Individual & Family Plans

Health Net®

HIPAA PPO Guaranteed Issue *Enrollment* Application

Requested effective date ☐☐/☐☐/☐☐☐☐

Application must be typed or completed in blue or black ink.

The application must be completed by the applicant applying for coverage and can be completed by the applicant for minor dependents or by an interpreter for applicants who do not read/write English. Neither broker nor any other person than those mentioned above may sign this application and agreement on behalf of the applicant.

Important: Can you read this form? If not, we can have somebody help you read it. You may also be able to get this form written in your language. For free help, please call right away at 1-800-909-3447, option 2.

Importante: ¿Puede leer este formulario? De no ser así, podemos hacer que alguien le ayude a leerlo. También puede obtener este formulario escrito en su idioma. Para obtener ayuda sin costo, llame inmediatamente al 1-800-909-3447, opción 2.

重要資訊：您是否能閱讀此文件?如果您無法閱讀，我們將請專人協助您。我們也能以您使用的語言翻譯此份文件。請立即致電 1-800-909-3447，再按 2，洽詢免費服務。

If you need assistance in completing this application, a broker may assist you. A broker who helped you read and complete this application must sign the application (see Part V).

Part I. Tell us who you are enrolling and select the product

A. Reason for application	B. Billing options	C. Choice of coverage
Family type ☐ Self ☐ Self and spouse/domestic partner ☐ Self and child ☐ Self and children ☐ Self, spouse/domestic partner and child(ren) ☐ **Please check box for domestic partner enrollment** **Enrollment type** ☐ New enrollment ☐ Add dependent	**First premium payment (select one)** ☐ Automated bank draft (Please complete the Simple Payment Option section on page 7.) ☐ Pay by check (Please include completed check and send with application. Amount must match monthly premium.) ☐ Credit card (Please complete the credit card section on page 7.) **Monthly premium payments (select one)** ☐ Automated bank draft (Please complete the Simple Payment Option section on page 7.) ☐ Monthly bill	**Health Net Life Insurance Company –** 1st and 15th of the month effective dates are available. ☐ **HIPAA PPO Value 4500** ☐ **HIPAA PPO Advantage 6500**

Part II. Applicant information

Primary applicant's last name:	First name:	MI:	☐ Male ☐ Female
Home address:			
City:	State:	ZIP:	County applicant resides in:
Home phone number: ( )	Work phone number: ( )	Email address:	
Primary applicant's birth date (mm/dd/yy):	Primary applicant's Social Security number:		
In the past 6 months, have you been a resident of the United States? ☐ Yes ☐ No If "No," where was your last residence? _____			

Primary's Social Security Number

Part III. Family member(s) to be enrolled

List all eligible family members to be enrolled other than yourself. If a listed family member's last name is different from yours, please explain on a separate sheet of paper. For additional dependents, please attach another sheet with the requested information.

☐ Check here if supplemental page is attached.

For domestic partner coverage, all requirements for eligibility, as required by the applicable laws of the State of California, must be met and a joint Declaration of Domestic Partnership must be filed with the California Secretary of State. **To be processed under one Policyholder, all family members must reside at the same address.**

Relation	Last name	First name	MI	Social Security number	Date of birth
☐ Husband ☐ Wife ☐ Domestic partner				– –	/ /
Relation Child 1	**Last name**	**First name**	**MI**	**Social Security number**	**Date of birth**
☐ Son ☐ Daughter				– –	/ /
Relation Child 2	**Last name**	**First name**	**MI**	**Social Security number**	**Date of birth**
☐ Son ☐ Daughter				– –	/ /
Relation Child 3	**Last name**	**First name**	**MI**	**Social Security number**	**Date of birth**
☐ Son ☐ Daughter				– –	/ /

Part IV. HIPAA guaranteed issue coverage

If you do not qualify for the Individual HMO or PPO plans, you may be considered for coverage under the HIPAA guaranteed issue plans. The HIPAA guaranteed issue plans do not require underwriting (medical history review and determination of coverage) and the rates are higher compared to the other Individual plans. If you qualify for coverage under the HIPAA guaranteed issue plans, please request the complete benefit details and rates for those plans. To be eligible for HIPAA guaranteed issue coverage, you must meet every condition below.

1. Have you had a total of at least 18 months of health care coverage (including COBRA or Cal-COBRA, if applicable) without more than a 63-day break (excluding any employer-imposed waiting periods) in coverage? Please note that you must apply for HIPAA coverage within the 63-day break after your group health care coverage (including COBRA or Cal-COBRA, if applicable) ended.	☐ Yes ☐ No
2. Was your most recent coverage through a group health plan (COBRA and Cal-COBRA are considered group coverage)?	☐ Yes ☐ No
3. Are you currently eligible for coverage under a group health plan, Medicare or Medicaid? ***(If "Yes," you are not eligible for HIPAA coverage.)***	☐ Yes ☐ No
4. Was your most recent coverage terminated because of nonpayment or fraud?	☐ Yes ☐ No
5. Were you eligible under COBRA or Cal-COBRA? Yes, start date: _____ end date: _____ If "Yes," did you accept and use up all benefits that were available? If "No," please explain: _____	☐ Yes ☐ No ☐ Yes ☐ No

Primary's Social Security Number

Part V. Applicant's agent/broker information

Complete agent/broker name and address is necessary for correspondence to be sent to the agent/broker.

Health Net Broker ID: 6173

Name (print):	Phone number:	Fax number:
BayCrest Ins Svcs,	408 2494611	408-243-9695
Address:	Email address:	
Applicant's broker signature/number *(required)*:	**Date signed *(required)*:**	

Broker certification

I, _____ (Name of broker),

(NOTE: You must select the appropriate box. You may only select one box.)

(_____) did not assist the applicant(s) in any way in completing or submitting this application. All information was completed by the applicant(s) with no assistance or advice of any kind from me. I understand that, if any portion of this statement by me is false, I may be subject to civil penalties, including but not limited to a fine of up to $10,000.

OR

(_____) assisted the applicant(s) in submitting this application. All information in the health questionnaire(s) was completed by the applicant(s). I advised the applicant(s) that he or she should answer all questions completely and truthfully and that no information requested on the application should be withheld. I explained that withholding information could result in rescission or cancellation of coverage in the future. The applicant(s) indicated to me that he or she understood these instructions and warnings. To the best of my knowledge, the information on the application is complete and accurate. I understand that, if any portion of this statement by me is false, I may be subject to civil penalties, including but not limited to a fine of up to $10,000.

Please answer all questions 1 through 4:

1. **Who filled out and completed the application form?** _____
2. Did you personally witness the applicant(s) sign the Application? ☐ Yes ☐ No
3. Did you review the application after the applicant(s) signed it? ☐ Yes ☐ No
4. Are you aware of any information, including but not limited to medical history, not disclosed in this application, that might have a bearing on the risk? ☐ Yes ☐ No

   If "Yes," please explain: _____

Part VI. Individual & Family Plans Exception to Standard Enrollment – Statement of Accountability

Instructions for Part VI: The following process is to be used when the applicant cannot complete the application because he or she cannot read, write and/or speak the language of the application. Health Net requires that if you need assistance in completing this application, you must employ the services of a qualified interpreter. Please contact Health Net at 1-800-909-3447, option 2, for information about qualified interpreter services and how to obtain them. This form must be submitted with the Individual & Family Plan HIPAA guaranteed issue enrollment application when applicable.

Health Net Qualified Interpreter – Please complete the following when assisted by a Health Net Qualified Interpreter.

I, _____, was assisted in the completion of this application by a qualified interpreter authorized by Health Net because I:

☐ Do not read the language of this application. ☐ Do not speak the language of this application.

☐ Do not write the language of this application. ☐ Other (explain): _____

A qualified interpreter assisted me with the completion of: ☐ The entire application.

☐ Other (explain): _____

A qualified interpreter read this application to me in the following language: _____

Primary's Social Security Number

Part VI. Statement of Accountability (cont.)

Signatures and date *(required in ink)*

Signature of applicant:	Today's date:
Date application was interpreted:	Time application was interpreted:
Qualified interpreter number:	

Qualified interpreter other than a Health Net Qualified Interpreter – Please complete the following when assisted by a qualified interpreter other than a Health Net Qualified Interpreter.

If a qualified interpreter, other than a qualified interpreter provided by Health Net, assisted you in completing this application, the interpreter must complete the following:

I, _____, understand that a qualified interpreter should: (a) have the vocabulary equivalent of a native speaker that has received an advanced education (college or university equivalent) in the non-English language; (b) be able to demonstrate cultural sensitivity in their communication, taking into consideration that every language encompasses a wide range of variation; (c) have native speaker language skills (native speaker language skills are developed by growing up or functioning in a language community); and (d) have corresponding reading and writing skills in the non-English language (the reading and writing skills would be demonstrated by advanced education in the native language).

As a qualified interpreter, I personally read and completed the application for the applicant named above because:

☐ Applicant does not read the language of this application.

☐ Applicant does not speak the language of this application.

☐ Applicant does not write the language of this application.

☐ Other (explain): _____

Under the penalty of perjury, I declare that I read to the applicant:

☐ The entire application ☐ Other: _____

I read this application to the applicant in the following language: _____

Please provide the following information regarding the qualified interpreter who assisted the applicant and who is not a Health Net Qualified Interpreter:

Last name:	First name:
Address of qualified interpreter:	City, State and ZIP:
Phone: ( )	Date:
Qualified interpreter signature:	

Primary's Social Security Number

Part VII. Conditions of enrollment

GENERAL CONDITIONS: **Health Net reserves the right to reject any application for enrollment if the applicant is not eligible for HIPAA guaranteed issue coverage. Health Net may selectively reject the applicant or a dependent who is not eligible for HIPAA guaranteed issue coverage.** There is no coverage unless this application is accepted by Health Net's Underwriting Department and a Notice of Acceptance is issued to the applicant even though you paid money to Health Net for the first month's premium. Cashing your check does not mean your application is approved. If rejected, your money will be returned to you. No other department, officer, agent or employee of Health Net is authorized to grant enrollment. The applicant's agent or broker cannot grant approval, change terms or waive requirements of this application. This application shall become a part of the Insurance Policy.

ANY FRAUDULENT OR WILLFUL NONDISCLOSURE OR MISREPRESENTATION OF MATERIAL FACTS in application materials is cause for disenrollment and rescission of the Insurance Policy, and Health Net may recoup from the policyholder (or from you or from the applicant) any amounts paid for covered services obtained as a result of such fraudulent or willful nondisclosure or misstatement of material fact. In addition, if a policyholder makes a fraudulent or willful nondisclosure or misrepresentation of material facts on application materials, Health Net shall have no liability for the provision of coverage under the Insurance Policy.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: I acknowledge and understand that health care providers may disclose health information about me or my dependents to Health Net. Health Net uses and may disclose this information for purposes of treatment, payment and health plan operations, including but not limited to, utilization management, quality improvement, disease or case management programs. Health Net's Notice of Privacy Practices is included in the Insurance Policy, and I may also obtain a copy of this Notice on the website at www.healthnet.com or through the Health Net Customer Contact Center. Authorization for use and disclosure of protected health information shall be valid for a period of 24 months from the date of my signature below.

IF SOLE APPLICANT IS A MINOR: If the sole applicant under this application is under 18 years of age, the applicant's parent 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.

IF APPLICANT CANNOT READ THE LANGUAGE OF THIS APPLICATION: If an applicant does not read the language of this application and an interpreter assisted with the completion of the application, the applicant must sign and submit the Statement of Accountability (see Part VI of this application, "Individual & Family Plans Exception to Standard Enrollment – Statement of Accountability").

Primary's Social Security Number

Part VIII. Important provisions

NOTICE: 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.

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health care services, plans or insurance companies as a condition of obtaining coverage.

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA) COMPLIANCE STATEMENT: Please do not include any family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which you believe you may be at risk.

ACKNOWLEDGEMENT AND AGREEMENT: I, the applicant, understand and agree that by enrolling with or accepting services from Health Net, I and any enrolled dependents shall comply with the terms, conditions and provisions of the Insurance Policy (to obtain a copy of the Insurance Policy, call Health Net at 1-800-909-3447, option 2). I, the applicant, 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, and I accept these terms.

BINDING ARBITRATION AGREEMENT: I, the applicant, 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 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 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.

Applicant or parent or legal guardian's signature if applicant is under 18 years old:	Date signed:	Signature of applicant's dependent (age 18 or older):	Date signed:
Signature of spouse/domestic partner or applicant's dependent (age 18 or older):	Date signed:	Signature of applicant's dependent (age 18 or older):	Date signed:
Signature of applicant's dependent (age 18 or older):	Date signed:	Signature of applicant's dependent (age 18 or older):	Date signed:

The application and this Arbitration Clause must be signed by the applicant(s). The applicant(s) must personally sign his or her name in ink and agree to comply with the Arbitration Clause and the terms, conditions and provisions of the application and the Insurance Policy in order for this application to be processed. For this application to be considered, neither broker nor any other person may sign this application and Arbitration Clause.

Make personal check payable to "Health Net." Return completed application to: Health Net Individual & Family Enrollment, PO Box 1150, Rancho Cordova, CA 95741-1150

Primary's Social Security Number

Primary applicant's name: _____

Part VIII. Important provisions (cont.)

You may submit a photocopy or facsimile of the application and authorizations. Health Net recommends that you retain a copy of this application and authorizations for your records.

All references to "Health Net" herein include the affiliates and subsidiaries of Health Net which underwrite or administer the coverage to which this enrollment application applies. "Insurance Policy" refers to Health Net Life Insurance Company Explanation of Your Insurance Plan, Health Net PPO Policy.

Simple Payment Option for Individual & Family Plans

Automatic Bank Draft (ABD) ☐ First month's payment ☐ Monthly premium payment

Monthly premium charge can be withdrawn directly from your personal checking or savings account. The premium will be withdrawn from your bank account about ten days in advance of the due date. Please select your account type: ☐ Checking ☐ Savings

Transit routing number (9 digits):	Account number:
Bank name:	State:

I understand that, by requesting the automatic payment option, I am authorizing Health Net of California, Inc. and Health Net Life Insurance Company ("Health Net"), and my financial institution named above, to debit my checking or savings account for my monthly premium payment(s).

I understand that the premium withdrawn from my account will be for the future billing period, plus any past due balances. I understand that my premium payments will automatically adjust if my monthly premium changes.

This authority is to remain in effect until revoked by me in writing, and, until Health Net actually receives such notice, I agree that Health Net shall be fully protected in honoring any such debit. ***(Note: A 30-day notice is required to discontinue this service due to the time required to initiate this change with my bank.)***

ABD transmissions are withdrawn from my bank account on approximately the 20th of every month, for the following month's premium. I understand that if there are insufficient funds at the time my account is debited, a service fee of $25.00 (in addition to any fees my bank may charge me) will be assessed by Health Net for all dishonored payments. I further agree that if any such debit is dishonored, whether with or without cause and whether intentionally or inadvertently, Health Net shall be under no liability whatsoever even though such dishonor may result in the loss of health coverage.

Signature of account holder (required to process):	Date:

☐ **Credit card for first month's payment**

First month's premium can be charged directly to your credit card account. All future premiums due may be made by Automatic Bank Draft (complete the form above) or by mailing a check. **Your card will be charged for the first month's premium on the day your application is approved by underwriting.**

First name (as on card):	Middle (as on card):	Last name (as on card):	Card type: ☐ Visa ☐ MasterCard
Account number 16 digits (complete):		Expiration date (mm/yy):	
Billing address:		City:	State: ZIP[1]:

As a convenience, I request and authorize Health Net to charge my credit card account identified above for the payment of my initial premium. I understand that my first month's withdrawal charge may be for multiple periods depending upon my date of approval and the bill period. This authority is to remain in effect until revoked by me in writing, and, until Health Net actually receives such notice, I agree that Health Net shall be fully protected in honoring any such charge. I further agree that if my credit card is declined for payment, whether with or without cause and whether intentionally or inadvertently, **I will be charged a $25 service charge.**

Signature of credit card account holder (required to process):	Date:

[1]The ZIP code must match the cardholder's address; otherwise, the credit card cannot be processed.

Health Net®

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card, or employer group applicants please call Health Net's Commercial Contact Center at 1-800-522-0088. Individual and Family Plan (IFP) or Farm Bureau applicants please call 1-800-909-3447, option 2. For more help call the CA Dept. of Insurance at 1-800-927-4357 if you are enrolling in a PPO plan. If you are enrolling in an HMO plan, call the DMHC Helpline at 1-888-HMO-2219.

English

Servicios de Idiomas Sin Costo. Usted puede solicitar un intérprete. Puede solicitar que una persona le lea los documentos y que algunos se le envíen en su idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación; los solicitantes de grupo de empleadores deben llamar al Centro de Comunicación Comercial de Health Net al 1-800-522-0088. Los solicitantes del Plan Individual y Familiar (IFP, por sus siglas en inglés) o de la Oficina Agrícola, deben llamar al 1-800-909-3447, opción 2. Para obtener ayuda adicional llame al Departamento de Seguros de California al 1-800-927-4357, si desea inscribirse en un plan PPO. Si usted se inscribe en un plan HMO, llame a la Línea de ayuda de DMHC, al 1-888-HMO-2219.

Spanish

免費語言服務。您可以取得口譯員服務。我們可以把文件朗讀給您聽，部分文件可以翻譯成您的語言並寄送給您。如需協助，請撥打您會員卡上所列的電話號碼，雇主團體申請人請致電 Health Net 的商業聯絡中心，電話 1-800-522-0088。個人和家庭計畫 (IFP) 或農業局申請人請撥打 1-800-909-3447，請按 2。若您投保 PPO 計畫，請致電 1-800-927-4357 與加州保險局聯絡，詢求額外協助。若您投保 HMO 計畫，請撥打加州醫療保健計畫管理局 (DMHC) 協助專線，電話 1-888-HMO-2219。

Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được cấp dịch vụ thông dịch. Quý vị có thể được người khác đọc giúp các tài liệu bằng ngôn ngữ của quý vị và cũng có thể được cấp tài liệu phiên dịch sang ngôn ngữ của quý vị. Để được giúp đỡ, xin gọi chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị. Những người muốn xin bảo hiểm theo nhóm do hãng sở đài thọ xin gọi Trung Tâm Liên Lạc Thương Mại của Health Net tại số 1-800-522-0088. Những người muốn xin bảo hiểm của Chương Trình Bảo Hiểm Cá Nhân và Gia Đình (IFP) hoặc Farm Bureau, xin gọi số 1-800-909-3447, bấm số 2. Để được giúp đỡ thêm, xin gọi Bộ Bảo Hiểm California tại số 1-800-927-4357 nếu quý vị đang tham gia một chương trình PPO. Nếu quý vị đang tham gia một chương trình HMO, xin gọi Đường Dây Trợ Giúp của DMHC tại số 1-888-HMO-2219.

Vietnamese

무료 언어 지원 서비스. 무료 통역사 서비스 및 여러분에게 편한 언어로 서류 낭독 서비스를 받을 수 있습니다. 도움이 필요하신 분은 본인의 ID 카드상에 적힌 안내 번호로 전화해 주십시오. 고용주 그룹 가입 신청자님의 경우 Health Net의 상업(Commercial) 고객 서비스 센터, 안내번호 1-800-522-0088 번으로 전화해 주십시오. 개인 및 가족 플랜 (IFP) 혹은 Farm Bureau 가입 신청자님은 안내번호 1-800-909-3447번, 옵션 2를 이용해 주십시오. PPO 플랜에 가입하신 경우, 더 많은 도움이 필요하신 분은 캘리포니아 보험 담당국 안내번호 1-800-927-4357번으로 문의하십시오. HMO 플랜에 가입하신 경우, DMHC(보건관리부) 헬프라인, 안내번호 1-888-HMO-2219번으로 문의하십시오.

Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa iyong wika ang mga dokumento. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card, o para sa employer group applicants, mangyaring tumawag sa Commercial Contact Center ng Health Net sa 1-800-522-0088. Para sa Individual and Family Plan (IFP) o Farm Bureau applicants, mangyaring tumawag sa 1-800-909-3447, opsyon 2. Para sa karagdagang tulong, tumawag sa CA Dept. of Insurance sa 1-800-927-4357 kung ikaw ay nag-eenroll sa isang PPO plan. Kung ikaw ay nag-eenroll sa isang HMO plan, tawagan ang DMHC Helpline sa 1-888-HMO-2219.

Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար ձեր լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տումսի վրա նշված համարով, կամ եթե գործատիրոջ խմբի դիմորդ եք, խնդրում ենք 1-800-522-0088 համարով զանգահարել Health Net-ի Հաճախորդի Կապի Կենտրոն: Անհատական և Ընտանեկան Ծրագրի (Individual and Family Plan/IFP) դիմորդներից խնդրվում է զանգահարել 1-800-909-3447 համարով, ընտրանք 2: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք, եթե գրանցվում եք PPO ծրագրում: Եթե գրանցվում եք HMO ծրագրում, 1-888-HMO-2219 համարով զանգահարեք DMHC-ի Օգնության գծին:

Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и вам могут прочесть документы на вашем языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте. Участники плана группового страхования по месту работы могут обратиться в коммерческий контактный центр компании Health Net по телефону 1-800-522-0088. Участники планов индивидуального или семейного страхования (Individual and Family Plan, IFP), а также планов страхования Фермерского бюро: пожалуйста, звоните по номеру 1-800-909-3447, добавочный 2. Если вы участвуете в плане системы предпочтительного выбора (Preferred Provider Organization, PPO), для получения дополнительной помощи звоните в Департамент страхования штата Калифорния по телефону 1-800-927-4357. Если вы состоите в плане организаций медицинского обслуживания (Health Maintenance Organizations, HMO), пожалуйста, звоните в горячую линию Департамента организованного медицинского обслуживания (DMHC) по телефону 1-888-HMO-2219.

Russian

無料の言語サービス。日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号までお問い合わせください。雇用者団体への加入申込の方は、Health Net 民間コンタクト・センター、1-800-522-0088 までご連絡ください。個人・家族プラン (IFP) またはファーム・ビューローへの加入申込の方は、1-800-909-3447（ダイアル後 2 を選択）までお問い合わせください。更なるお問い合わせ事項がある場合、PPO プランにご加入の方は、カリフォルニア州保険庁、1-800-927-4357 までご連絡ください。HMOプランにご加入の方は、カリフォルニア州管理医療庁 (DMHC) の相談窓口、1-888-HMO-2219 までご連絡ください。

Japanese

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی برخوردار شده و بگوئید مدارک به زبان خودتان برایتان خوانده شوند. برای دریافت کمک با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است تماس بگیرید. و یا متقاضیان گروههای کارفرمایان لطفاً با مرکز جاری Health Net به شماره 1-800-522-0088 تماس بگیرند. متقاضیان «طرح افراد و خانواده ها» (IFP) یا «دفتر مزارع» لطفاً به شماره 1-800-909-3447 گزینه 2 تلفن کنند. برای دریافت کمک بیشتر به اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تلفن کنید اگر در یک طرح PPO ثبت نام میکنید. اگر در یک طرح HMO ثبت نام میکنید به خط کمکی DMHC به شماره 1-888-HMO-2219 تلفن کنید.

Farsi

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ, ਜਾਂ, ਇੰਪਲਾਇਰ ਗਰੁੱਪ ਦੇ ਮੈਂਬਰ ਕਿਰਪਾ ਕਰਕੇ ਹੈਲਥ ਨੈੱਟ ਦੇ ਵਪਾਰਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ 1-800-522-0088 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਪਲਾਨ (IFP) ਜਾਂ ਫਾਰਮ ਬਿਊਰੋ ਅਰਜ਼ੀਦਾਤਾ ਕਿਰਪਾ ਕਰਕੇ 1-800-909-3447, ਔਪਸ਼ਨ ੨ ਤੇ ਫੋਨ ਕਰੋ। ਜੇ ਤੁਸੀਂ ਕਿਸੇ ਫਫੋ ਪਲਾਨ ਲਈ ਨਾਂ ਲਿਖਵਾ ਰਹੇ ਹੋ ਤਾਂ ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫੋਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਜੇ ਤੁਸੀਂ ਕਿਸੇ ਪਲਾਨ ਲਈ ਨਾਂ ਲਿਖਵਾ ਰਹੇ ਹੋ ਤਾਂ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਮੈਨੇਜਡ ਹੈਲਥ ਕੇਅਰ (DMHC) ਦੀ ਹੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ।

Punjabi

ការបកប្រែភាសាដោយឥតគិតថ្លៃ ។ អ្នកអាចទទួលអ្នកបកប្រែភាសា និងផ្ទៀតអានឯកសារជូនអ្នកជាភាសាខ្មែរបាន ។ សំរាប់ជំនួយ សូមទូរស័ព្ទមកយើង តាមលេខដែលមានកត់នៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក ឬអ្នកដាក់ពាក្យសុំជាក្រុមនៃក្រុមហ៊ុនការងារ សូមទូរស័ព្ទទៅ មណ្ឌលទំនាក់ទំនងពាណិជ្ជកម្មរបស់ Health Net តាមលេខ 1-800-522-0088 ។ គំរោងបុគ្គលម្នាក់ៗ និងជាគ្រួសារ (IFP) ឬអ្នកដាក់ពាក្យសុំ Farm Bureau សូមទូរស័ព្ទទៅលេខ 1-800-909-3447 ចុចជំរើសទី 2 ។ សំរាប់ជំនួយថែមទៀត សូមទូរស័ព្ទទៅ ក្រសួងធានារ៉ាប់រងកាលីហ្វ័រនីញ៉ា តាមលេខ 1-800-927-4357 បើសិនជាអ្នកកំពុងតែចុះឈ្មោះក្នុងគំរោង PPO ។ បើសិនជាអ្នកកំពុងតែចុះឈ្មោះក្នុងគំរោង HMO សូមទូរស័ព្ទទៅ ខែ្យជំនួយ DMHC តាមលេខ 1-888-HMO-2219 ។

Khmer

Cov Kev Pab Txhais Lus Uas Tsis Tau Them Nqi. Koj thov tau kom muaj ib tug neeg txhais lus thiab nyeem cov ntawv ua koj hom lus rau koj. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis cov neeg thov kev pab tom hauj lwm thov hu rau Health Net's Commercial Contact Center ntawm 1-800-522-0088. Cov neeg thov kev pab hauv pawg Tus Kheej thiab Tsev Neeg (Individual and Family Plan [IFP]) los sis Farm Bureau thov hu rau 1-800-909-3447, xaiv nqe 2. Yog xav tau kev pab ntxiv hu rau CA Qhov Chaw Saib Xyuas Txog Kev Tuav Pov Hwm (Dept. of Insurance) ntawm 1-800-927-4357 yog hais tias koj koom rau hauv ib qho kev pab los ntawm PPO. Yog hais tias koj koom rau hauv ib qho kev pab los ntawm HMO, hu rau DMHC Tus Xov Tooj Muab Kev Pab ntawm 1-888-HMO-2219.

Hmong

T'áá Hó Hasaad Bee 'Áka'e'eyeed Doo Bą́ą́h 'Íliní Da. Haíshíí́ shá 'ata' hodoolnih nínízinígíí łá' ná choídoot'eeł. Ła' naaltsoos t'áá ni nizaad bee nich'į' yídóolta dóó naaltsoos bee hadadilyaago nich'į' 'ádadoolnííł. Shiká'e'doowoł nínízingo, ninaaltsoos nitł'izí bine'dęę́' béésh bee hane'í biká'ígíí bich'į' holne' dooleeł, doodago nidaalnishí hada'diilaaígíí 'éí Na'iiłniihí 'Atsíís Bik'ih 'Adeest'íí́' 'Iłnáhane' Bił Haz'áníjį' kojį' béésh bee holne' dooleeł 1-800-522-0088. T'áá Ła' Jizí dóó Hooghan Haz'ánígi Bił Nahat'a' (IFP) doodago Dá'ák'eh Yá Dah Háaztánígíí bił náha'dit'éego kojį' béésh bee holne' dooleeł 1-800-909-3447, naaki góne'ígíí bił yaa 'adidíílchił. PPO bił náhadilnéédhą́ą́' 'éí CA Béeso 'Ách'ą́ą́h Naa'nil Bił Haz'ánígííjį' shiká'e'doowoł diníigo béésh bee holne dooleeł 1-800-927-4357. HMO bił náhadilnéédhą́ą́', DMHC 'Áka'aná'áwo'go Bił Haz'áníjį' béésh bee holne' dooleeł 1-888-HMO-2219.

Navajo

خدمات لغوية بدون تكلفة. يمكنك الاستعانة بمترجم وطلب قراءة الوثائق لك بلغتك. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك (ID). وبالنسبة لمجموعات المصالح التجارية رجاء الاتصال بمركز خدمات القطاع التجاري لمؤسسة Health Net على الرقم 1-800-522-0088. المتقدمين بطلبات الحصول على تأمين لشخص واحد أو لعائلة (IFP) أو Farm Bureau رجاء الاتصال بالرقم 1-800-909-3447، خيار 2. للحصول على المزيد من المساعدة، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357 إذا كنت مشتركاً في برنامج PPO. إذا كنت مشتركاً في برنامج HMO اتصل بالخط الساخن لـ DMHC على الرقم 1-888-HMO-2219.

Arabic