



OPEN ENROLLMENT MEDICAL PLAN CHANGE REQUEST FORM

Please use this form to indicate plan changes for your employees and their dependents during your renewal. Please call your authorized Health Net broker or Health Net Account Manager or refer to the Small Business Group Policy and Procedures Guide for acceptable plan changes and guidelines.

GROUP CONTACT INFORMATION

Group Number:	Group Name:	Renewal Effective Date:	
Group Contact:	Contact Phone:	Contact Fax:	Contact Email Address:
<p>As an owner or officer of stated company, I hereby authorize the below changes to our Health Net Small Business group medical coverage. I have informed said Employees listed below that the enrollment terms of the Health Net form they completed previously at enrollment are still in force and a copy is available upon request. Employees enrolling in PPO coverage from HMO coverage have been informed that their PPO coverage may be subject to the pre-existing condition limitation if insufficient creditable coverage was accumulated to offset the pre-existing limitation.</p>			
Printed Name:	Signature:	Date:	

Please indicate with a check, using blue or black ink, the plan each member wishes to move into. Please list all **currently enrolled** members making plan changes during Open Enrollment on this form. New enrollees will need to submit separate enrollment applications. Please photocopy this form if more space is required.

Please fax completed forms to the Health Net Account Management department. For groups located in Southern California, please fax to (818) 676-6297, and for Northern California, please fax to (800) 303-3110.

	Member's Name	Member's SSN or Reference ID	For HMO Plans Indicate Primary Care Physician ID	For HMO Plans Indicate Silver Network	Group #	HMO 10		HMO 20		HMO 30		HMO 40		EOA 10		EOA 20		EOA 30		EOA 40		POS 10	POS 20
						Standard	Value	Standard	Value	Standard	Value	Standard	Value	Standard	Value	Standard	Value	Standard	Value	Standard	Value		
1				<input type="checkbox"/> Y <input type="checkbox"/> N																			
2				<input type="checkbox"/> Y <input type="checkbox"/> N																			
3				<input type="checkbox"/> Y <input type="checkbox"/> N																			
4				<input type="checkbox"/> Y <input type="checkbox"/> N																			
5				<input type="checkbox"/> Y <input type="checkbox"/> N																			
6				<input type="checkbox"/> Y <input type="checkbox"/> N																			
7				<input type="checkbox"/> Y <input type="checkbox"/> N																			
8				<input type="checkbox"/> Y <input type="checkbox"/> N																			



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	Member's Name	Member's SSN or Reference ID	For HMO Plans Indicate Primary Care Physician ID	For HMO Plans Indicate Silver Network	Group #	PPO 10		PPO 20		PPO 30		PPO 40		Standard HSA 2000	Standard HSA 3000	Standard HSA 4000	Value HSA 1500	Value HSA 2500	Value HSA 3500	Value HSA 4500	Salud HMO y Más 15	Salud HMO y Más 25	Salud EPO	Salud PPO	Salud Mexico	
						Standard	Value	Standard	Value	Standard	Value	Standard	Value													
1				<input type="checkbox"/> Y <input type="checkbox"/> N																						
2				<input type="checkbox"/> Y <input type="checkbox"/> N																						
3				<input type="checkbox"/> Y <input type="checkbox"/> N																						
4				<input type="checkbox"/> Y <input type="checkbox"/> N																						
5				<input type="checkbox"/> Y <input type="checkbox"/> N																						
6				<input type="checkbox"/> Y <input type="checkbox"/> N																						
7				<input type="checkbox"/> Y <input type="checkbox"/> N																						
8				<input type="checkbox"/> Y <input type="checkbox"/> N																						