CA Small Manufacturing Health & Welfare Trust Fund

Application for Employee Benefits (Rev. 4/17/23)

IMPORTANT INSTRUCTIONS:

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. A list of those events is located HERE.

When complete, please email all 5 pages of the application to **Vanessa_Jones@rpadmin.com**

INSTRUCCIONES IMPORTANTES:

Utilice 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 de Open Enrollment requieren un Evento de vida calificado. Una lista de esos eventos se encuentra AQUÍ.

Cuando esté completo, envíe por correo electrónico las 5 páginas de la solicitud a AMBAS direcciones a continuación ***Vanessa_Jones@rpadmin.com***

CA Small Manufacturing Health & Welfare Trust Fund

Purchaser ID / Company Name:	Enrollment Unit:	Benefit Effective Date:

PERSONAL INFORMATION

Last Name:	First Name:	MI:	□ Male □ Female
Address:	Apt #:	City:	State: Zip:
Date of Hire: (MM/DD/YY)	Home PH#:	Work PH#:	E-Mail Address:
Date of Birth (MM/DD/YY):	Social Security #:	Job Title:	Salary:
Marital Status: □ Single □ Married □ Domestic Partner		If available, I would prefer to receive plan information and communication in Spanish: □ Yes □ No	

Reason for Application:

☐ New Hire ☐ Open Enrollment ☐ Loss of prior coverage Date:_____

☐ Re-Hire Date:_____ ☐ Part-time to Full-Time Employment Date:_____

☐ Family Addition/ Change:_____ Qualifying Event:_____Qualifying event date:_____

☐ COBRA: ☐ 18 Months ☐ 29 Months ☐ 36 Months

Start Date:_____ End Date:_____COBRA Event:_____COBRA Event Date:_____

If there is other Health Coverage, please list family member, carrier name/group number and effective date

PRIOR COVERAGE (PPO PLANS ONLY): fill out the following information to receive proper credit for previous coverage.

DEPENDENT INFORMATION

Relation	Coverage ☐ Medical	NAME (Last, First MI)	SSN	Gender	Date of Birth	Medical HMO: PPG/PCP#	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 ☐ Domestc Partner	☐ Medical ☐ Dental ☐ Vision			☐Female ☐Male			☐ Yes ☐ No		IRS Qualified Dependent
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

HealthNet	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
HMO Full Network **JN1** (HSS)	□	□	□	□
HMO Full Network **JN4** (HSV)	□	□	□	□
HMO ExcelCare **JPS** (HVH)	□	□	□	□
HMO ExcelCare **JPY** (HVN)	□	□	□	□
HMO ExcelCare **JQ0** (HVP)	□	□	□	□
HMO ExcelCare **JQ4** (HVT)	□	□	□	□
HMO Salud Y Mas - **JON** (HUG)	□	□	□	□
HMO Salud Y Mas - **JPB** (HUV)	□	□	□	□
HMO SmartCare **JLY** (HSF)	□	□	□	□
HMO SmartCare **JM1** (HSJ)	□	□	□	□
HMO SmartCare **JLT** (HSC)	□	□	□	□
HMO SmartCare **JLP** (HS8)	□	□	□	□
PPO - **JQL** (HX5)	□	□	□	□
PPO - **JQM** (HX6)	□	□	□	□
PPO - HSA **JQN** (HXL)	□	□	□	□
PPO - HSA **JQT** (HXH)	□	□	□	□

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.

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
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 Name: _____ **SSN** _____

DENTAL PPO ELECTIONS □ Enroll □ Decline

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

DENTAL DHMO ELECTIONS □ Enroll □ Decline

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

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:

	Dental
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 Name: _____ **SSN** _____

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:

	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\l 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 بگویند 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’dęę’ béésh bee haneí biká’ígíí bee nich’į’ hodíilnih, doodago ninaalishí bił hada’dil’ínígíí t’áá shǫǫdí Health Net Commercial Hane’ ‘Íił‘įh Bił Haz’ánįįʼ 1-800-522-0088 hodíilnih. Ła’ Jizíh 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’ą́ąh naa’nil bibee haz’áanii Health Net Life Insurance Company, bich’į’ haidiilaaígíí bił ha’dít’éhígíí bił ha’diléehgo, CA Dept. béeso ‘áchą́ąh 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’dęę’ 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

សេវាបកប្រែភាសាដ៏ឥតគិតថ្លៃ។ អ្នកអាចទទួលអ្នកបកប្រែភាសា និងឯកសារបានដាក់ជូនអ្នកជាភាសាខ្មែរបាន។ សំរាប់ជំនួយ សូមទូរស័ព្ទមកលេខ តាមរយៈទាក់ទងតាមលេខនៅលើប័ណ្ណ ID របស់អ្នក ក្រុមអតិថេរជាតិអ្នកជាក់ជាក្បាលំ សូមទូរស័ព្ទទៅផ្នែកទំនាក់ទំនងពាណិជ្ជកម្មរបស់ Health Net តាមរយៈ 1-800-522-0088។ អ្នកដាក់ពាក្យសុំដំណើរប្រជុំរយៈពេលខ្លី និងគ្រួសារ (IFP) សូមទូរស័ព្ទទៅលេខ 1-877-609-8711។ សំរាប់ព័ត៌មានបន្ថែម : បើអ្នកបានចុះឈ្មោះក្នុងគម្រោងមានការធានារ៉ាប់រង PPO ឬ EPO ដែលផ្តល់ជូនដោយ Health Net Life Insurance Company ទូរស័ព្ទទៅក្រុមប្រឹក្សាធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមរយៈ 1-800-927-4357។ បើអ្នកបានចុះឈ្មោះក្នុងគម្រោង HMO ឬ HSP ដែលបានផ្តល់ជូនដោយ Health Net of California, Inc.។ ទូរស័ព្ទទៅខ្សែជំនួយ DMHC តាមរយៈ 1-888-HMO-2219។ ប័ណ្ណ ID របស់អ្នក បង្ហាញថាតើជំណាងរបស់អ្នកបានធ្វើការជាមួយ 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

California Small Manufacturing Health & Welfare Trust

Num. Identificaciòn / Nombre de Empresa:	Unidad:	Fecha de vigencia:

Informacion Personal

Apellido:	Nombre:	MI:	□ M □ F

Dirección:	Apt #:	Ciudad:	Estado:	Codigo postal:

Fecha de contratación: (MM/DD/AAAA)	Num.de telefono principal	Num Tel Trabajo#:	Correo Electrònico:
Fecha de nacimiento (MM/DD/AAAA):	Seguro Social #:	Título:	Salario:
Estado Civil: □ Soltero □ Casado □ Vive in paraje		Si está disponible, yo preferiría la información en Español: □ Si □ No	

Tipo de solicitud:

☐ Inscripción Nueva ☐ Inscripción Abierta ☐ Pèrdida de cobertura (fecha):_____

☐ Fecha de Recontrataciòn: _____ ☐ Fecha de medio tiempo a tiempo completo:_____

☐ Agregar Familia/ Cambios:_____ Evento calificado:_____ Fecha de el evento:_____

☐ COBRA: ☐ 18 Meses ☐ 29 Meses ☐ 36 Meses

Fecha de inicio:_____ Fecha Final:_____ Evento de COBRA:_____ Fecha de COBRA :_____

Si hay otra cobertura de salud, favor de escribir el nombre su familia, el nombre y numero de poliza de la compania y fecha

Nombre	Relaciòn	Nombre de Aseguradora	# de Grupo	Fecha de vigencia	Primario
					□ Si □ No
					□ Si □ No

Cobertura Anterior (Solo Planes PPO): Complete la siguiente informaciòn para recibir crèdito apropiado para la cobertura anterior.

Nombre	Fecha de cobertura	Fecha de Fin de cobertura	Nombre de Aseguradora	Rason por terminar cobertura

Informaciòn de Dependiente

Relacion	Cobertura	Nombre (Apeido, Nombre)	SSN	Genero	Fec. De. Nac.	Medico HMO: Providor #	Medico HMO: Actual PCP	Dental HMO Providor #	Si sus hijos son mayores de 26, debe marcar la casilla apropiada abajo.
	☐ Medical								
Yo	☐ Dental ☐ Vision	Igual que arriba	Igual que arriba	Igual que arriba	Igual que arriba		☐ Si ☐ No		
☐ Cònyuge ☐ Pareja Domestica	☐ Medical ☐ Dental ☐ Vision			☐ F ☐ M			☐ Si ☐ No		IRS Depende Calificado
Hijo	☐ Medical ☐ Dental ☐ Vision			☐ F ☐ M			☐ Si ☐ No		☐ Si ☐ No
Hijo	☐ Medical ☐ Dental ☐ Vision			☐ F ☐ M			☐ Si ☐ No		☐ Si ☐ No
Hijo	☐ Medical ☐ Dental ☐ Vision			☐ F ☐ M			☐ Si ☐ No		☐ Si ☐ No
Hijo	☐ Medical ☐ Dental ☐ Vision			☐ F ☐ M			☐ Si ☐ No		☐ Si ☐ No

Nombre del Empleado: _____ **SSN** _____

Elecciones Mèdicas **□ Inscribirse** **□ Declinar**

HealthNet	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
HMO Full Network **JN1** (HSS)	□	□	□	□
HMO Full Network **JN4** (HSV)	□	□	□	□
HMO ExcelCare **JPS** (HVH)	□	□	□	□
HMO ExcelCare **JPY** (HVN)	□	□	□	□
HMO ExcelCare **JQ0** (HVP)	□	□	□	□
HMO ExcelCare **JQ4** (HVT)	□	□	□	□
HMO Salud Y Mas - **JON** (HUG)	□	□	□	□
HMO Salud Y Mas - **JPB** (HUV)	□	□	□	□
HMO SmartCare **JLY** (HSF)	□	□	□	□
HMO SmartCare **JM1** (HSJ)	□	□	□	□
HMO SmartCare **JLT** (HSC)	□	□	□	□
HMO SmartCare **JLP** (HS8)	□	□	□	□
PPO - **JQL** (HX5)	□	□	□	□
PPO - **JQM** (HX6)	□	□	□	□
PPO - HSA **JQN** (HXL)	□	□	□	□
PPO - HSA **JQT** (HXH)	□	□	□	□

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

Nombre del Empleado: _____ **SSN** _____

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.

Reconocimiento de Declinaciòn

Las coberturas disiponibles han sido explicado. Se me ha dado la oportunidad de solicitar las coberturas disponibles. He decidido no inscribir a mi mismo y/o a mi dependiente(s) en la siguiente cobertura.

	Medico
Empleado	☐
Cònyuge	☐
Hijo(s)	☐

Por la disminuciòn de la cobertura, reconozco que mis dependientes y yo puede que tengan que esperar para inscribirse hasta el pròximo periòdo de inscripciòn abierta o evento calificado.

Firma del Empleado: _____

Imprime su Nombre: _____ Fecha: _____

Nombre del Empleado: _____ **SSN** _____

Elecciones PPO Dentales

□ **Inscribirse** □ **Declinar**

MetLife	Empleado Solo	Empleado + Cònyuge	Empleado + Hijo(s)	Empleado + Famila
PPO - **High** Option	□	□	□	□
PPO - **Low** Option	□	□	□	□

Elecciones DHMO Dentales

□ **Inscribirse** □ **Declinar**

MetLife	Empleado Solo	Empleado + Cònyuge	Empleado + Hijo(s)	Empleado + Famila
HMO **High** Option (MET 85)	□	□	□	□
HMO **Low** Option (MET 185)	□	□	□	□

Reconocimiento de Declinaciòn

Las coberturas disiponibles han sido explicado. Se me ha dado la oportunidad de solicitar las coberturas disponibles. He decidido no inscribir a mi mismo y/o a mi dependiente(s) en la siguiente cobertura.

	Dental
Empleado	☐
Cònyuge	☐
Hijo(s)	☐

Por la disminuciòn de la cobertura, reconozco que mis dependientes y yo puede que tengan que esperar para inscribirse hasta el pròximo periòdo de inscripciòn abierta o evento calificado.

Firma del Empleado: _____

Imprime su Nombre: _____ Fecha: _____

Nombre del Empleado: _____ **SSN** _____

Elecciones Visiòn

□ **Inscribirse** □ **Declinar**

MetLife (VSP)	Empleado Solo	Empleado + Cònyuge	Empleado + Hijo(s)	Empleado + Famila
MetLife (VSP) **High** Option	□	□	□	□
MetLife (VSP) **Low** Option	□	□	□	□

Reconocimiento de Declinaciòn

Las coberturas disiponibles han sido explicado. Se me ha dado la oportunidad de solicitar las coberturas disponibles. He decidido no inscribir a mi mismo y/o a mi dependiente(s) en la siguiente cobertura.

	Visiòn
Empleado	☐
Cònyuge	☐
Hijo(s)	☐

Por la disminuciòn de la cobertura, reconozco que mis dependientes y yo puede que tengan que esperar para inscribirse hasta el pròximo periòdo de inscripciòn abierta o evento calificado.

Firma del Empleado: _____

Imprima su nombre: _____ Fecha: _____

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 HealthNet'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 HealthNet 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 HealthNet of California, Inc., call the DMHC Helpline at 1-888-HMO-2219. Your ID card indicates whether your plan was issued by HealthNet Life Insurance Company or HealthNet 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 HealthNet al 1-800-522-0088. Los solicitantes del 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 HealthNet Life Insurance Company, llame al Departamento de Seguros de CA al 1-800-927-4357. Si esta inscrito en un plan HMO o HSP proporcionado por HealthNet of California, Inc., llame a la Linea de Ayuda del 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 HealthNet Life Insurance Company o HealthNet of California, Inc.

Spanish

[illegible]

Chinese

Djch V1,1 ngon ngu mien phi. Quyvi c6 the duqc cap thong cijch vien va ngu<':li d9c giup cac tai li[illegible]u bang ngon ngu cu.a quyvi cho quyvi, De duqc tr(J giup, vui long gQi cho chung toi theo so di[illegible]n thofμ ghi tren the hc;,i vien cu.a quyvi; ngu<':li ghi danh theo nh6m cu.a hang sci :xin gQi Trung tam Lien l[illegible]c Thucmg mfμ cu.a Health Net theo so 1-800-522-0088. Nguc:li ghi danh theo Chue1ng trlnh bao hiem danh cho ca nhan va gia dlnh (Individual and Family Plan, IFP) :xin gQi so 1-877-609-8711. De duqc trq giup M rue: Neu quyvi ghi danh trong cac h<Jp dong bao hiem PPO ho[illegible]c EPO do Health Net Life Insurance Company cam ket tai *trq,* vui long gQi BQ Bao hiem cu.a California theo so 1-800-927-4357. Neu quyvi ghi danh trong chue1ng trinh bao hiem HMO ho[illegible]c HSP do Health Net of California, Inc. cung cap, :xin gQi Du<':lng day *trq* giup cu.a DMHC theo so 1-888-HM0-2219. Tren the hc;>i vien cu.a quyvi c6 ghi r6 chudng trlnh bao hiem cu.a quyvi la do Health Net Life Insurance Company hay Health Net of California, Inc. cung cap.

Vietnamese

-9-E e:! Ol XI[illegible]kl t:ll[illegible] -9-E [illegible]Ql Af kl t:ll[illegible]gJ Ol 2.HEOJIJ-ll l!:! et e:! 01£ kl[illegible]kl t:ll[illegible]E!:!"[illegible]4' 2J. §LI Cf. .5:.§01 [illegible]Hoft.! J:Eg [illegible]<:?.! ID 3f[illegible]OJI 2J. e e!-LH\:!:!.2£ [illegible]1-oH [illegible]Al 2.. .::il[illegible]::J.[illegible]JfgJ 61 [illegible]Xf'a.<:?.l [illegible]9- HealthNet.<:?.! [illegible]gj (Commercial) .::il2.!l kl t:ll[illegible]El, e!-LH !:!::!.2 1-800-522-0088\:!:![illegible]£ [illegible]foH [illegible]Al 2.. JH [illegible]gJ Jf[illegible]:!! (IFP) JfgJ 61 [illegible]Xf'a g e!-LH !:!::!.2 1-877-609-8711\:!:![illegible]£ [illegible]oH [illegible]Al.2.. [illegible] Btg .5:.§01 [illegible]HofAl eI: eI-[illegible]-ti ofJf HealthNet Life Insurance CompanyJf [illegible]4'e!- PPO !Ee EPO [illegible]gt ¥clAl0JI JfgJ oft.! [illegible]9-, [illegible]2.I ±t.LI Of [illegible] (CA Dept. of Insurance), e!-LH !:!::!.2 1-800-927-4357\:!:![illegible]£ [illegible]<:?.l of[illegible]Al 2.. el-[illegible] TlofJf HealthNet of California, Inc.OJI kl [illegible]ofe HMO !Ee HSP [illegible]:!!OJI Jfgjoft.! [illegible]9-, [illegible]c!c.1¥ (DMHC) [illegible]:!.2.f[illegible], e!-LH !:!::!.2 1-888-HMO-2219\:!:![illegible]£ [illegible]<:?.lof[illegible]Al.2.. Tlof.<:?.l ID 3f[illegible]OJI -=tlof.<:?.l [illegible] HealthNet Life Insurance CompanyOJI A[illegible]:l XI !Ee HealthNet of California, Inc.OJI kl [illegible]:l XI [illegible]Al5:l Ol 2J. §LI Cf.

Korean

Uuil_fiwr Lbqil_w[illegible]wu UwnWJMLjiJJnLUUbr: 'l-nL[illegible] [illegible]wrn'l. b[illegible] pwuwil_nr FJwr[illegible].iwL c\bn.p pbrbL L. i./,wu,nwFf'lFfbr[illegible]uFJbr9bi LnWL .2br ibqil_nil_: O[illegible].unLjiJJwL C.wi.iwr i.ibq qwL[illegible]wC.wrb[illegible] .2br fiL[illegible]unLjiJJWU (ID) Lnni.iufi il.rw L2il_wa C.wi.iwrnil_, [illegible]w..r bjifb [illegible].nraw,nfirn**i** fui.ipfi '1-fii.inr'l- b[illegible], fuu[illegible].rnLLi bu[illegible] 1-800-522-0088 C.wi.iwrnil. qwu[illegible].wC.wrbL Health Net-ti l.wnwfunr[illegible].r l:iwUfr libu,nrnu: UuC.w,nw[illegible]wu L. (!u,nwub[illegible]wL Urw[illegible].rr (Individual and Family Plan/IFP) 1J-f!Linr1J-ubrfi9 fuu[illegible].ril.nLLi t qwu[illegible].wC.wrbL 1-877-609-8711 C.wi.iwrnil_: Lrw9nL9fiL o[illegible].unLjiJJwL C.wi.i**wr** 1-800-927-4357 C.wi.iwrnil. qwu[illegible].wC.wrb[illegible] liwiti=f>nrurwJr U[illegible]wC.nil_w[illegible].rnLjiJJWU P.wd-wui.inLU[illegible] (CA Dept. oflnsurance), bjifb [illegible].rwu9il_bi b[illegible] PPO [illegible]w..r EPO W[illegible]WC.m.l_w[illegible].rw[illegible]wL W[illegible]WC.nil_w[illegible].rr, nrr [illegible]rn'l.L t Health Net Life Insurance Company-u: bjifb [illegible].rwu9il_bi b[illegible] HMO [illegible]w..r HSP arw[illegible].rmi.i, nrr i.iw,nw[illegible]wrwru t Health Net of California, Inc.-[illegible] 1-888-HM0-2219 C.wi.iwrnil. qwu[illegible].wC.wrb[illegible] DMHC-ti O[illegible].unLjiJJWU q.atiu: .2br fiu[illegible]LnLjiJJWU Lnni.iu[illegible] u2nLLi t, jifb nil_ t Ffn'lwr[illegible]bl .2br arw[illegible].rri Health Net Life Insurance Company-u, jifb'" Health Net of California, Inc.-[illegible]

Armenian

BecrniaTHble yc1iyn1 TiepeBoμ;a. Bbl MO)KeTe BOCTIOJib30BaTbCJI ycnyraMJf nepeBOW!JfKa, [illegible] BaM MOryT TipoqJfTaTb μ;oKyMeHTbl Ha BalIIeM H3blKe. ECJIJf BaM Tpe6yeTCJI TIOMOID;b, 3BOHJfTe HaM TIO HOMepy Teneq>oHa,)'Ka.3aHHOMY Ha BalIIeH lf,D;eHTJfq>lfKan;HOHHOH KapTe. YqacTHJfKH IIJiaHa rpynTIOBOro cTpaxoBaHIDI TIO MecTy pa6oThI MOryT o6parnThCJI B KoMMepqecKHH KOHTaKTHblH n;eHTP KOMTiaHlflf Health Net (Commercial Contact Center) TIO Teneq>oHy 1-800-522-0088. YqacTHmrn IIJiaHOB lfH,Il;JfBlfp;y.IJibHOro [illegible] ceMeti:Horo CTpaxoBaHIDI (Individual and Family Plan, IFP), nO)KaJIYHCTa, 3BOHJfTe TIO HOMepy 1-877-609-8711. ,Il;JIH TionyqeHIDI ,D;OTIOJIHJfTeJibHOH TIOMOID;Jf: eCJIJf y Bae CTpaxoBOH TIOJIJfC OpraHJf3[illegible]fl[illegible] c npeμ;rroqrnTeJibHblMJf TIOCTaBID;JfKaMJf ycnyr (Preferred Provider Organization, PPO) JfJIJf OpraHJf3[illegible]flf c o6H3aTeJibHblMJf TIOCTaBID;JfKaMJf *ycnyr* (Exclusive Provider Organization, EPO), KOTopblti: Tipeμ;ocTaBJIHeTCJI KOMnaHJfe:i1 Health Net Life Insurance Company, o6pam;ati:Tecb B ,Il;eTiapTaMeHT cTpaxoBaHIDI IIITaTa KanHq>opHHH (CA Dept. of Insurance) TIO Teneq>OH)' 1-800-927-4357. Ecnlf Bbl 3apemcTpHpoBaHbl B IIJiaHe HMO lfJIJf HSP, KOTOpbr:i1 Tipeμ;ocTaBneH KOMTiaHHe:i1 Health Net of California, Inc., 3BOHHTe Ha Teneq>OH fopHqeti: JIJfHJflf ,Il;eTiapTaMeHTa opraHJf30BaHHoro Me,D;lfD;JfHCKoro o6cny)KHBaHIDI (DMHC Helpline) TIO HOMepy 1-888-HMO-2219. Ha Bameti: Hμ;eHTlfq>lfK[illegible]lfOHHOH KapTe yicaaaHo, 6brn JIJf BaIII TIJiaH oqiopMJieH KOMTiaHJfe:i1 Health Net Life Insurance Company JfJIJf KOMTiaHJfe:i1 Health Net of California, Inc.

Russian

[illegible]

Japanese

خدمات بی هزینه مربوط به زبان. می توانید از خدمات یک مترجم شفاهی برخوردار شده و بگویند 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’dęę’ béésh bee haneí biká’ígíí bee nich’į’ hodíilnih, doodago ninaalishí bił hada’dil’ínígíí t’áá shǫǫdí Health Net Commercial Hane’ ‘Íił‘įh Bił Haz’ánįįʼ 1-800-522-0088 hodíilnih. Ła’ Jizíh 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’ą́ąh naa’nil bibee haz’áanii Health Net Life Insurance Company, bich’į’ haidiilaaígíí bił ha’dít’éhígíí bił ha’diléehgo, CA Dept. béeso ‘áchą́ąh 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’dęę’ 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

សេវាបកប្រែភាសាដ៏ឥតគិតថ្លៃ។ អ្នកអាចទទួលអ្នកបកប្រែភាសា និងឯកសារបានដាក់ជូនអ្នកជាភាសាខ្មែរបាន។ សំរាប់ជំនួយ សូមទូរស័ព្ទមកលេខ តាមរយៈទាក់ទងតាមលេខនៅលើប័ណ្ណ ID របស់អ្នក ក្រុមអតិថេរជាតិអ្នកជាក់ជាក្បាលំ សូមទូរស័ព្ទទៅផ្នែកទំនាក់ទំនងពាណិជ្ជកម្មរបស់ Health Net តាមរយៈ 1-800-522-0088។ អ្នកដាក់ពាក្យសុំដំណើរប្រជុំរយៈពេលខ្លី និងគ្រួសារ (IFP) សូមទូរស័ព្ទទៅលេខ 1-877-609-8711។ សំរាប់ព័ត៌មានបន្ថែម : បើអ្នកបានចុះឈ្មោះក្នុងគម្រោងមានការធានារ៉ាប់រង PPO ឬ EPO ដែលផ្តល់ជូនដោយ Health Net Life Insurance Company ទូរស័ព្ទទៅក្រុមប្រឹក្សាធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមរយៈ 1-800-927-4357។ បើអ្នកបានចុះឈ្មោះក្នុងគម្រោង HMO ឬ HSP ដែលបានផ្តល់ជូនដោយ Health Net of California, Inc.។ ទូរស័ព្ទទៅខ្សែជំនួយ DMHC តាមរយៈ 1-888-HMO-2219។ ប័ណ្ណ ID របស់អ្នក បង្ហាញថាតើជំណាងរបស់អ្នកបានធ្វើការជាមួយ 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