



HEALTH NET® Individual Enrollment Application

For Assistance call: (877)-433-7868

Requested Effective Date

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PART I. Tell us who you are enrolling and select the product:

A. Complete the following

FAMILYTYPE

- Self
- Self & Spouse
- Self & Child Process as separate policies
- Self & Children
- Self, Spouse and Child(ren)

ENROLLMENTTYPE

- New Enrollment Change Plan** Add Dependent**

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

B. Billing options (please choose one)

- Quarterly (no administrative charge)
- Monthly (electronic funds transfer--no administrative charge)
If chosen, attach a completed Simple Pay Option form
- Monthly (billed--\$5 administrative fee)

C. Choice of coverage

Health Net, California's Health Plan

- HMO 15
- HMO 40

- HMO 15 Plus
(includes dental and vision coverage)

Primary Dentist Number

Health Net Life Insurance Company

- Value PPO 20
- Value PPO - No Deductible
- Value PPO 2500
- Value PPO 500
- Value PPO 1000

PART II. Primary applicant information

(Note: For the most favorable rate, make the younger spouse the primary applicant.)

Last Name _____ First Name _____ MI _____

Home Address _____

City _____ State _____ ZIP _____

County Resides In _____ Social Security Number _____ - _____ - _____

Birth Date _____ / _____ / _____ Home Phone Number _____ - _____ - _____

Work Phone Number _____ - _____ - _____ Fax Number _____ - _____ - _____

E-mail Address _____

Occupation _____

PART III. Applicant/family member to be enrolled

List yourself and all eligible family members to be enrolled. 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 reside at the same address.

***HMO only:** If you are applying for HMO coverage, you must select a Physician Group and Primary Care Physician. You may choose the same or different Physician Group and Primary Care Physician for each family member you are enrolling. If you do not select a Primary Care Physician, one will be selected for you within your regional area.

SELF (Primary)

Male Female Height _____ ft. _____ in. Weight _____ lbs. Primary Care Physician ID Number* _____ Existing Patient Physician Group ID Number* _____

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PART IV (a). Statement of health -- (continued)

Primary's Social Security Number

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2)	Have you or any applying family member had an abnormal physical exam, laboratory results, EKG, x-rays, MRI, CT scan or been advised to have diagnostic tests, treatment(s), surgery or hospitalization(s)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3)	Have you or any applying family member been a patient in a hospital, clinic, surgicenter, sanatorium or other medical facility as an inpatient or outpatient?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4)	Are you or any applying family member eligible for Medicare benefits as a result of disability or chronic illness?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5)	Have you or any applying family member ever had any signs or symptoms, been consulted for, received advice, sought treatment, had treatment recommended, received treatment or been hospitalized for the following conditions? If "Yes", please list the specific condition and provide requested details in section IV (b).		
A.	Chest pain, high or low blood pressure, heart disease, heart murmur, palpitations or irregular heart beat, peripheral vascular disease, blood clot, phlebitis, varicose veins, blood disorder, anemia, enlarged lymph nodes, or any other heart, cardiovascular, or circulatory disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
B.	Headaches, dizziness, paralysis, stroke, loss of consciousness, seizure disorder, sleep apnea, multiple sclerosis, cerebral palsy, or any other disorder of the brain or nervous system?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
C.	Disorder of the mouth, throat or esophagus, tonsillitis, ulcers, colitis, ulcerative colitis, spastic colitis, Crohn's disease, gall bladder disorder, chronic diarrhea, hernia, hemorrhoids, hepatitis, pancreatitis, intestinal or rectal problems, liver disease, cirrhosis, stomach disorder, or any other disorder of the digestive system?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
D.	Allergies, sinusitis, bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), pneumonia, tuberculosis, coughing up blood, or any other lung or respiratory disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
E.	Asthma? (i) If "yes", have you been hospitalized or been to an emergency room in the past 24 months? (ii) Have you received any adrenaline or epinephrine injections?	Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/>
F.	Disorder of the kidney or bladder, infections, blood in urine, pyelonephritis, or any other disorder of the urinary tract?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
G.	Arthritis, rheumatoid arthritis, bursitis, gout, disorder of the back, spine, bone or joint, herniated, ruptured, or bulging disc, muscle or tendon pain, carpal tunnel syndrome, muscular dystrophy, or any other disorder of the musculoskeletal system?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

H.	Jaw problems, temporalmandibular joint syndrome (TMJ), pain or difficulty breathing, chewing or swallowing?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I.	Diabetes, thyroid disorder, adrenal disorder, lupus, Raynaud's disease, chronic fatigue syndrome, Epstein-Barr virus, unintentional weight loss, AIDS, or any other disorder of the metabolic system?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
J.	Cancer, melanoma, tumor, cyst, growth, leukemia, Hodgkin's disease, or any other malignancy?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
K.	Psoriasis, keratosis, herpes, burns, birthmarks, warts, or any other disorder of the skin?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
L.	Disorder of the eyes or sight, glaucoma, cataracts, disorder of the ears or hearing, otitis, disorder of the nose or breathing, deviated nasal septum?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
M.	Nervous, mental, or emotional disorder, behavioral disorder, panic attacks, anxiety, depression, manic depression, schizophrenia, attention deficit disorder, ADHD, or eating disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
N.	Alcoholism, alcohol, drug or substance abuse?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
O.	Premature birth, developmental delay, congenital abnormalities, club foot, cleft lip or palate, or Down's syndrome?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
P.	Cosmetic or reconstructive surgery, including breast implants?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Q.	Male reproductive system: disorder of the prostate, infections, impotency, sexual dysfunction, infertility, sexually transmitted disease or any other disorder of the reproductive system?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
R.	Female reproductive system: disorder of the breast, fibroid tumors, infertility, menstruation disorders, abnormal Pap test, infections, sexually transmitted disease, abnormal bleeding, endometriosis or any other disorder of the uterus or reproductive system?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6)	Have you or any applying family member consulted a provider for any condition or symptom(s) for which a diagnosis has not been established?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7)	During the past 12 months, have you or any applying family members smoked cigarettes, cigars, pipes, or used chewing tobacco?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8)	During the past three years, have you or any applying family members consulted a physician for any reason not already indicated on this form?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9)	During the past 12 months, have you or any applying family members experienced symptoms for which a physician has not been consulted?	Yes <input type="checkbox"/>	No <input type="checkbox"/>



PART IV (a). Statement of health -- (continued)

Primary's Social Security Number

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10) Is the applicant or any applying family member currently taking medication? If "Yes", please complete section IV (b).
 Yes No

11) Has the applicant of any applying family member taken a prescription medication during the past 12 months for a period of more than two weeks? If "Yes", please complete Part IV (b).
 Yes No

Female applicant's only (applicable to all females listed on the application)

<p>Applicant Name: _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>12) A. (i) Do you menstruate? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(ii) Date of first day of last menstrual period (Mo/Dy/Yr:) ____/____/____</p> <p>(iii) Average number of days from first of menstrual period to first day of next period _____</p> <p>B. (i) Have you had a pelvic exam? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>(ii) Date of last pelvic exam (Mo/Dy/Yr:) ____/____/____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>(iii) Were the results of the exam normal? If "No", please explain _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Applicant Name: _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>12) A. (i) Do you menstruate? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(ii) Date of first day of last menstrual period (Mo/Dy/Yr:) ____/____/____</p> <p>(iii) Average number of days from first of menstrual period to first day of next period _____</p> <p>B. (i) Have you had a pelvic exam? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>(ii) Date of last pelvic exam (Mo/Dy/Yr:) ____/____/____ Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>(iii) Were the results of the exam normal? If "No", please explain _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p>
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PART IV (b). Statement of health -- If you answered "Yes" to any questions in Section IV (a), please list condition(s) and explain in FULL DETAIL below. If additional space is necessary, please attach extra pages.

Question number	Family member name and name used on doctor's records	Diagnosis and treatment	Still under treatment? Yes/No	Dates of treatment, hospitalization (Mo/Yr):		Name of hospital, full name and address of every physician, clinic or hospital (include ZIP Code)
				Began	Ended	

DOCTOR'S VISITS -- Please provide information regarding the last doctor visit/physical examination for ALL family members you wish to cover.

Name of individual	Date of visit	Reason for and results of visit	Name, phone number and address of a attending physician

MEDICATIONS -- Please list all medications taken currently or within the last year by anyone listed on this application.

Name of individual	Condition	Name of medication	Dosage and frequency (list last refill date)	Name, phone number and address of a attending physician



Primary's Social Security Number
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PART V. Other health coverage

A. During the previous 30 days, have you been covered by health insurance? Yes No

If "Yes",

Current Carrier

[] []

Effective Date

[] [] / [] [] / [] [] [] []

Termination Date

[] [] / [] [] / [] [] [] []

Type of coverage:

- Individual & Family HMO Group HMO
 Individual & Family PPO Group PPO
 Disability, Short Term, or Interim
 Other _____

Benefit Level (deductible, coinsurance, etc):

B. Have any applicants identified on this application been declined, postponed, waiver applied or charged an extra premium for life, disability or health insurance or had such insurance rescinded? Yes No

If "Yes", provide name of applicant, company name and a brief explanation: _____

C. 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: _____

Member ID Number (listed on your ID card):

[] []

Group Number (listed on your ID card): _____

How did you hear about Health Net's Individual and Family plan?

Radio Billboard Newspaper YellowPages Broker Internet Other _____

VI. Writing agent information -- Without complete agent name and address, correspondence will not be sent.

Health Net Writing Agent Number

[] []

Federal Tax ID: 95-3860-414

Office Assigned Number: _____

Name and Address: M. E. Andrews & Associates Insurance Agency, Inc

Phone Number: 1 (877) 433-7868

8190 E. Kaiser Blvd Suite #100

Fax Number: 1 (714) 279-1990

Anaheim Hills, CA 92808

E-mail Address: info@3DQuotes.com

Writing Agent's Signature

Marsha Andrews LD # 0670130

[] [] / [] [] / [] [] [] []

Date Signed (required)

Writing Agent Certification

Are you aware of any information not disclosed in this application that might have a bearing on the risk? Yes No

If "Yes", please explain: _____

Did you personally see the applicant (and spouse, if applying) at the time this application was executed? Yes No

Application was mailed to agent.

Please mail your completed application to:

M.E. Andrews Insurance
8190 E. Kaiser Blvd.
Suite #100
Anaheim Hills, CA 92808

For Assistance call: 1 (877)-433-7868



