



Health Net

Health Net Health Plan of Oregon, Inc.
Quick Net PPO Daily / Monthly Policy

Non-Renewable Short-Term Health Insurance Application

Applicant must be the oldest person in the family unit, at least one year of age, less than 65 years of age, a U.S. citizen or permanent resident and not eligible for Medicare on the policy's effective date in order to qualify as an eligible applicant.

Applicant's Last Name, First Name, MI, Gender, Applicant's Birth Date, Home Address, City, State, Zip, County, Home Phone Number, Work Phone Number, Email Address, Applicant's Social Security Number

Dependents must be legal dependents of the applicant, at least 31 days of age, less than 65 years of age, a U.S. citizen or permanent resident and not eligible for Medicare on the policy's effective date in order to qualify as an eligible dependent. All applicants must reside at the same address.

Table with columns: Last Name, First Name, MI, Relationship to Applicant, Social Security Number, Sex, Date of birth. Rows for Spouse, Child 1, Child 2.

For additional dependents, please attach another sheet with the requested information.

PLAN CHOICE

Please designate your plan choice: \$500 Deductible, \$1,000 Deductible, \$2,500 Deductible, Optional Alcohol Treatment Benefits. Please request your effective date: (cannot precede the postmark date of this application). Requested effective date: \_\_\_/\_\_\_/\_\_\_ Please designate your plan type: Daily Plan, Monthly Plan

DAILY POLICY (COMPLETE ONLY IF CHOOSING DAILY PLAN)

Benefit Coverage Period: Please choose the number of days for your Benefit Period. Once enrolled, there are no changes permitted and the policy cannot be renewed. \_\_\_ days (30 - 185 Days). Calculate your total premium due: \$ \_\_\_ daily rate\* (please see rates) x \_\_\_ # of coverage days + \$20 non-refundable application fee = \$ \_\_\_ Total Amount Due. Please remit a check payable to "Health Net" for the full amount owed for the Policy Benefit Period and one-time application fee.

MONTHLY POLICY (COMPLETE ONLY IF CHOOSING MONTHLY PLAN)

Calculate your first month's premium due: \$ \_\_\_ monthly rate (please see rates) + \$20 non-refundable application fee = \$ \_\_\_ Total Amount Due. Please remit a check payable to "Health Net" for the first month's premium and one-time application fee.

MEDICAL QUESTIONS

During the previous 62 days, have you or any person applying for coverage been covered by other health insurance? Yes No. If Yes, please complete the prior coverage information below for all periods in the last 12 months. For additional dependents, please attach additional sheets.

Table with columns: Insured's name, Current carrier, Effective date, Expected termination date

1) Do you, or any person to be insured, now have hospital, major medical, group health or medical insurance coverage that will not terminate prior to the beginning of this policy? 2) Are you, or any person to be insured, including male applicants and dependent males or females, now pregnant or responsible for a current pregnancy? 3) Within the last 12 months, have you or any person to be insured, been advised to have or contemplated having an operation or medical procedure not yet performed? 4) Within the last 5 years, has anyone listed on this application had any diagnosis, treatment or advice relating to any of the following: heart, chest pain or angina, stroke, paralysis, diabetes, sugar in urine, cancer, alcohol, chemical or drug abuse or habit, liver, hepatitis or kidney disorder; or AIDS (acquired Immune Deficiency Syndrome) or ARC (AIDS-related Complex)?

5) Please provide the following information for each female on this application: Family Member: a. Initial menstrual cycle begun? b. Date of last menstrual period. c. If (b) is more than 35 days ago, please explain: d. Excessive or absent menstrual bleeding? e. If (d) is yes, please explain: Date of last DEPO Provera shot? Abnormal Pap smears? Prior Cesarean section or miscarriage?

How did you hear about Health Net Health Plan of Oregon, Inc.? Please check the box that best describes how your heard about us. Radio Mail Billboard Newspaper Yellow Pages Broker Internet Other

**IMPORTANT INFORMATION**

**I UNDERSTAND THAT:**

- The minimum coverage time under the Health Net Health Plan of Oregon, Inc. Quick Net **Daily Policy is 30 Days** and for the **Monthly Policy it is one calendar month**. The maximum length of coverage time is **185 Days for the Daily Policy and 6 months for the Monthly Policy**.
- Under no circumstances will I, or my dependents, be allowed to make changes except as outlined in the policy once it goes into force. **There is no ten-day free look period, and no refunds whatsoever under the Daily Policy**. No exceptions will be made.
- No benefits are payable for any expenses incurred as a result of a Pre-Existing Condition. Pre-Existing Condition means a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period preceding the effective date of coverage. Genetic information does not constitute a Pre-Existing Condition in the absence of a diagnosis of the condition related to such information. The Pre-existing Condition exclusion does not apply to a newborn or newly adopted child.
- If I am approved under a Health Net renewable plan I must exhaust my coverage under this Quick Net plan before the new plan becomes effective.
- My check will be held in trust while my application is reviewed by Health Net. Applications submitted **without payment** or with **partial payment** will be **pending** until payment is received. If my payment is not received within 2 weeks of the application signature date, my application will be withdrawn.

**Additional information for Monthly Policies Only:**

- If my Monthly policy is terminated due to lack of payment, my policy will **not** be reinstated.
- I may terminate my policy at any time, and refunds are limited as outlined in the policy.

INITIALS \_\_\_\_\_

**CERTIFICATION AND AUTHORIZATION**

**CERTIFICATION OF COMPLETION AND CORRECTNESS:** I affirm that the answers given in this application are complete and correct. I am providing these answers as part of the application procedure required by Health Net Health Plan of Oregon, Inc. to enroll in the insurance coverage. I understand that if this application contains any material misstatements or omissions, Health Net may, deny coverage, modify or cancel the contract, and/or take any other legal action available to it by law. I will promptly inform Health Net in writing if anything happens before my coverage takes effect that makes this incomplete or incorrect. I understand and agree that no coverage shall be in force until approved by Health Net. If approved, coverage will be in force as of the effective date determined by Health Net. Health Net may phone me to clarify answers on this application. As the applicant, I understand I have the right to inspect the information in my file.

**CONDITIONAL AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION**

**To any physician; health care provider, including OHSU; hospital, including OHSU; insurance or reinsurance company; the Medical Information Bureau, Inc. (MIB), or other insurance information exchange:** Each of us authorizes you to give Health Net Health Plan of Oregon, Inc. or its representatives any medical information (including alcohol, chemical dependency, mental treatment, or HIV treatment) you have about my family members or me. Such information may be used for processing application for coverage, for prior authorizing services or processing claims for benefits, or for purposes of health care provider credentialing, quality assurance, utilization review, case management, peer review, and audit. A photocopy of this authorization is as valid as the original. I understand that I may receive a copy of this authorization upon request.

This authorization takes effect on the date signed and it remains in effect as follows:

- For information used to process this application – 30 months.
- For information used for all the other reasons listed above – as long as coverage is in effect or until the completion of processing any claim, whichever is longer.

I affirm that I received a disclosure statement and outline of coverage from Health Net or Oregon or its authorized agent. I understand that a PPO policy will not pay benefits for any loss incurred during the first six months after the effective date on account of a disease of physical conditions, which I now have or have had in the past. I understand that if my application for coverage is accepted, I will have ten days after receiving notice of acceptance during which I may either make a replacement election or cancel the policy for a full refund. I affirm that my employer is not paying the premium for this coverage.

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

**Acceptance of a short-term policy will impact eligibility for individual guaranteed issue health insurance according to the requirements within the Health Insurance Portability and Accountability Act of 1996.**

**Signatures (REQUIRED IN INK)**

Family contact name, if different than the Primary Applicant Name	Date Signed
Applicant Signature	Date Signed
Spouse Signature	Date Signed
Signature of Applicant Dependent (age 18 or older)	Date Signed

**FOR AGENT USE ONLY: HEALTH NET AGENT ID: \_\_\_\_\_**

_____ Name (PRINT)	_____ Phone number:	_____ Fax number:
_____ Address	_____ Email address:	
_____ Agreement Signature/Number	_____ Date Signed (required)	

**Mail your completed application to: Health Net Individual & Family Enrollment, 13221 SW 68<sup>th</sup> Parkway, Suite 200, Tigard, Oregon 97223**