CA Small Manufacturing Health & Welfare Trust Fund

Application for Employee Benefits Effective 6/1/2025 - 5/31/2026

(Rev. 4/8/2025)

IMPORTANT INSTRUCTIONS

Employees: Use the attached application for first-time enrollments or changes to medical, dental, and vision benefits. All changes and enrollments outside of Open Enrollment require a Qualifying Life Event (QLE). **Complete and return all pages, including documentation of your QLE (if applicable) to HR at your employer**.

Employers: Please review the completed application for accuracy, then email **all pages** of the application and any supporting QLE documentation to **Vanessa_Jones@rpadmin.com.**

INSTRUCCIONES IMPORTANTES

Empleados: *Utilicen la solicitud adjunta para inscripciones por primera vez o cambios en los beneficios médicos, dentales y de la vista. Todos los cambios e inscripciones fuera del período de Inscripción Abierta requieren un Evento de Vida Calificativo (EVC).* ***Completen y devuelvan todas las páginas, incluyendo la documentación de su EVC (si corresponde), al departamento de Recursos Humanos de su empleador.***

Empleadores: *Revisen la solicitud completa para verificar su exactitud y envíen por correo electrónico todas las páginas de la solicitud y cualquier documentación de respaldo del EVC a* ***Vanessa_Jones@rpadmin.com.***

CA Small Manufacturing Health & Welfare Trust Fund

Company Name / Business Unit:	HR Contact Name:	Benefit Effective Date:

PERSONAL INFORMATION

Last Name:	First Name:	MI:	□ Male □ Female
Address:	Apt #:	City:	State: Zip:
Date of Hire: (MM/DD/YY)	Personal Phone #:	Job Title:	E-Mail Address:
Date of Birth: (MM/DD/YY)	Social Security #:	# of Scheduled Hours/Week:	Hourly Rate or Annual Salary:
Marital Status: □ Single □ Married □ Domestic Partner		If available, I would prefer to receive plan information and communication in Spanish: □ Yes □ No	
Class: □ 1000 ACTIVE CA SO CAL □ 1001 ACTIVE CA NOR CAL □ 100A ACTIVE OOS SO CAL □ 101A ACTIVE OOS NOR CAL			

Reason for Application:

☐ New Hire ☐ Open Enrollment ☐ Part-time to Full-time Employment Date: _____

☐ Qualifying Event*: _____ Qualifying Event Date*: _____

*A Qualifying Life Event will require proper documentation which includes the full name of the insured and the date of the event. Common examples are a birth certificate, marriage certificate, loss of coverage letter, etc.

DEPENDENT INFORMATION

Relation	Coverage ☐ Medical	NAME (Last, First MI)	SSN	Gender	Date of Birth	Medical HMO: PCP name, #	Medical HMO: Current PCP	Dental HMO: Provider #	If children are age 26 or over you must check the appropriate boxes below
Self	☐ Dental ☐ Vision	Same as above	Same as above	Same as above	Same as above		□ Yes □ No		
□ Spouse □ Domestic Partner	☐ Medical ☐ Dental ☐ Vision			☐Female ☐Male			□ Yes □ No		Is Dependent disabled? (documentation required)
Child	☐ Medical ☐ Dental ☐ Vision			☐Female ☐Male			□ Yes □ No		□ Yes □ No
Child	☐ Medical ☐ Dental ☐ Vision			☐Female ☐Male			□ Yes □ No		□ Yes □ No
Child	☐ Medical ☐ Dental ☐ Vision			☐Female ☐Male			□ Yes □ No		□ Yes □ No
Child	☐ Medical ☐ Dental ☐ Vision			☐Female ☐Male			□ Yes □ No		□ Yes □ No

Employee Name: _____ **SSN:** _____

MEDICAL ELECTIONS

□ Enroll □ Decline

Blue Shield of CA and Health Net	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Blue Shield of CA Access+ HMO 20	□	□	□	□
Blue Shield of CA Local Access+ HMO 20	□	□	□	□
Blue Shield of CA Local Access+ HMO 30	□	□	□	□
Blue Shield of CA Local Access+ HMO 50	□	□	□	□
Blue Shield of CA Trio HMO 20	□	□	□	□
Blue Shield of CA Trio HMO 30	□	□	□	□
Blue Shield of CA Trio HMO 50	□	□	□	□
Blue Shield of CA PPO 1000	□	□	□	□
Blue Shield of CA PPO 2000	□	□	□	□
Blue Shield of CA PPO 3000	□	□	□	□
Blue Shield of CA PPO 4000 (HSA)	□	□	□	□
Health Net HMO SmartCare M2B	□	□	□	□
Health Net HMO SmartCare M2F	□	□	□	□
Health Net HMO SmartCare M2M	□	□	□	□
Health Net HMO SmartCare M2Q	□	□	□	□
Health Net HMO Salud M7V	□	□	□	□
Health Net HMO Salud M8R	□	□	□	□

Do you have other health care coverage? _ Yes _ No If "Yes", complete the following:
Name of insurance carrier: _____ Prior coverage start date: _____

THE 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, DBP and/or Fidelity. Health Net, DBP and/or Fidelity use 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 provides members with a Notice of Privacy Practices that describes how it uses and discloses protected health information; the individual's rights to access and to request amendments,restrictions and an accounting of disclosures of protected health information; and the procedures for filing complaints. Health Net's Notice of Privacy Practices is included in the Evidence of Coverage or Certificate of Insurance for coverage underwritten by Health Net. I may also obtain a copy of this notice on the website at www.healthnet.com or through the Health Net Customer Contact Center. **California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.**

ACKNOWLEDGMENT AND AGREEMENT: I understand and agree that by enrolling with or accepting services from Health Net, DBP and/ or Fidelity, I and any enrolled dependents are obligated to understand and abide by the terms, conditions and provisions of the Plan Contract or 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 information and belief, 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 Evidence of Coverage or Certificate of Insurance or my Health Net membership or 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 Evidence of Coverage or Certificate of Insurance. Mandatory Arbitration may not apply to certain disputes if the Employer's plan 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.

I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE (THAT IS, AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR CLAIMS SUBJECT TO ERISA, BETWEEN MYSELF AND MY DEPENDENTS ENROLLED IN THE PLAN (INCLUDING ANY HEIRS OR ASSIGNS) AND UNITEDHEALTHCARE OF CALIFORNIA, UNITEDHEALTHCARE OR ANY OF ITS PARENTS, SUBSIDIARIES OR AFFILIATES, SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS THE FEDERAL ARBITRATION ACT PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. ALL PARTIES TO THIS AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHTS TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

1. Blue Shield Authorization: I agree: All information on this form is correct and true to the best of my knowledge and belief. I understand that it is the basis on which coverage may be issued under the plan. I understand that if I have committed fraud or made an intentional misrepresentation of any material fact in conjunction with this application within the first 24 months of coverage, my coverage may be canceled, or, following notice, rescinded.

I further authorize my employer to deduct from my earnings the contribution (if any) required toward the cost of this plan. I understand that coverage does not become effective until this and my employer's application have been approved by Blue Shield of California/Blue Shield Life.

2. Privacy Disclosure Statement: Blue Shield uses the following privacy disclosure statement in its standard enrollment application. The disclosure does not require a signature.

Disclosure of Personal and Health Information: Blue Shield of California or Blue Shield of California Life & Health Insurance Company (collectively, "Blue Shield") understand the importance of keeping your and your dependents' personal and health information private. Blue Shield protects this information in electronic, written, and oral forms when used throughout our company. Blue Shield will not disclose this information without your authorization except as permitted by law.

For the purpose of administering your Blue Shield coverage, Blue Shield is permitted by state and federal law to obtain your and your dependents' health information from a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent. Also, by state and federal law, Blue Shield is permitted to disclose your and your dependents' health information to a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent.

A complete explanation of Blue Shield's policies and procedures ("Notice of Confidentiality and Privacy Practices") for preserving the confidentiality of your personal and health information is available and will be furnished to you upon request by calling the Customer Service Department or by accessing Blue Shield's web site.

Employee Name: _____ **SSN:** _____

DENTAL ELECTIONS

□ Enroll □ Decline

MetLife	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
PPO - High Option	□	□	□	□
PPO - Low Option	□	□	□	□
HMO High Option (MET 85)	□	□	□	□
HMO Low Option (MET 185)	□	□	□	□

VISION ELECTIONS

□ Enroll □ Decline

MetLife (VSP)	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
MetLife (VSP) High Option	□	□	□	□
MetLife (VSP) Low Option	□	□	□	□

Declination Acknowledgement

The available coverages have been explained to me. I have been given the chance to apply for the available coverages. I have decided not to enroll myself and/or my dependent(s) in the following coverage:

	Medical	Dental	Vision
Employee	☐	☐	☐
Spouse	☐	☐	☐
Child(ren)	☐	☐	☐

By declining coverage, I acknowledge that my dependents and I may have to wait to be enrolled until the next Open Enrollment Period or qualifying event.

Employee Signature: _____

Print Name: _____ **Date:** _____

EMPLOYEE ELECTION CONFIRMATION- SIGNATURE REQUIRED

Employee Authorization

Each person signing below declares that all information given in this enrollment form is true and complete to the best of his/ her knowledge and beliefs. Each person understands that this information will be used to determine his/her eligibility.

I understand that these elections cannot be changed during the plan years unless I experience a qualified life event as outlined in employer benefit plan documents. Qualified life events that may change my benefit elections must be reported to the Benefits Administration within 30 days of the event.

Employee Signature: _____

Print Name: _____ **Date:** _____

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 & Family Plan (IFP) applicants please call 1-877-609-8711. For more help: If you are enrolled in a PPO or EPO insurance policy underwritten by Health Net Life Insurance Company, call the CA Dept. of Insurance at 1-800-927-4357. If you are enrolled in a HMO or HSP plan provided by Health Net of California, Inc., call the DMHC Helpline at 1-888-HMO-2219. Your ID card indicates whether your plan was issued by Health Net Life Insurance Company or Health Net of California, Inc.

English

Servicios de Idiomas Sin Costo. Usted puede solicitar un interprete. Puede solicitar que se le lean los documentos y que algunos de ellos se le envien en su idioma. Para obtener ayuda, llamenos al numero que aparece en su tarjeta de identificaci6n; los solicitantes de grupo de empleadores deben llamar al Centro de Comunicaci6n Comercial de Health Net al 1-800-522-0088. Los solicitantes de! Plan Individual y Familiar (por sus siglas en ingles, IFP) deben llamar al 1-877-609-8711. Para obtener mas ayuda: Si esta inscrito en una p6liza de seguro PPO o EPO asegurada por Health Net Life Insurance Company, llame al Departamento de Seguros de CA al 1-800-927-4357. Siesta inscrito en un plan HMO o HSP proporcionado por Health Net of California, Inc., llame a la Linea de Ayuda de! Departamento de Cuidado Medico (por sus siglas en ingles, DMHC) de California al 1-888-HMO-2219. Su tarjeta de identificaci6n indica si su plan fue emitido por Health Net Life Insurance Company o Health Net of California, Inc.

Spanish

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Chinese

Djch V\I ngon ngu mien phi. Quy vi c6 the duqc cap thong djch vien va ngubi d9c giup cac tai li u bang ngon ngu cua quy vi cho quy tj. De duqc *trq* giup, vui long g9i cho chung toi theo so di n tho<ali ghi tren the hQi vien cua quy tj; nguai ghi danh theo nh6m cua hang *so* xin g9i Trung tam Lien l<alc Thuong m<ali cua Health Net theo so 1-800-522-0088. Ngubi ghi danh theo Chuong trinh bao hiem danh cho ca nhan va gia dinh (Individual and Family Plan, IFP) xin g9i so 1-877-609-8711. De duqc *trq* giup bo tuc: Neu quy vi ghi danh trong cac hqp dong bao hiem PPO ho c EPO do Health Net Life Insurance Company cam ket tai *trq*, vui long g9i B9 Bao hiem cua California theo so 1-800-927-4357. Neu quy tj ghi danh trong chuong trinh bao hiem HMO ho c HSP do Health Net of California, Inc. cung cap, xin g9i Dubng day *trq* giup cua DMHC theo so 1-888-HMO-2219. Tren the hQi vien cua quyvi c6 ghi ro chuong trinh bao hiem cua quyvi la do Health Net Life Insurance Company hay Health Net of California, Inc. cung cap.

Vietnamese

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Korean

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Armenian

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Russian

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Japanese

خدمات بی هزینه مربوط به زبان. می توانید از خدمات یک مترجم شفاهی برخوردار شده و بگوئید تا نوشته ها به زبان خودتان برایتان خوانده شوند. برای دریافت کردن کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است تماس بگیرید، و یا متقاضیان گروه کارفرمایان لطفا با مرکز تجارتی تماس Health Net به شماره 1-800-522-0088 تماس بگیرند. متقاضیان "طرح افراد و خانواده ها" (IFP) لطفاً به شماره 1-877-609-8711 تلفن کنند. برای دریافت کمک بیشتر: اگر برای یک بیمه نامه PPO یا EPO که توسط Health Net Life Insurance Company تضمین شده است ثبت نام کرده اید، به اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تلفن کنید. اگر در یک طرح HMO یا HSP که توسط .Health Net of California, Inc فراهم شده است ثبت نام میکنید، به خط کمکی DMHC به شماره 1-888-HMO-2219 تلفن کنید. کارت شناسائی تان نشان میدهد که آیا طرح شما توسط Health Net Life Insurance Company صادر شده است یا .Health Net of California, Inc.

Farsi

Walang Gastusin na Mga Serbisyo sa Wika. Maaari kang kumuha ng interpreter at basahin sa iyong wika ang mga dokumento. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card, o para sa mga aplikante ng pangkat ng employer, mangyaring tawagan ang Commercial Contact Center ng Health Net sa 1-800-522-0088. Para sa mga aplikante ng Individual & Family Plan (IFP), mangyaring tumawag sa 1-877-609-8711. Para sa karagdagang tulong: Kung naka-enroll ka sa isang insurance policy ng PPO o EPO na napapailalim sa Health Net Life Insurance Company, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Kung naka-enroll ka sa isang plano ng HMO o HSP na ipinagkakaloob ng Health Net of California, Inc., tawagan ang DMHC Helpline sa 1-888-HMO-2219. Isinasaad ng iyong ID card kung ang iyong plano ay ibinigay ng Health Net Life Insurance Company o Health Net of California, Inc.

Tagalog

Kev Pab Lus Tsis Muaj Nqi Them. Koj txais tau tus neeg txhais lus thiab muab tau cov ntawv los nyeem rau koj ua koj hom lus. Kom tau kev pab, hu rau peb ntawm tus xovtooj sau rau koj daim npav ID, lossis cov tib neeg yuav thov kev pab tom chaw haujlwm thov hu rau Health Net Lub Chaw Pab Cov Tib Neeg Siv Cov Kev Pab (Customer Contact Center) ntawm 1-800-522-0088. Cov neeg thov kev pab hauv pawg Tus Kheej & Tsev Neeg (Individual and Family Plan; IFP) thov hu rau 1-877-609-8711. Yog xav tau kev pab ntxiv: Yog koj muaj npe nkag nrog PPO lossis EPO cov kev tuav pov hwm los ntawm Health Net Life Insurance Company, hu rau CA Qhov Chaw Saib Xyuas Txog Kev Tuav Pov Hwm (Dept. of Insurance) ntawm 1-800-927-4357. Yog koj muaj npe nkag nrog ib qho kev npaj pab HMO lossis HSP uas los ntawm Health Net of California, Inc., hu rau DMHC Tus Xovtooj Muab Kev Pab ntawm 1-888-HMO-2219. Koj daim npav ID yuav qhia tau tias koj qhov kev npaj pab yog los ntawm Health Net Life Insurance Company lossis Health Net of California, Inc.

Hmong

Doo Bąąh 'Alínígóó Saad Bee 'áka'anída'awo'ígíí. 'Ata' halne'í dóó naaltsoos bee 'éédahozinígíí t'áá ni nizaad bee hadadilyaago nich'į' yídóoltah. 'Áka'a'eyeed biniiyégo, ninaaltsoos nitł'izí bee nééhozinígíí bine'dę́ę́' béésh bee haneí biká'ígíí bee nich'į' hodíilnih, doodago ninaalishí bił hada'dil'íníígíí t'áá shǫǫdí Health Net Commercial Hane' 'Íił'į́h Bił Haz'ánįįį' 1-800-522-0088 hodíilnih. Ła' Jizį́h dóó Hooghan Haz'ą́ągi Naaltsoos Hadadít'éhígíí (IFP) hada'dile'ígíí t'áá shǫǫdí kohjį' 1-877-609-8711 hodíilnih. T'áá náásgóó 'áka'a'eyeed biniiyégo: PPO doodago EPO béeso 'ách'ą́ą́h naa'nil bibee haz'áanii Health Net Life Insurance Company, bich'į' haidiilaaígíí bił ha'dít'éhígíí bił ha'diléehgo, CA Dept. béeso 'ácháą́h naa'nil bił haz'ánígíí bich'į' kohjį' 1-800-927-4357 hodíilnih. Health Net of California, Inc. biyaadóó HMO doodago HSP bił ha'dít'éhígíí bił ha'diléehgo, DMHC 'Áka'aná'awo' Bił Haz'ánígíí kohjį'1-888-HMO-2219 hodíilnih. Health Net Life Insurance Company doodago Health Net of California, Inc. bił naaltsoos bił náha'dít'éhígíí ninaaltsoos nitł'izí bine'dę́ę́' bikáá'.

Navajo

ਭਾਸ਼ਾ ਦੀਆਂ ਮੁਫਤ ਸੇਵਾਵਾਂ। ਤੁਹਾਨੂੰ ਦੁਭਾਸ਼ੀਆ ਮਿਲ ਸਕਦਾ ਹੈ ਅਤੇ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈ ਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ, ਜਾਂ ਇੰਪਲਾਇਰ ਗਰੁੱਪ ਦੇ ਅਰਜ਼ੀਦਾਤਾ ਕਿਰਪਾ ਕਰਕੇ Health Net ਦੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ 1-800-522-0088 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਯੋਜਨਾ (IFP) ਵਾਲੇ ਅਰਜ਼ੀਦਾਤਾ ਕਿਰਪਾ ਕਰਕੇ 1-877-609-8711 ਨੰਬਰ ਤੇ ਸੰਪਰਕ ਕਰੋ। ਹੋਰ ਮਦਦ ਲਈ: ਜੇ ਤੁਸੀਂ Health Net Life Insurance Company ਵਲੋਂ ਜਾਰੀ ਕਿਸੇ PPO ਜਾਂ EPO ਬੀਮਾ ਪਾਲਿਸੀ ਲਈ ਨਾਂ ਲਿਖਵਾਇਆ ਹੈ ਤਾਂ ਕੈਲੀਫੋਰਨਿਆ ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ 1-800-927-4357 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਜੇ ਤੁਸੀਂ Health Net of California, Inc. ਵਲੋਂ ਮੁਹੱਈਆ ਕੀਤੀ ਗਈ ਕਿਸੇ HMO ਜਾਂ HSP ਯੋਜਨਾ ਲਈ ਨਾਂ ਲਿਖਵਾਇਆ ਹੈ ਤਾਂ DMHC ਦੀ ਹੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਤੁਹਾਡੇ ਆਈ ਡੀ ਕਾਰਡ ਤੇ ਦਿਖਾਇਆ ਗਿਆ ਹੈ ਕਿ ਤੁਹਾਡੀ ਯੋਜਨਾ Health Net Life Insurance Company ਵਲੋਂ ਜਾਰੀ ਕੀਤੀ ਗਈ ਸੀ ਜਾਂ Health Net of California, Inc. ਵਲੋਂ।

Punjabi

សេវាបកប្រែភាសាឥតអស់ថ្លៃ។ អ្នកអាចទទួលអ្នកបកប្រែភាសា និងឲ្យគេអានឯកសារជូនអ្នកជាភាសាខ្មែរបាន។ សំរាប់ជំនួយ សូមទូរស័ព្ទមកយើង តាមលេខមានកត់នៅលើប័ណ្ណ ID របស់អ្នក ក្រុមនិយោជកអ្នកដាក់ពាក្យសុំ សូមទូរស័ព្ទទៅមជ្ឈមណ្ឌលទំនាក់ទំនងពាណិជ្ជកម្មរបស់ Health Net តាមលេខ 1-800-522-0088។ អ្នកដាក់ពាក្យសុំគំរោងបុគ្គលម្នាក់ៗ និងគ្រួសារ (IFP) សូមទូរស័ព្ទទៅលេខ 1-877-609-8711។ សំរាប់ព័ត៌មានបន្ថែម : បើអ្នកបានចុះឈ្មោះក្នុងក្រុមបណ្ណសន្យាធានារ៉ាប់រង PPO ឬ EPO បានធានារ៉ាប់រងដោយ Health Net Life Insurance Company ទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357។ បើអ្នកបានចុះឈ្មោះក្នុងគំរោង HMO ឬ HSP ដែលបានផ្តល់ដោយ Health Net of California, Inc.។ ទូរស័ព្ទទៅខ្សែជំនួយ DMHC តាមលេខ 1-888-HMO-2219។ ប័ណ្ណ ID របស់អ្នក បង្ហាញថាតើគំរោងរបស់អ្នកបានចេញដោយ Health Net Life Insurance Company ឬ Health Net of California, Inc.។

Khmer

الخدمات اللغوية المجانية: يمكنك الحصول على مترجم فوري للمساعدة في قراءة مستنداتك باللغة التي تتحدث بها. للحصول على المساعدة يُرجى الاتصال بنا على الرقم الموضح على بطاقة التعريف الخاصة بك، أو إذا كنت من مقدّمي الطلبات من الموظفين يُرجى الاتصال بمركز التواصل مع العملاء لدى Health Net على الرقم 1-800-522-0088. بالنسبة لمقدّمي طلبات خطة الفرد والأسرة (IFP)، يُرجى الاتصال على الرقم 1-877-609-8711. للحصول على المزيد من المساعدة: إذا كنت مسجلاً في سياسة التأمين بخطة PPO أو EPO التي تكتتبها شركة التأمين على الحياة Health Net Life Insurance Company، يُرجى الاتصال بـ CA Dept. of Insurance (وزارة التأمين بولاية كاليفورنيا) على الرقم 1-800-927-4357. إذا كنت مسجلاً في خطة HMO أو HSP التي توفرها شركة .Health Net of California, Inc، يُرجى الاتصال بخط المساعدة لدى DMHC على الرقم 1-888-HMO-2219. توضح بطاقة التعريف الخاصة بك ما إذا كان تم إصدار خطتك عبر شركة التأمين على الحياة Health Net Life Insurance Company أو شركة .Health Net of California, Inc.

Arabic