng PPO o EPO na napapailalim sa Health Net Life Insurance Company, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Kung naka-enroll ka sa isang plano ng HMO o HSP na ipinagkakaloob ng Health Net of California, Inc., tawagan ang DMHC Helpline sa 1-888-HMO-2219. Isinasaad ng iyong ID card kung ang iyong plano ay ibinigay ng Health Net Life Insurance Company o Health Net of California, Inc.

**Tagalog**

Keypab Lus Tsis Muaj Nqi Them. Koj txais tau tus neeg txhais lus thiab muab tau cov ntawv los nyeem rau koj ua koj hom lus. Kom tau keypab, hu rau pob ntawm tus xovtooj sau rau koj daim npav ID, lossis cov tib neeg yuav thov keypab tom chaw haujlwm thov hu rau Health Net Lub Chaw Pab Cov Tib Neeg Siv Cov Keypab (Customer Contact Center) ntawm 1-800-522-0088. Cov neeg thov keypab hauv pawg Tus Kheej & Tsev Neeg (Individual and Family Plan; IFP) thov hu rau 1-877-609-8711. Yog xav tau keypab ntawv: Yog koj muaj npe nkaug nrog PPO lossis EPO cov kev tuav pov hwm los ntawm Health Net Life Insurance Company, hu rau CA Qhov Chaw Saib Xyuas Txog Kev Tuav Pov Hwm (Dept. of Insurance) ntawm 1-800-927-4357. Yog koj muaj npe nkaug nrog ib qho kev npaj pab HMO lossis HSP uas los ntawm Health Net of California, Inc., hu rau DMHC Tus Xovtooj Muab Keypab ntawm 1-888-HMO-2219. Koj daim npav ID yuav qhia tau tias koj qhov kev npaj pab yog los ntawm Health Net Life Insurance Company lossis Health Net of California, Inc.

**Hmong**

Doo Bqah 'Alinígóó Saad Bee 'áka'anida'awo'ígíí. 'Ata' halne'í dóó naaltsoos bee 'éedahozinígíí t'áa ni nizaad bee hadadilyaago nich'í' yidóolta. 'Áka'a'eyeed biniiyégo, ninaaltsoos nit'izi bee néehozinígíí bine'déq' béesh bee haneí biká'ígíí bee nich'í' hodíilnih, doodago ninaalishí bíl hada'díl'ínígíí t'áa shqodí Health Net Commercial Hane' 'Íl'íh Bíl Haz'ánijí' 1-800-522-0088 hodíilnih. Lá' Jizíh dóó Hooghan Haz'áagi Naaltsoos Hadadít'éhígíí (IFP) hada'dile'ígíí t'áa shqodí kohjí' 1-877-609-8711 hodíilnih. T'áa náásgóó 'áka'a'eyeed biniiyégo: PPO doodago EPO béeso 'ách'áqáh naa'nil bíbee haz'ánii Health Net Life Insurance Company, bich'í' haidíilaagíí bíl ha'dít'éhígíí bíl ha'díleehgo, CA Dept. béeso 'ách'áqáh naa'nil bíl haz'ánígíí bich'í' kohjí' 1-800-927-4357 hodíilnih. Health Net of California, Inc. biyaadóó HMO doodago HSP bíl ha'dít'éhígíí bíl ha'díleehgo, DMHC 'Áka'aná'awo' Bíl Haz'ánígíí kohjí' 1-888-HMO-2219 hodíilnih. Health Net Life Insurance Company doodago Health Net of California, Inc. bíl naaltsoos bíl náha'dít'éhígíí ninaaltsoos nit'izi bine'déq' bikáá'.

**Navajo**

ਭਾਸ਼ਾ ਦੀਆਂ ਮੁਢਲੀਆਂ ਸੇਵਾਵਾਂ। ਤੁਹਾਨੂੰ ਦੁਬਾਰੀਆਂ ਮਿਲ ਸਕਦਾ ਹੈ ਅਤੇ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈ ਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ, ਜਾਂ ਇੰਪਲਾਇਰ ਗਰੁੱਪ ਦੇ ਅਰਜ਼ੀਦਾਰ ਕਿਰਪਾ ਕਰਕੇ Health Net ਦੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ 1-800-522-0088 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਯੋਜਨਾ (IFP) ਵਾਲੇ ਅਰਜ਼ੀਦਾਰ ਕਿਰਪਾ ਕਰਕੇ 1-877-609-8711 ਨੰਬਰ ਤੇ ਸੰਪਰਕ ਕਰੋ। ਹੋਰ ਮਦਦ ਲਈ: ਜੇ ਤੁਸੀਂ Health Net Life Insurance Company ਵਲੋਂ ਜਾਰੀ ਕਿਸੇ PPO ਜਾਂ EPO ਬੀਮਾ ਪਾਲਿਸੀ ਲਈ ਨਾਂ ਲਿਖਵਾਇਆ ਹੈ ਤਾਂ ਕੈਲੀਫੋਰਨੀਆ ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ 1-800-927-4357 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਜੇ ਤੁਸੀਂ Health Net of California, Inc. ਵਲੋਂ ਮੁਹੱਈਆ ਕੀਤੀ ਗਈ ਕਿਸੇ HMO ਜਾਂ HSP ਯੋਜਨਾ ਲਈ ਨਾਂ ਲਿਖਵਾਇਆ ਹੈ ਤਾਂ DMHC ਦੀ ਹੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਤੁਹਾਡੇ ਆਈ ਡੀ ਕਾਰਡ ਤੇ ਦਿਖਾਇਆ ਗਿਆ ਹੈ ਕਿ ਤੁਹਾਡੀ ਯੋਜਨਾ Health Net Life Insurance Company ਵਲੋਂ ਜਾਰੀ ਕੀਤੀ ਗਈ ਸੀ ਜਾਂ Health Net of California, Inc. ਵਲੋਂ।

**Punjabi**

ਸੇਵਾਵਾਂ ਦੀਆਂ ਮੁਢਲੀਆਂ ਸੇਵਾਵਾਂ। ਤੁਹਾਨੂੰ ਦੁਬਾਰੀਆਂ ਮਿਲ ਸਕਦਾ ਹੈ ਅਤੇ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈ ਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ, ਜਾਂ ਇੰਪਲਾਇਰ ਗਰੁੱਪ ਦੇ ਅਰਜ਼ੀਦਾਰ ਕਿਰਪਾ ਕਰਕੇ Health Net ਦੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ 1-800-522-0088 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਯੋਜਨਾ (IFP) ਵਾਲੇ ਅਰਜ਼ੀਦਾਰ ਕਿਰਪਾ ਕਰਕੇ 1-877-609-8711 ਨੰਬਰ ਤੇ ਸੰਪਰਕ ਕਰੋ। ਹੋਰ ਮਦਦ ਲਈ: ਜੇ ਤੁਸੀਂ Health Net Life Insurance Company ਵਲੋਂ ਜਾਰੀ ਕਿਸੇ PPO ਜਾਂ EPO ਬੀਮਾ ਪਾਲਿਸੀ ਲਈ ਨਾਂ ਲਿਖਵਾਇਆ ਹੈ ਤਾਂ ਕੈਲੀਫੋਰਨੀਆ ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ 1-800-927-4357 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਜੇ ਤੁਸੀਂ Health Net of California, Inc. ਵਲੋਂ ਮੁਹੱਈਆ ਕੀਤੀ ਗਈ ਕਿਸੇ HMO ਜਾਂ HSP ਯੋਜਨਾ ਲਈ ਨਾਂ ਲਿਖਵਾਇਆ ਹੈ ਤਾਂ DMHC ਦੀ ਹੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਤੁਹਾਡੇ ਆਈ ਡੀ ਕਾਰਡ ਤੇ ਦਿਖਾਇਆ ਗਿਆ ਹੈ ਕਿ ਤੁਹਾਡੀ ਯੋਜਨਾ Health Net Life Insurance Company ਵਲੋਂ ਜਾਰੀ ਕੀਤੀ ਗਈ ਸੀ ਜਾਂ Health Net of California, Inc. ਵਲੋਂ।

**Khmer**

خدمات اللغوية المجانية: يمكنك الحصول على مترجم فوري للمساعدة في قراءة مستنداتك باللغة التي تتحدث بها. للحصول على المساعدة يرجى الاتصال بنا على الرقم الموضح على بطاقة التعريف الخاصة بك، أو إذا كنت من مقدمي الطلبات من الموظفين يرجى الاتصال بمرکز التواصل مع العملاء لدى Health Net على الرقم 1-800-522-0088. بالنسبة لمقدمي طلبات خطة الفرد والأسرة (IFP)، يرجى الاتصال على الرقم 1-877-609-8711. للحصول على المزيد من المساعدة: إذا كنت مسجلاً في سياسة التأمين بخطة PPO أو EPO التي تكتبها شركة التأمين على الحياة Health Net Life Insurance Company، يرجى الاتصال بـ CA Dept. of Insurance (وزارة التأمين بولاية كاليفورنيا) على الرقم 1-800-927-4357. إذا كنت مسجلاً في خطة HMO أو HSP التي توفرها شركة Health Net of California, Inc.، يرجى الاتصال بخطة المساعدة لدى DMHC على الرقم 1-888-HMO-2219. توضح بطاقة التعريف الخاصة بك ما إذا كان تم إصدار خطتك عبر شركة التأمين على الحياة Health Net Life Insurance Company أو شركة Health Net of California, Inc.

**Arabic**

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