

**Please print out the form below and  
mail your completed form to:**

**Health Net Medicare Advantage  
13221 SW 68<sup>th</sup> Parkway, Suite 200  
Tigard, OR 97223**



**Health Net**<sup>®</sup>  
MEDICARE PROGRAMS

# Health Net Pearl Private-Fee-For-Service Plan

*Why* is choosing a health care company so complicated?  
The simple truth is, it doesn't have to be.

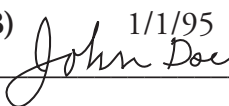
Health Net knows how challenging Medicare can be. We make enrolling simple and easy.

## HOW TO ENROLL IN HEALTH NET'S PEARL PRIVATE-FEE-FOR-SERVICE PLAN:

- Clearly print all information and complete all sections of the enclosed enrollment application.
- Copy the information from your Medicare card directly onto the application or attach a photocopy of your Medicare card (see sample below).
- Please keep the **goldenrod member copy** for your records. If you are completing this application yourself, please mail the top three copies to Health Net in the enclosed postage-paid envelope.

*After your application is received . . .*

- Once Health Net receives your application, a Customer Service Representative will call to follow-up. This call is to make sure that you understand how a Private Fee-for-Service Plan works and to answer any questions that you have.
- Please allow two weeks to process your enrollment. In most cases, your coverage begins the first of day of the month following the date you submit your application. Health Net will contact the Centers for Medicare & Medicaid (CMS) to verify your eligibility as well as confirm your effective date. For questions regarding benefits, how to enroll or how to complete this form, speak to your agent or call us before signing this form at 1-800-593-7892, TTD/TTY 1-800-929-9955 8 a.m. - 8 p.m., 7 days a week.

MEDICARE		HEALTH INSURANCE	
<b>SAMPLE ONLY</b>			
NAME OF BENEFICIARY			
John D. Doe			
MEDICARE CLAIM NUMBER		SEX	
123-45-6879A		MALE	
Is Entitled To		Effective Date	
<b>HOSPITAL (Part A)</b>		1/1/95	
<b>MEDICAL (Part B)</b>		1/1/95	
SIGN HERE			

- If any information is missing, or if the name on your Medicare card does not match your enrollment application exactly, Health Net will not be able to process your application.

**Please Note:** A Medicare Advantage Private Fee-for-Service plan works differently than a Medicare supplement plan. Your doctor or hospital must agree to accept the plan's terms and conditions prior to providing healthcare services to you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may not provide healthcare services to you, except in emergencies. Providers can find the plan's terms and conditions on our website at: [www.healthnet.com](http://www.healthnet.com).



# HEALTH NET PEARL PRIVATE FEE-FOR-SERVICE

## MEDICARE ADVANTAGE INDIVIDUAL ENROLLMENT FORM

TO ENROLL IN HEALTH NET *PEARL*, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Please refer to the Summary of Benefits for detailed information, service areas, benefits and costs associated with each plan. Please check one (1) plan you want to enroll in:

**Oregon Pearl Plan Option:**

Option 7 - \$99 / month

Option 16 - \$29 / month

**Optional Supplemental Benefit Packages Available for All PFFS Plans:\***

\$23 / month

**Option 7 available in these counties only:** Baker, Deschutes, Douglas, Gilliam, Jefferson, Klamath, Lake, Malheur, Morrow, Umatilla, Union, Wasco

**Option 16 available in these counties only:** Baker, Deschutes, Douglas, Gilliam, Jefferson, Klamath, Lake, Malheur, Morrow, Umatilla, Union, Wasco

\* Monthly premiums for Optional Supplemental Benefit Packages are in addition to monthly premiums for Health Net *Pearl* Private-Fee-For-Services plans. Please consult Health Net's Explanation for Coverage for more information.

<b>LAST Name:</b>	<b>FIRST Name:</b>	<b>Middle Initial:</b>	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
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<b>Birth Date:</b> (__ / __ / ____) (M M / D D / Y Y Y Y)	<b>Sex:</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Social Security Number:</b> (providing this information is optional)	<b>Home Phone Number:</b> (     )
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<b>Permanent Residence Street Address:</b>	<b>County:</b>
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<b>City:</b>	<b>State:</b>	<b>ZIP Code:</b>
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**Mailing Address:** (only if different from your Permanent Residence Street Address)

Street Address:	City:	State:	ZIP Code:
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**Emergency Contact:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Relationship to You:** \_\_\_\_\_


**E-mail Address:** \_\_\_\_\_

**PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION:**

Please take out your Medicare Card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card
- OR -
- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

**You must have Medicare Part A and Part B to join a Medicare Advantage plan.**

<b>MEDICARE HEALTH INSURANCE</b>	
	
<b>1-800-MEDICARE (1-800-633-4227)</b>	
Name: _____	
Medicare Claim Number _____	Sex _____
_____ - _____ - _____	
Is Entitled To _____	Effective Date _____
<b>HOSPITAL (Part A)</b>	_____
<b>MEDICAL (Part B)</b>	_____

**YOUR PLAN PREMIUM OPTIONS:**

You DO NOT have to choose a payment option if you have selected a \$0 Premium plan. You can pay your monthly plan premium by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security Check each month.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover.

If you don't select a payment option, you will receive a bill each month.

**How would you like to pay the premium?** (please check one):

- I want monthly premiums electronically transferred from my bank account.** Please complete a "Quick Pay" form and provide a voided check if your checking account is to be used.
- I want a bill sent directly to me.** We will send you a bill.
- I want the Social Security Administration to directly deduct the premium cost from my monthly Social Security Benefits Check.** Social Security Administration's withholding request process can take two or more months to begin. Health Net cannot control the timing of payment transactions between Social Security and Medicare. In most cases, the first deduction from your SSA benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.

\* Please refer to the Summary of Benefits for detailed information, service areas, benefits and costs associated with each plan.

**PLEASE READ AND ANSWER THESE IMPORTANT QUESTIONS:**

1. Do you have End-Stage Renal Disease (ESRD) ?     Yes     No

If you answered "yes" to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to Health Net Pearl?     Yes     No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage:            ID number for this coverage:            Group number for this coverage:

\_\_\_\_\_

4. Are you enrolled in your State Medicaid program?  Yes  No

If yes, please provide your Medicaid number: \_\_\_\_\_

5. Do you or your spouse work?  Yes  No

PLEASE PROVIDE THE NAME(S) OF YOUR CURRENT PHYSICIAN(S)/CLINICS:

Provider/Clinic Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

Office Number ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_\_

Provider/Clinic Address: \_\_\_\_\_

County: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Provider/Clinic Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

Office Number ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_\_

Provider/Clinic Address: \_\_\_\_\_

County: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Provider/Clinic Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

Office Number ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_\_

Provider/Clinic Address: \_\_\_\_\_

County: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Provider/Clinic Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

Office Number ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_\_

Provider/Clinic Address: \_\_\_\_\_

County: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Please check one of the boxes below if you would prefer us to send you information in a language other than English.  Spanish  Japanese  Chinese  Other: \_\_\_\_\_



PLEASE READ THIS IMPORTANT INFORMATION:

**If you currently have health coverage from an employer or union, joining Health Net Pearl could affect your employer or union health benefits.** If you have health coverage from an employer or union, joining Health Net Pearl may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

PLEASE READ:

**By completing this enrollment application, I agree to the following:** Health Net Pearl is a Medicare Advantage plan and I will need to keep my Parts A and B. I can only be in one Medicare Advantage plan at a time. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I do not have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to Health Net Pearl or by calling 1-800-Medicare. TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week.

Health Net Pearl serves a specific service area. If I move out of the area that Health Net Pearl serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Health Net Pearl, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Health Net Pearl when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan.

**PLEASE READ AND SIGN BELOW:**

**Release of Information:** By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Health Net *Pearl* will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Health Net *Pearl* or by Medicare.

<b>Your Signature:</b> _____	<b>Today's Date:</b> ___/___/___
	<b>Proposed Effective Date:</b> ___/___/___

If you are the authorized representative, you must provide the following information:

**Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**Phone Number:** ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ **Relationship to Enrollee:** \_\_\_\_\_

**INFORMATION TO DETERMINE ENROLLMENT PERIODS:**

During the **Annual Election Period from November 15 through December 31** you may choose to join any plan for which you are eligible. From **January 1 through March 31 most beneficiaries may change once. Beginning April 1 through the end of the calendar year, most beneficiaries are then "locked-in" to their plan.** Exceptions may apply, so please contact Health Net if you have questions. From the list below, please choose the situation that most closely resembles your personal circumstance. Health Net may contact you if additional information is needed.

- |  |  |
|--|--|
| <input type="checkbox"/> I have recently or will soon become eligible for Medicare Parts A and B due to age, retirement, or disability.<br><input type="checkbox"/> I am eligible to apply during the open enrollment period (January 1 - March 31).<br><input type="checkbox"/> I am eligible to switch to a similar medical and/or Part D plan after the open enrollment period.<br><input type="checkbox"/> I presently have Medicare only or a Medicare supplemental policy.<br><input type="checkbox"/> I have recently moved into a Health Net Medicare plan service area. | <input type="checkbox"/> I have both Medicare and Medicaid coverage or the State helps pay for my Medicare premiums, or I have recently lost such coverage or aid.<br><input type="checkbox"/> I reside in a long term care facility (such as a nursing home) or have moved from a long term care facility within the past two months.<br><input type="checkbox"/> I recently lost eligibility for a "PACE" program.<br><input type="checkbox"/> I am losing medical coverage provided by my employer, union, or retiree health plan.<br><input type="checkbox"/> Other: _____ |
|--|--|

**Authorized Agent Use Only:**

Broker or Agency Name: \_\_\_\_\_ Broker or Agency HN ID #: \_\_\_\_\_  
 Broker or Agency Phone #: \_\_\_\_\_ GA/FMO Name: \_\_\_\_\_ GA/FMO HN ID #: \_\_\_\_\_  
 Health Net Rep Name: \_\_\_\_\_ Health Net Rep ID #: \_\_\_\_\_ Health Net Rep Phone #: \_\_\_\_\_