



Small Business Application for Group Service Agreement

New Sales

Renewal

1 HEALTH PLAN INFORMATION

HMO <input type="checkbox"/> HMO 15 <input type="checkbox"/> HMO 20 <input type="checkbox"/> HMO 35 <input type="checkbox"/> HMO 40 <input type="checkbox"/> HMO VCP 25 (So. CA only) <input type="checkbox"/> HMO VCP 35 (So. CA only) <input type="checkbox"/> HMO Silver Network 20 <input type="checkbox"/> HMO Silver Network 40 <input type="checkbox"/> HMO Xtra Value 20 <input type="checkbox"/> HMO Xtra Value 40	EOA <input type="checkbox"/> EOA 10 <input type="checkbox"/> EOA 20 <input type="checkbox"/> EOA 25 <input type="checkbox"/> EOA 30 POS <input type="checkbox"/> POS 10 <input type="checkbox"/> POS 20 <input type="checkbox"/> POS 30 FLEX NET (Out of service area only) <input type="checkbox"/> Indemnity	PPO <input type="checkbox"/> PPO 10 <input type="checkbox"/> PPO 15 <input type="checkbox"/> PPO 20 <input type="checkbox"/> PPO 30 <input type="checkbox"/> PPO 40 <input type="checkbox"/> PPO Catastrophic Saver <input type="checkbox"/> PPO 2000 <input type="checkbox"/> PPO 3000	<input type="checkbox"/> ENHANCED CHOICE (Allows all medical plans except VCP)	OPTIONAL RIDER <input type="checkbox"/> Chiropractic <input type="checkbox"/> Acupuncture <input type="checkbox"/> Combined (all riders for HMO, Salud HMO, EOA and POS only)	Salud con Health Net <input type="checkbox"/> Salud HMO (Available in Los Angeles and Orange Counties) <input type="checkbox"/> Salud PPO (Available in Los Angeles) <input type="checkbox"/> Salud Mexico (Available in San Diego and Imperial) <input type="checkbox"/> Salud EPO (Available in Ventura and Los Angeles)	DENTAL DHMO <input type="checkbox"/> Advantage 150 Plan <input type="checkbox"/> Advantage 225 Plan DPPO <input type="checkbox"/> HB Plan _____ <input type="checkbox"/> HC Plan _____ <input type="checkbox"/> HD Plan _____ VISION PPO <input type="checkbox"/> Preferred 1025-2 <input type="checkbox"/> Preferred 1025-3 <input type="checkbox"/> Value-10-2
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Medical and Life/AD&D plans are provided by Health Net of California, Inc. and/or Health Net Life Insurance Company (together, the "Health Net Entities"). Dental plans are provided by SafeGuard Health Plans, Inc. and/or its affiliate, SafeHealth Life Insurance Company, (together "SafeGuard Entities"). Vision plans are provided by Fidelity Security Life Insurance Company and serviced by Eyemed Vision Care LLC (together the "Fidelity Entities").

Neither the SafeGuard Entities nor The Fidelity Entities are affiliated with the Health Net Entities. Obligations under dental and vision plans are not obligations of, and are not guaranteed by, the Health Net Entities.

Application is hereby made for a Group Policy provided by the Health Net Entities, the SafeGuard Entities, and/or the Fidelity Entities, the provisions of which are to be made available to all eligible employees, as defined, and their eligible dependents desiring coverage hereunder. The following information regarding employee data is being submitted to allow the Health Net Entities, the SafeGuard Entities and/or the Fidelity Entities to determine the eligibility of employees seeking enrollment.

2 EMPLOYER GROUP INFORMATION (Please only complete sections 2, 3, 5 & 6 if changing existing coverage)

Company Name		DBA	Group #	SIC Code
Type of Business		How Long in Business		Effective Date / (Renewal Date)
Company Contact	E-mail Address	Telephone #	Fax #	
Mailing Address (if P.O. Box, please provide physical address)		City	State	Zip
Billing Address (if Different)		City	State	Zip

3 EMPLOYER CONTRIBUTION (Note: Employer Contribution for health is a minimum of 50%¹ and for life is 100% (2-9) Enrollees and 25% (10-50 Enrollees)

Employee Health: _____% or, *\$_____ Employee Life: _____% Employee Dental: _____% Employee Vision: _____%
 Dependent Health: _____% or, *\$_____ Dependent Life: _____% Dependent Dental: _____% Dependent Vision: _____%

NOTE: Dental and Vision can be either voluntary (i.e., the employer contributes less than 50% of the premium) or employer sponsored (i.e., the employer contributes a minimum of 50% of the premium). If employer sponsored, you must complete the employee contribution. If you select Dental or Vision and no contributions are indicated, it is presumed that the plans will be voluntary. *Flat dollar contribution applies to Enhanced Choice option only.

¹Enhanced Choice only requires 50% of the lowest cost plan (excluding Salud), or \$100 minimum.

4 ELIGIBILITY INFORMATION

1. Probationary Period for New Hires/Rehires - First of the month following; <input type="checkbox"/> Date of hire <input type="checkbox"/> 1 mo. <input type="checkbox"/> 2 mos. <input type="checkbox"/> 3 mos. <input type="checkbox"/> ___mos. (6 max)				
2. Number of hours worked per week required to be eligible for medical insurance coverage: <input type="checkbox"/> 20 <input type="checkbox"/> 30				
	MEDICAL	LIFE	DENTAL	VISION
3. Number of Eligible Employees (include eligible owner(s))	_____	_____	_____	_____
4. Total Number of Health Net Enrollees (excluding COBRA enrollees)	_____	_____	_____	_____
5. Number of Health Net COBRA Enrollees (applying for health coverage)	_____	_____	_____	_____
6. Number of Waivers (Please include an enrollment form with Section 9 "Declination of Coverage" indicated.)	_____	_____	_____	_____
7. What type of COBRA ² are you subject to: If Federal COBRA, how would you like your COBRA enrollees to be billed:	<input type="checkbox"/> Federal COBRA <input type="checkbox"/> Group Billed	<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> Member Billed		
8. Within the last 12 months, has the employer held a Health Net contract?	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
9. Do the eligible enrollees represent a carve-out either; by class, location or union affiliation?	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
10. Has the group supplied the most recent quarter of their DE-6 with this application?	<input type="checkbox"/> YES	<input type="checkbox"/> NO ³		

²Note: Generally, employers who normally employed 20 or more employees during the previous calendar year are subject to federal COBRA. Employers who employed 2-19 employees on at least 50% of its working days the previous calendar year are subject to Cal-COBRA. Please consult your legal counsel if you need help determining which law applies to you.

³If a DE-6 is not available, please provide a letter of explanation and supporting documentation, subject to underwriting approval, with this group service agreement application.

5 LIFE AND AD&D BENEFIT SELECTION If Health Net Life is selected; all full time employees are eligible.

(Note: Options A & B are for 2-50 employees. Options C-G vary by group size.)

- Option A - \$15,000 flat amount for all employees.
- Option B - A flat amount higher than \$15,000; maximum \$100,000 \$ _____

Dependent Life: (choose one)

- High: \$5,000 spouse, \$2,000 child, \$200 infant (14 days-6 mos.)
- Low: \$2,000 spouse, \$1,000 child, \$100 infant (14 days-6 mos.)

- Option C - One (1) X Annual Salary; _____ or two(2) X Annual Salary; maximum \$50,000
- Option D - One (1) X Annual Salary; _____ or one and a half (1.5) X Annual Salary; _____ or two (2) X Annual Salary; maximum \$100,000
- Option E - Graded benefits by job title: Class I (officers, managers, supervisors) --- \$25,000; Class II (all other employees) --- \$15,000.
- Option F - Graded benefits by job title: Class I (officers, managers, supervisors) --- \$50,000; Class II (all other employees) --- \$25,000.
- Option G - Graded benefits by job title: Class I (officers, managers, supervisors) --- \$100,000; Class II (all other employees) --- \$50,000.

6 PRE-TAX SOLUTIONS (e.g. IRS code sections 125 and 132; Premium Only Plans and Flex Plans)

Are you interested in learning about the tax-savings potential for your employees and company? Yes No

If you have any questions, call Legal Systems at 1-888-738-5841, a Health Net dedicated number.

7 CURRENT CARRIER (List current carrier if any)

Is your company currently active with other health insurance? Yes No

If so, will you be canceling your other health insurance if approved with Health Net? Yes No

Health and/or Life: _____ Worker's Compensation: _____

Will one or both of the Health Net Entities be the only carrier(s)? Yes No If no, name of other carrier: _____

Plan offered: _____

Number of Enrollees not covered by Worker's Compensation: (Employers required to have Worker's Compensation must have a policy in effect to be eligible with Health Net.) _____

8 HEALTH QUESTIONNAIRE (For new groups only)

All employer groups must answer YES or NO to the following questions.

Employer groups of 6-9 enrolling employees must have each employee complete the Health Questionnaire with the Enrollment form.

1. To your knowledge is there any employee, dependent of an employee, or person to be covered who has received more than \$5,000 of medical care in the past two (2) years? YES NO
2. To your knowledge is any employee, dependent of an employee, or person to be covered unable to work due to injury or illness? YES NO
3. To your knowledge are there any current pregnancies or recent hospitalization for any employee, dependent of an employee, or person covered? YES NO
4. To your knowledge has any employee, dependent of an employee, or person to be covered ever had, consulted for, had treatment rendered, been advised to have treatment or received treatment, or been hospitalized for any of the following conditions:
Cardiovascular disease or heart attack; disorder of the kidney, stomach, intestines or liver; mental or nervous condition; central nervous system disorders; diabetes; respiratory disorders or cancer? YES NO
5. To your knowledge has any employee, dependent of an employee, or person to be covered ever been diagnosed as having AIDS or aids-related complex (ARC) by a medical professional? YES NO

For each "YES" answer, please provide the person(s) name and submit their completed employee health questionnaire.

9 ON LINE AUTHORIZATION (eServices)

Please complete this section to register and receive your bills on-line and/or process eligibility on-line. You will be notified by e-mail once your on-line account is created. Type of access requested (please check all that apply):

- Process Eligibility & Billing View and Process Eligibility View Billing only (no Eligibility access) Process Billing only (no Eligibility access)
- Allow access for both Employer and Broker Allow Employee access (no Billing permitted)

Please indicate below all parties who should be granted access to administer your billing and/or eligibility on-line. (Select all that apply):

- Employer only Broker only Employer and Broker Employer and Employee (eligibility only)*

*New enrollments, cancellations, and changes to eligibility data that are requested on-line by an employee will be pended for approval by the Benefit Administrator prior to being sent to Health Net for processing. Employees are not permitted access to on-line billing information.

10 UNDERWRITING CRITERIA

General Conditions

The issuance of coverage and a Group Service Agreement and/or Group Policy is subject to Underwriting review and approval by the Health Net Entities, the Safeguard Entities and/or the Fidelity Entities and receipt of first month's premium. The initial quoted rates are subject to the Health Net Entities, the Safeguard Entities and/or the Fidelity Entities review and revision based on actual enrollment and any other variations in the group from conditions outlined in the Underwriting Assumptions.

Coverage will be effective on the noted effective date if the application is accepted and approved by the Health Net Entities, the Safeguard Entities and/or the Fidelity Entities as appropriate within specified time requirements.

11 DISCLAIMER AGREEMENT

Please complete all of the information requested before signing this application. Please initial any changes.

This is an application only. Coverage and the issuance of a Group Service Agreement is subject to review and approval by Health Net Entities, the SafeGuard Entities and/or Fidelity Entities and receipt of first month's premium.

The undersigned hereby acknowledge that the preceding information constitutes true and complete representations to Health Net Entities, the SafeGuard Entities and/or Fidelity Entities. Should it be determined at the time of enrollment and/or at a future date that there are misstatements in this application, Health Net Entities, the SafeGuard Entities and/or Fidelity Entities may at their respective sole options either rescind the quote or initiate termination of the respective group contract(s).

Upon policy anniversary date, submission of renewal premium will confirm acceptance of that renewal and subsequent premium year.

Applicant, in the event this application is accepted, agrees to make authorized payroll dues deductions for such eligible employees who enroll under the agreement(s)/Policy and to forward such amounts in advance of the due date to the Health Net Entities, the Safeguard Entities and/or the Fidelity Entities, together with the reports necessary to maintain accurate and complete membership records. Furthermore, applicant agrees to comply with the applicable regulations pertaining to membership requirements, additions to the group and deletions from the group. Please return this application to your Health Net of California, Inc. and/or Health Net Life Insurance Company Account Executive or Broker as specified.

This "APPLICATION FOR GROUP SERVICE AGREEMENT" and any attached Addendum together with the Health Net Entities, the Safeguard Entities and/or the Fidelity Entities Group Policies (as referenced herein) and the employee enrollment forms form the entire agreement between the parties.

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

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

Arbitration Agreement: On behalf of Group Applicant, I understand and agree that any and all disputes or disagreements between Group (or enrolled members) and the Health Net Entities, the Safeguard Entities and/or the Fidelity Entities regarding the construction, interpretation, performance or breach of the Health Net Entities, the Safeguard Entities and/or the Fidelity Entities Group Policies, or regarding other matters relating to or arising out of the Health Net Entities, the Safeguard Entities and/or the Fidelity Entities Group Policies, whether stated in tort, contract or otherwise, must be submitted to final and binding arbitration in lieu of a jury or court trial. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties, including the Health Net Entities, the Safeguard Entities and/or the Fidelity Entities are giving up their constitutional rights to the extent permitted by law to have their dispute decided in a court of law before a jury. I also understand that disputes with the Health Net Entities, the Safeguard Entities and/or the Fidelity Entities involving claims for medical, services malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) are also subject to final and binding arbitration. A more detailed arbitration provision is included in the Health Net Entities, the Safeguard Entities and/or the Fidelity Entities Group Policies.

Effective July 1, 2002, members who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. § 1001 et seq., a federal law regulating benefit plans, are not required to submit disputes about certain "adverse benefit determinations" made by Health Net Entities, the Safeguard Entities and/or the Fidelity Entities to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by Health Net Entities, the Safeguard Entities and/or the Fidelity Entities to deny, reduce, terminate or not pay for all or a part of a benefit. However, members and Health Net Entities, the Safeguard Entities and/or the Fidelity Entities may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

Officer of the Company Signature	Officer Title	Date
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12 BROKER INFORMATION

Broker Name	Health Net Broker ID#	Broker Lic. #	Date Submitted
Agency Name	Telephone #	Fax#	E-mail Address
Address	City	State	Zip
Broker/Consultant Signature	Date	General Agent / ID#	

13 WHERE WOULD YOU LIKE YOUR ADMINISTRATION KIT MAILED

Broker Employer

14 FOR HEALTH NET USE ONLY

Underwriter Signature	Date	Approved: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision Declined: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Billing #	Effective Date
SBG Representative Signature	Date	Group# (Health)	Policy Holder # (Life)	Medical Plan

Health Net of California Inc. offers the following products: ELECT Open Access, HMO, SELECT POS

Health Net Life Insurance Company offers the following products: EPO, Flex Net , PPO, Life and AD&D insurance

SafeHealth Life Insurance Company offers the following products: PPO Dental

SafeGuard Health Plans, Inc. offers the following products: Dental HMO (DHMO)

Fidelity Security Life Insurance Company offers the following product serviced by EyeMed Vision Care, LLC: PPO Vision

