Health Net®
LIFE INSURANCE COMPANY

FOR INTERNAL USE ONLY		
Eligibility verified:	Group #:	Effective date:
Dependent plan: Stanford Student Dependent Health Insurance Plan		

Enrollment and Change Form

Important – Please print all sections in black ink. For the application to be valid, you must submit all applicable pages.

Part I. Selected coverage

Plan offered by your school:

☑ PPO

Plan enrollees:

- ☐ Child (N5274A)
- ☐ Children (N5274B)
- ☐ Spouse (N5274C)
- ☐ Spouse + child (N5274D)
- ☐ Spouse + children (N5274E)

Reason for application:

- ☐ Dependent of new student
- ☐ Qualifying event
  - ☐ Marriage
    Qualifying event date: _____
  - ☐ Birth or adoption of child
    Qualifying event date: _____
  - ☐ Involuntary loss of prior coverage
    Qualifying event date: _____

Reason for change:

- ☐ Change address/name
- ☐ Delete dependent(s)
  (list names in section 3)
- ☐ Other: _____

Part II. Stanford student personal information

Last name:	First name:	MI:	☐ Male ☐ Female
U.S. residence address:			
City:		State:	ZIP:
U.S. mailing address (if different from residence):			
City:		State:	ZIP:

Date of birth (mm/dd/yyyy):	Student ID number:	Social Security # (required):
Home telephone number: ( )	Mobile telephone number: ( )	Marital status: ☐ Single ☐ Married ☐ Domestic partner
Email address:	Student type: ☐ Undergrad ☐ Grad ☐ International undergrad	Campus: ☐ Palo Alto ☐ Monterey
Do you have other health care coverage? ☐ Yes ☐ No If "Yes," complete the following: Name of insurance carrier: Prior coverage start date:		Group #/Policy ID #:

The Affordable Care Act (ACA) requires Health Net to provide to the IRS confirmation of health care coverage for yourself, as the subscriber, and your covered dependents. The IRS uses this information to confirm each member has essential coverage and is not subject to the ACA's individual shared responsibility payment provision. Please ensure that the Social Security number (SSN) is accurate for yourself and each dependent you are enrolling. For more information on the individual shared responsibility payment provision, go to http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision.

Student name: ______________________________

Part III. Dependent information

Please list all eligible family members to be enrolled. (Attach additional sheets if necessary.)

☐ Spouse ☐ M ☐ F	Last name:	First name:	MI:

U.S. residence address: ☐ Check here if same as student

City:	State:	ZIP:

Date of birth (mm/dd/yyyy):	Social Security # (required for all applicants):	Coverage type: ☑ Medical
Home telephone number: ( )	Mobile telephone number: ( )	Email address:

Do you have other health care coverage? ☐ Yes ☐ No If "Yes," complete the following:
Name of insurance carrier: Prior coverage start date: Group #/Policy ID #:

☐ Son ☐ Daughter	Last name:	First name:	MI:

U.S. residence address: ☐ Check here if same as student

City:	State:	ZIP:

Date of birth (mm/dd/yyyy):	Social Security # (required for all applicants):	Coverage type: ☑ Medical
Home telephone number: ( )	Mobile telephone number: ( )	Email address:

Do you have other health care coverage? ☐ Yes ☐ No If "Yes," complete the following:
Name of insurance carrier: Prior coverage start date: Group #/Policy ID #:

☐ Son ☐ Daughter	Last name:	First name:	MI:

U.S. residence address: ☐ Check here if same as student

City:	State:	ZIP:

Date of birth (mm/dd/yyyy):	Social Security # (required for all applicants):	Coverage type: ☑ Medical
Home telephone number: ( )	Mobile telephone number: ( )	Email address:

Do you have other health care coverage? ☐ Yes ☐ No If "Yes," complete the following:
Name of insurance carrier: Prior coverage start date: Group #/Policy ID #:

☐ Son ☐ Daughter	Last name:	First name:	MI:

U.S. residence address: ☐ Check here if same as student

City:	State:	ZIP:

Date of birth (mm/dd/yyyy):	Social Security # (required for all applicants):	Coverage type: ☑ Medical
Home telephone number: ( )	Mobile telephone number: ( )	Email address:

Do you have other health care coverage? ☐ Yes ☐ No If "Yes," complete the following:
Name of insurance carrier: Prior coverage start date: Group #/Policy ID #:

(continued)

Part III. Dependent information (continued)

☐ Son ☐ Daughter	Last name:	First name:	MI:
U.S. residence address: ☐ Check here if same as student			
City:		State:	ZIP:
Date of birth (mm/dd/yyyy):	Social Security # (required for all applicants):		Coverage type: ☑ Medical
Home telephone number: ( )	Mobile telephone number: ( )	Email address:	
Do you have other health care coverage? ☐ Yes ☐ No If "Yes," complete the following: Name of insurance carrier:	Prior coverage start date:		Group #/Policy ID #:

Part IV. Acceptance of coverage

(Signature required.)

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

Acknowledgement and agreement: I understand and agree that by enrolling with or accepting services from Health Net Life Insurance Company, I and any enrolled dependents are obligated to understand and abide by the terms, conditions and provisions of the Insurance Policy. I have read and understand the terms of this application, and my signature below indicates that the information entered in this application is complete, true and correct to the best of my knowledge and belief, and I accept these terms.

BINDING ARBITRATION AGREEMENT: I, the student, understand and agree that any and all disputes between me (including any of my enrolled family members or heirs or personal representatives) and Health Net must be submitted to final and binding arbitration instead of a jury or court trial. This Agreement to arbitrate includes any disputes arising from or relating to the Insurance Policy[1] or my Health Net coverage, stated under any legal theory. This agreement to arbitrate any disputes applies even if other parties, such as health care providers or their agents or employees, are involved in the dispute. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties including Health Net are giving up their constitutional right to have their dispute decided in a court of law by a jury. I also hereby waive all rights to participate in any class action or class arbitration. I also understand that disputes that I may have with Health Net involving claims for medical 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. I understand that a more detailed arbitration provision is included in the Insurance Policy. Mandatory Arbitration may not apply to certain disputes if the Insurance Policy is subject to ERISA, 29 U.S.C. §§ 1001-1461. My signature below indicates that I understand and agree with the terms of this Binding Arbitration Agreement and agree to submit any disputes to binding arbitration instead of a court of law.

Print student name: _____

Student signature: _____ Date: _____

Premiums are due by the first day of a given month. Failure to remit your monthly premium to Health Net by the end of that month may result in termination of your coverage under the policy.

[1]"Insurance Policy" refers to the Health Net Life Insurance Company Blanket Policy.

Part V. Additional information

Please contact the Health Net Customer Contact Center at the toll-free numbers below should you need assistance in completing this form or if you have questions about your coverage:

English and Spanish	1-800-250-5226
Cantonese	1-877-891-9050
Korean	1-877-339-8596
Mandarin	1-877-891-9053
Tagalog	1-877-891-9051
Vietnamese	1-877-339-8621

Important: Use your copy of the Health Net enrollment form as your temporary ID card until you receive your permanent ID card.

PRECERTIFICATION

You, the member, are responsible for obtaining certification for certain services. Please check your student handbook for a list of services requiring precertification

For precertification, please call 1-800-977-7282

DISABLING CONDITIONS

If you or your family member were disabled as of the date of termination of coverage with a prior health insurer, and the loss of coverage was due to the termination of the student's insurance policy, you may be entitled to an extension of health benefits according to California Insurance Code section 10128. Under this law, the prior insurer retains responsibility until whichever of the following occurs first: (a) the member is no longer totally disabled; (b) the maximum benefits of the prior insurer's coverage are paid; or (c) a period of 12 consecutive months has passed since the date coverage ended with the prior insurer.

PRODUCTS

Health Net Life Insurance Company offers the following product: PPO.

Please visit us at: www.healthnet.com/cardinalcare

Health Net Life Insurance Company ("Health Net") complies with applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, sexual orientation, age, disability, or sex.

Health Net:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at **1-800-250-5226 (TTY: 711)**

If you believe that Health Net has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by calling the number above and telling them you need help filing a grievance; Health Net's Customer Contact Center is available to help you. You can also file a grievance by mail, fax or online at:

Health Net Life Insurance Company
P.O. Box 10348
Van Nuys, CA 91410-0348

Fax: 1-877-831-6019

Online: healthnet.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

Complaint forms are available at http://**www.hhs.gov/ocr/office/file/index.html.**

Spanish
Servicios de idiomas sin costo. Puede solicitar un intérprete. Puede obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación o al 1-800-250-5226 (TTY: 711). Para obtener más ayuda, llame al Departamento de Seguros de California, al 1-800-927-4357.

Chinese
免費語言服務。您可使用口譯員。您可請人將文件內容唸給您聽，並將部分文件以您的語言寄給您。
如需協助，請致電您會員卡上所列的電話號碼或致電1-800-250-5226（TTY：711）與我們聯絡。
如需更多協助：請致電 1-800-927-4357 與 CA Dept. of Insurance 聯絡。

Korean
무료 언어 서비스. 통역 서비스를 받으실 수 있으며, 한국어로 문서를 번역해 읽어달라고 하거나 일부 서류를 번역해 우송해 달라고 요청하실 수 있습니다. 도움이 필요하시면 보험 ID 카드에 인쇄된 번호 또는 1-800-250-5226 (TTY: 711) 번으로 전화해 주십시오. 추가 도움이 필요하시면 캘리포니아 주 보험국에 1-800-927-4357번으로 전화해 주십시오.

Arabic
خدمات اللغة مجانية. يمكنك الحصول على مترجم فوري. ويمكنك الحصول على وثائق مقروءة لك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة الهوية، أو اتصل على الرقم 1-800-250-5226 (TTY: 711) للحصول على مزيد من المساعدة: اتصل بدائرة الصحة في كاليفورنيا على الرقم 1-800-927-4357.

Armenian
Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեզ: Օգնության համար զանգահարեք մեզ ձեր ID քարտի վրա նշված հեռախոսահամարով կամ զանգահարեք 1-800-250-5226 (TTY՝ 711) հեռախոսահամարով: Լրացուցիչ օգնության համար՝ զանգահարեք Կալիֆորնիայի Ապահովագրության բաժին՝ 1-800-927-4357 հեռախոսահամարով:

Hindi
नि:शुल्क भाषा सेवाएँ। आप एक दुभाषिया प्राप्त कर सकते हैं। आपको दस्तावेज़ आपकी भाषा में पढ़कर सुनाए जा सकते हैं और कुछ आपको आपकी भाषा में भेजे जा सकते हैं। सहायता के लिए, आपके आईडी कार्ड पर दिये नम्बर पर या 1-800-250-5226 (TTY: 711) पर हमें फोन करें। अधिक सहायता के लिए: कैलिफोर्निया डिपार्टमेंट ऑफ इंशोरेंस (बीमा विभाग) को 1-800-927-4357 पर फोन करें।

Japanese
無料の言語サービス。通訳をご利用いただけます。文書をお読みします。援助が必要な場合は、IDカードに記載されている番号または 1-800-250-5226 (TTY: 711) までお電話ください。さらに援助が必要な場合は、カリフォルニア州保険局 1-800-927-4357 までお電話ください。

Khmer
មិនមានការគិតថ្លៃសេវាភាសា។ អ្នកអាចទទួលបានអ្នកប្រែម្នាក់។ អ្នកអាចឲ្យគេអានឯកសារឲ្យអ្នកស្តាប់។ សម្រាប់ជំនួយ សូមហៅទូរស័ព្ទមកកាន់យើងខ្ញុំតាមរយៈលេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក ឬហៅ មកកាន់លេខ 1-800-250-5226 (TTY: 711)។ សម្រាប់ព័ត៌មានបន្ថែម សូមទូរស័ព្ទមកកាន់ក្រសួងធានារ៉ាប់រងរដ្ឋ CA តាមរយៈលេខ 1-800-927-4357។

Punjabi
ਮੁਫ਼ਤ ਵਿੱਚ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ ਅਤੇ ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-800-250-5226 (TTY: 711) 'ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੀ ਮਦਦ ਲਈ: ਕੈਲੀਫ਼ੋਰਨੀਆਂ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ (ਬੀਮਾ ਵਿਭਾਗ) ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ।

Russian
Бесплатная помощь переводчиков. Вы можете получить помощь устного переводчика. Вам могут прочитать документы. За помощью обращайтесь к нам по телефону, приведенному на вашей идентификационной карточке участника плана, или по телефону 1-800-250-5226 (TTY: 711). За дополнительной помощью обращайтесь в Департамент страхования штата Калифорния (CA Dept. of Insurance), телефон 1-800-927-4357.

Tagalog
Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng isang interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo. Para sa tulong, tawagan kami sa nakalistang numero sa inyong ID card o tumawag sa 1-800-250-5226 (TTY: 711). Para sa karagdagang tulong: Tawagan ang Kagawaran ng Insurance ng CA sa 1-800-927-4357.

Thai
ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังได้ สำหรับความช่วยเหลือ โทรหาเราตามหมายเลขที่ให้ไว้บนบัตรประจำตัวของคุณ หรือ โทร 1-800-250-5226 (TTY: 711) สำหรับความช่วยเหลือเพิ่มเติม โปรดโทรหากรมการประกันภัยแคลิฟอร์เนียที่ 1-800-927-4357

Vietnamese
Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu cầu được đọc cho nghe tài liệu. Để nhận trợ giúp, hãy gọi cho chúng tôi theo số được liệt kê trên thẻ ID của quý vị hoặc gọi số 1-800-250-5226 (TTY: 711). Để được trợ giúp thêm: vui lòng gọi đến Sở Bảo hiểm California theo số 1-800-927-4357.

Persian (Farsi)
خدمات زبان به طور رایگان. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید که اسناد برایتان قرائت شوند. برای دریافت کمک، تماس بگیرید. برای دریافت راهنمایی 1-800-250-5226 (TTY: 711) با ما به شماره ای که در کارت شناسایی شما قید شده یا به شماره بیشتر: با سازمان بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید.

Hmong
Kev Pab Txhais Lus Dawb. Koj xav tau ib tug neeg txhais lus los tau. Koj xav tau neeg nyeem cov ntaub ntawv xa tuaj rau koj los tau. Xav tau kev pab, hu peb tus xov-tooj ntawm koj daim npav (ID Card) los sis hu 1-800-250-5226 (TTY: 711). Xav tau kev pab ntxiv: hu lub xeev California qhov Chaws Pov-Hwm ntawm 1-800-927-4357.

Navajo
Saad dco báhílínígóó bee háká'at'oowoł. At'a'hani' shóodíłt'eeł. Saad naaltsoos biká'ígíí nich'į yídóot'ah. Naaltsoos bee nééhoozinígíí neít'áánígíí bekáagi bek'ego béésh bee hodíłne'ĥígíí bik'áá' éidoodagóó t'óó kojį' hodíłne 1-800-250-5226 (TTY:711). Náásgóó níká'at'oowoł: Ahéédháshíjjí Béeso Ách'ą́ąh naa'nil bich'į hwodíłne 1-800-927-4357.