Dear Health Net *Pearl* Member:

If you would like to change which Health Net *Pearl* plan you are currently enrolled in, please fill out the enclosed Health Net *Pearl* Short / Abbreviated Enrollment Form. Please check the new *Pearl* plan you want to enroll in, sign the form, and mail the completed form back to us in the enclosed postage-paid envelope.

Please be aware that you can change health plans only at certain times during the year. Between November 15 and December 31, 2007, anyone can join our plan. During the Open Enrollment Period, you can switch plans. However, if you have Part D coverage, the plan you switch to must have Part D coverage. If you do not have Part D coverage, the plan you switch to cannot have Part D coverage.

Please complete the attached form only if you wish to change to a different Pearl plan option.

To help you with your decision, we have also included a 2008 Summary of Benefits for the available *Pearl* options in your area.

If you have any questions, please call our Member Services Department at 1-800-977-8221, 8:00 A.M. – 8:00 P.M., 7 days a week. TTY/TDD users should call 1-800-929-9955, 8:00 A.M. – 8:00 P.M., 7 days a week.

Thank you again for choosing Health Net. We'll help you make A *better* DECISION℠.

Sincerely,

Mark El-Tawil
Chief Senior Products Officer

PDP43083
SAP: 6014973
CMS Approval: 11/07
Material ID: M0004_PFFS_07_085 (H5721, H5996)

Health Net Pearl, Post Office Box 1728, Augusta, GA 30903-1728

HEALTH NET *PEARL*

SHORT / ABBREVIATED ENROLLMENT FORM

Name:		
Home Phone Number:	**Member Number:**	
Permanent Street Address:		
City:	**State:**	**ZIP:**

Mailing Address (only if different from your Permanent Residence Address):

Street Address: ____

City: ______________________________ State: _______ ZIP: ________

PLEASE FILL OUT THE FOLLOWING:

I want to switch from my current *Pearl* plan to the plan I have selected below. I understand that if this form is received by the end of the month, my new plan will generally be effective the first of the following month.

I am currently a member of Health Net *Pearl* Option #___ with a monthly premium of $ _______________.

I would like to change to Health Net *Pearl* Option # ____. I understand that this plan has different health benefits and a monthly premium of $__________________.

I understand that if I choose a *Pearl* plan that includes Part D Prescription Drug coverage, I will be disenrolled from my current Part D plan.

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 services areas, benefits and costs associated with each plan.

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 any applicable 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 Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the United States border. 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.

Your Signature: ______________________________	**Today's Date:** _____/____/_____
	Proposed Effective Date: _____/_____/_____

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

Name: ______________________________

Address: ______________________________

Phone Number: (______) _______ - __________ **Relationship to Enrollee:** ____________________

Please mail this form to: *Health Net Pearl, P.O. Box 1728, Augusta, GA 30903-1728*

Office Use Only:

Name of Staff Member (if assisted in enrollment):______________________________

Plan ID:______________________________ Effective Date of Coverage:__________________

ICEP/IEP:______________________________ OEP:_________AEP:_______SEP (type):_______

PDP43019
SAP: 6014963
Material ID# M0004_PFFS_07_086 (H5721, H5996)
CMS Approval (11/07)