



**Health Net**<sup>®</sup>  
LIFE INSURANCE COMPANY

For internal use only		
Eligibility verified:	Group #:	Effective date:
Dependent plan: Stanford Student Dependent Health Insurance Plan		

# Enrollment *and* Change Form

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

Part I. Selected coverage			
<b>Plan offered by your school:</b> <input checked="" type="checkbox"/> PPO	<b>Reason for application:</b> <input type="checkbox"/> Dependent of new student <input type="checkbox"/> Qualifying event <input type="checkbox"/> Marriage Qualifying event date: _____ <input type="checkbox"/> Birth or adoption of child Qualifying event date: _____ <input type="checkbox"/> Involuntary loss of prior coverage Qualifying event date: _____	<b>Reason for change:</b> <input type="checkbox"/> Change address/name <input type="checkbox"/> Delete dependent(s) (list names in section 3) <input type="checkbox"/> Other: _____	
<b>Plan enrollees:</b> <input type="checkbox"/> Child (N5274A) <input type="checkbox"/> Children (N5274B) <input type="checkbox"/> Spouse (N5274C) <input type="checkbox"/> Spouse + child (N5274D) <input type="checkbox"/> Spouse + children (N5274E)			
Part II. Stanford student personal information			
Last name:	First name:	MI:	<input type="checkbox"/> Male <input type="checkbox"/> Female
U.S. residence address:			
City:		State:	ZIP:
U.S. mailing address (if different from residence):			
City:		State:	ZIP:
Date of birth (mm/dd/yyyy):	Student ID number:	Social Security # (required):	
Home telephone number: (    )	Mobile telephone number: (    )	Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic partner	
Email address:	Student type: <input type="checkbox"/> Undergrad <input type="checkbox"/> Grad <input type="checkbox"/> International undergrad	Campus: <input type="checkbox"/> Palo Alto <input type="checkbox"/> Monterey	
Do you have other health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," complete the following:		Group #/Policy ID #:	
Name of insurance carrier:		Prior coverage start date:	

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

Student name: \_\_\_\_\_

<b>Part III. Dependent information</b>			
<b>Please list all eligible family members to be enrolled. (Attach additional sheets if necessary.)</b>			
<input type="checkbox"/> Spouse	<input type="checkbox"/> M	Last name:	First name:
<input type="checkbox"/> Domestic partner	<input type="checkbox"/> F		MI:
U.S. residence address: <input type="checkbox"/> Check here if same as student			
City:		State:	ZIP:
Date of birth (mm/dd/yyyy):		Social Security # (required for all applicants):	
		Coverage type: <input checked="" type="checkbox"/> Medical	
Home telephone number: ( )	Mobile telephone number: ( )	Email address:	
Do you have other health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," complete the following:			Group #/Policy ID #:
Name of insurance carrier:		Prior coverage start date:	
<input type="checkbox"/> Son		Last name:	First name:
<input type="checkbox"/> Daughter			MI:
U.S. residence address: <input type="checkbox"/> Check here if same as student			
City:		State:	ZIP:
Date of birth (mm/dd/yyyy):		Social Security # (required for all applicants):	
		Coverage type: <input checked="" type="checkbox"/> Medical	
Home telephone number: ( )	Mobile telephone number: ( )	Email address:	
Do you have other health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," complete the following:			Group #/Policy ID #:
Name of insurance carrier:		Prior coverage start date:	
<input type="checkbox"/> Son		Last name:	First name:
<input type="checkbox"/> Daughter			MI:
U.S. residence address: <input type="checkbox"/> Check here if same as student			
City:		State:	ZIP:
Date of birth (mm/dd/yyyy):		Social Security # (required for all applicants):	
		Coverage type: <input checked="" type="checkbox"/> Medical	
Home telephone number: ( )	Mobile telephone number: ( )	Email address:	
Do you have other health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," complete the following:			Group #/Policy ID #:
Name of insurance carrier:		Prior coverage start date:	
<input type="checkbox"/> Son		Last name:	First name:
<input type="checkbox"/> Daughter			MI:
U.S. residence address: <input type="checkbox"/> Check here if same as student			
City:		State:	ZIP:
Date of birth (mm/dd/yyyy):		Social Security # (required for all applicants):	
		Coverage type: <input checked="" type="checkbox"/> Medical	
Home telephone number: ( )	Mobile telephone number: ( )	Email address:	
Do you have other health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," complete the following:			Group #/Policy ID #:
Name of insurance carrier:		Prior coverage start date:	

(continued)

### Part III. Dependent information (continued)

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

### Part IV. Acceptance of coverage

**(Signature required.)**

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

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

**BINDING ARBITRATION AGREEMENT:** I, the student, understand and agree that any and all disputes between me (including any of my enrolled family members or heirs or personal representatives) and Health Net must be submitted to final and binding arbitration instead of a jury or court trial. This Agreement to arbitrate includes any disputes arising from or relating to the Insurance Policy 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.

Print student name: \_\_\_\_\_

Student signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Premiums are due by the last day of the month for the following month. Failure to pay your monthly premium to Health Net by this date will result in permanent cancellation of your policy.*

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

## Part V. Additional information

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

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

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

### Precertification

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

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

### Disabling conditions

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

### Products

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

**Please visit us at: [www.healthnet.com/cardinalcare](http://www.healthnet.com/cardinalcare)**

Health Net Life Insurance Company (Health Net) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health Net does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Health Net:

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

If you need these services, contact Health Net's Customer Contact Center at **1-800-522-0088 (TTY: 711)**.

If you believe that Health Net has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by calling the number above and telling them you need help filing a grievance; Health Net's Customer Contact Center is available to help you. You can also file a grievance by mail: Health Net, PO Box 10348, Van Nuys, California 91410-0348, by fax: 1-877-831-6019, or online: [healthnet.com](http://healthnet.com).

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

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

**Spanish**

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

**Chinese**

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

**Korean**

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

**Arabic**

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

**Armenian**

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

**Hindi**

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

**Japanese**

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

**Khmer**

មិនមានការគិតថ្លៃសេវាភាសា។ អ្នកអាចទទួលបានអ្នកប្រែប្រាស់។ អ្នកអាចឲ្យគេអានឯកសារឲ្យអ្នកស្តាប់។ សម្រាប់ជំនួយសូមហៅទូរស័ព្ទមកកាន់យើងខ្ញុំតាមរយៈលេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក ឬហៅ មកកាន់លេខ 1-800-250-5226 (TTY: 711)។ សម្រាប់ព័ត៌មានបន្ថែម សូមទូរស័ព្ទមកកាន់ក្រសួងធានារ៉ាប់រងរដ្ឋ CA តាមរយៈលេខ 1-800-927-4357។

**Punjabi**

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

**Russian**

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

**Tagalog**

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

**Thai**

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

**Vietnamese**

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

**Persian (Farsi)**

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

**Hmong**

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

**Navajo**

Saad doo báhílnígóó bee háká'at'ooowł. At'a'hani' shóodít'eeł. Saad naaltsos bik'ígíí nich'í yídóot'ah. Naaltsos bee néehoozinígíí neít'áánígíí bekáagi bek'ego béésh bee hodítne'hígíí bik'áá' éidoodagóó t'óó kojí' hodítne 1-800-250-5226 (TTY:711). Náásgóó níká'at'ooowł: Ahééháshíjí Béeso Ách'áá' naa'nil bich'í hwodítne 1-800-927-4357.