



Health Net®

Open Enrollment Medical Plan Change Request Form

Small Business Group

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:

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 the 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.

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 1-800-303-3110.

Member's name	Member's SSN or Reference ID	For HMO plans, indicate primary care physician ID	Group #	For HMO or EOA plans, indicate option	For HMO or EOA plans, indicate network	HMO 10	HMO 15	HMO 20	HMO 25	HMO 30	HMO 35	HMO 40	HMO 45	HMO 50	EOA 10	EOA 15	EOA 20	EOA 25	EOA 30	EOA 35	EOA 40	EOA 45	EOA 50	Salud y Más 15	Salud y Más 25	Salud y Más 35	Salud EPO	Salud PPO	Salud Mexico
1				<input type="checkbox"/> Standard <input type="checkbox"/> Value <input type="checkbox"/> Advantage	<input type="checkbox"/> Silver <input type="checkbox"/> Bronze																								
2				<input type="checkbox"/> Standard <input type="checkbox"/> Value <input type="checkbox"/> Advantage	<input type="checkbox"/> Silver <input type="checkbox"/> Bronze																								
3				<input type="checkbox"/> Standard <input type="checkbox"/> Value <input type="checkbox"/> Advantage	<input type="checkbox"/> Silver <input type="checkbox"/> Bronze																								
4				<input type="checkbox"/> Standard <input type="checkbox"/> Value <input type="checkbox"/> Advantage	<input type="checkbox"/> Silver <input type="checkbox"/> Bronze																								
5				<input type="checkbox"/> Standard <input type="checkbox"/> Value <input type="checkbox"/> Advantage	<input type="checkbox"/> Silver <input type="checkbox"/> Bronze																								
6				<input type="checkbox"/> Standard <input type="checkbox"/> Value <input type="checkbox"/> Advantage	<input type="checkbox"/> Silver <input type="checkbox"/> Bronze																								
7				<input type="checkbox"/> Standard <input type="checkbox"/> Value <input type="checkbox"/> Advantage	<input type="checkbox"/> Silver <input type="checkbox"/> Bronze																								
8				<input type="checkbox"/> Standard <input type="checkbox"/> Value <input type="checkbox"/> Advantage	<input type="checkbox"/> Silver <input type="checkbox"/> Bronze																								



Health Net®

Open Enrollment Medical Plan Change Request Form

Small Business Group

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:

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 1-800-303-3110.

	Member's name	Member's SSN or Reference ID	Group #	For PPO or HSA plans, indicate option	POS	PPO 10	PPO 15	PPO 20	PPO 25	PPO 30	PPO 35	PPO 40	PPO 45	HSA 1500	HSA 2500	HSA 3500	HSA 4000	HSA 4500	HRA 3000	HRA 5000	
1				<input type="checkbox"/> Standard <input type="checkbox"/> Value <input type="checkbox"/> Advantage																	
2				<input type="checkbox"/> Standard <input type="checkbox"/> Value <input type="checkbox"/> Advantage																	
3				<input type="checkbox"/> Standard <input type="checkbox"/> Value <input type="checkbox"/> Advantage																	
4				<input type="checkbox"/> Standard <input type="checkbox"/> Value <input type="checkbox"/> Advantage																	
5				<input type="checkbox"/> Standard <input type="checkbox"/> Value <input type="checkbox"/> Advantage																	
6				<input type="checkbox"/> Standard <input type="checkbox"/> Value <input type="checkbox"/> Advantage																	
7				<input type="checkbox"/> Standard <input type="checkbox"/> Value <input type="checkbox"/> Advantage																	
8				<input type="checkbox"/> Standard <input type="checkbox"/> Value <input type="checkbox"/> Advantage																	