Small Business Application

for Group Service Agreement/Group Policy

Medical and Life/AD&D plans are provided by Health Net of California, Inc. and/or Health Net Life Insurance Company (together, the "Health Net Entities"). Dental HMO plans are provided by Dental Benefit Providers of California, Inc., and dental PPO and indemnity insurance plans are underwritten by Unimerica Life Insurance Company (together, the "DBP Entities"). Vision plans are provided by Fidelity Security Life Insurance Company and serviced by EyeMed Vision Care, LLC (together, the "Fidelity Entities").

Neither the DBP Entities nor the Fidelity Entities are affiliated with the Health Net Entities. Obligations under dental and vision plans are not obligations of, and are not guaranteed by, the Health Net Entities.

Application is hereby made for a Group Service Agreement/Group Policy provided by the Health Net Entities, the DBP Entities and/or the Fidelity Entities, the provisions of which are to be made available to all eligible employees, as defined, and their eligible dependents desiring coverage hereunder. The following information regarding employee data is being submitted to allow the Health Net Entities, the DBP Entities and/or the Fidelity Entities to determine the eligibility of employees seeking enrollment.

Small Business Group: 1-800-361-3366 *(English)*
1-800-331-1777 *(Spanish)*
1-877-891-9053 *(Mandarin)*

Health Net Life: 1-800-865-6288

Health Net Dental: 1-866-249-2382

Health Net Vision: 1-866-392-6058

Existing Business/Group
PO Box 9103
Van Nuys, CA 91409-9103
www.healthnet.com

New Business/Group
Please send all completed paperwork to your designated Account Executive or Broker.

Health Net®

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1A. Health plan information (Select one network option only) *(Applicable to HMO and EOA plans only)*

Groups with a single plan, select your network:

☐ Full Network (HMO and EOA) ☐ Silver Network[5] (HMO and EOA) ☐ Bronze Network[6] (HMO only)

Groups taking multiple plans, select your choice package:

☐ Enhanced Choice ☐ Silver Choice ☐ Bronze Choice ☐ Hn Options ☐ Hn Options Silver ☐ Hn Options Bronze

Mental Health Parity and Addiction Equity Act (MHPAEA)-compliant plans ☐ Yes ☐ No

HMO		EOA	PPO	HSA	Hn Options	Salud con Health Net®
Standard	**Value**	**Standard**	**Standard**	**Standard**	☐ PPO 250	**Salud HMO y Más**[4]
☐ 10	☐ 10	☐ 10	☐ 10	☐ 4000	☐ PPO 500	☐ HMO y Más 15
☐ 15	☐ 20	☐ 15	☐ 15	**Value**	☐ PPO 1500	☐ HMO y Más 25
☐ 20	☐ 30	☐ 20	☐ 20	☐ 1500	☐ PPO 1750	☐ HMO y Más 35
☐ 20 Dual[3]	☐ 30 Dual[3]	☐ 25	☐ 25	☐ 2500	☐ PPO 3000[5]	☐ Salud PPO[6]
☐ 25	☐ 40	☐ 30	☐ 30	☐ 3500	☐ PPO 4000[5]	☐ Salud EPO[6]
☐ 30	☐ 40 Dual[3]	☐ 35	☐ 35	☐ 4500	☐ HMO 25	☐ Salud Mexico[7]
☐ 30 Dual[3]	☐ 50	☐ 40	☐ 40	**HRA**	☐ HMO 35	**Flex Net**
☐ 35	**Advantage**	☐ 50	☐ 45	☐ 3000	☐ EOA 25	☐ Indemnity *(Out of service area only)*
☐ 40	☐ 25	**Value**	**Value**	☐ 5000	☐ EOA 35	
☐ 50	☐ 35	☐ 10	☐ 10	**POS**		
	☐ 45	☐ 20	☐ 15	☐ 10		
		☐ 30	☐ 20	☐ 20		
		☐ 40	☐ 25			
		☐ 50	☐ 30			
		Advantage	☐ 35			
		☐ 25	☐ 40			
		☐ 35	☐ 45			
		☐ 45	**Advantage**			
			☐ 35			
			☐ 45			

Dental (DHMO)	Dental (DPPO)	Vision (PPO)
☐ HN Plus ☐ HN Value (renewing groups only) Plan #:______________________	☐ Classic ☐ Classic Plus ☐ Basic ☐ Essential ☐ Essential Value Plans below for renewing groups only ☐ Value ☐ Preferred Value ☐ Plus Plan #:______________________	☐ Preferred 1025-2 ☐ Preferred 1025-3 ☐ Value 10-2 **Optional Rider** ☐ Chiropractic ☐ Acupuncture ☐ Combined Chiropractic/Acupuncture[7]

2. Employer group information *(If adding dental or vision to your existing coverage, please complete sections 2, 3, 4, 7, 9, 11, 12 and 13; for all other changes to existing coverage, please complete only sections 2, 3, 4 and 14.)*

Company name:	DBA:	Group #:	SIC code:
Tax ID Number (TIN):	Total number of employees worldwide: ☐ 2–19 ☐ 20–99 ☐ 100 or more		

2. Employer group information *(continued)*

Type of business:	Type of entity *(corporation, sole prop., LLC, partnership)*:	How long in business:	Effective date *(renewal date)*:

Company contact:	Telephone:	Fax:

Mailing address *(if PO Box, please provide physical address)*:	City:	State:	ZIP:
Billing address *(if different)*:	City:	State:	ZIP:

Email address *(print clearly)*:

Company contact for coordination of benefits *(if different from above)*:

Mailing address *(if PO Box, please provide physical address)*:	City:	State:	ZIP:

3. Employer contribution *(Note: Employer contribution for health is a minimum of 50%[9] and for life is 100% (2–9 enrollees) and 25% (10–50 enrollees).)*

Employee Health: ______% or, $_______[10] Employee Life: ______% Employee Dental: _______% Employee Vision: _____%

Dependent Health: ______% or, $_______[10] Dependent Life: ______% Dependent Dental: _______% Dependent Vision: _____%

Note: Dental and Vision can be either voluntary or employer-paid. If employer-paid, you must complete the employer contribution. If you select Dental and/or Vision with no contribution, indicate "0."

4. Eligibility information

1. Probationary priod for new hires/rehires – First of the month following: ☐ Date of hire ☐ 1 mo. ☐ 2 mos. ☐ 3 mos. ☐ ___ mos. (6 max.)
2. Do you want to waive the probationary period for all enrollees at initial enrollment? ☐ Yes ☐ No
3. Number of hours worked per week required to be eligible for medical insurance coverage: ☐ 20 ☐ 30

	Medical	**Life**	**Dental**	**Vision**
4. Number of eligible employees (including eligible owner(s)):	________	________	________	________
5. Total number of Health Net enrollees (excluding COBRA enrollees):	________	________	________	________
6. Number of Health Net COBRA enrollees (applying for health coverage):	________	________	________	________
7. Number of waivers (Please include an enrollment form with Section 7 "Declination of Coverage" indicated.):	________	________	________	________

8. What type of COBRA[11] are you subject to: ☐ Federal COBRA ☐ Cal-COBRA

   If federal COBRA, how would you like your COBRA enrollees to be billed: ☐ Group billed ☐ Member billed
9. Within the last 12 months, has the employer held a Health Net contract? ☐ Yes ☐ No
10. Do the eligible enrollees represent a carve-out either by class, location or union affiliation? ☐ Yes ☐ No
11. Does the group file a DE-6? ☐ Yes ☐ No[12]

5. Life and AD&D benefit selection *(If Health Net Life is selected, all full-time employees are eligible.)*

(Note: Option A is for 2–50 employees. Options B–G vary by group size.)

☐ **Option A** – $15,000 flat amount for all employees.

☐ **Option B** – A flat amount higher than $15,000; maximum $100,000:
$ ___________________.

☐ **Option C** – One (1) X annual salary; ______ or two (2) X annual salary; maximum $50,000.

☐ **Option D** – One (1) X annual salary; ______ or one and a half (1.5) X annual salary; ______ or two (2) X annual salary; maximum $100,000.

☐ **Option E** – Graded benefits by job title: Class I (officers, managers, supervisors) – $25,000; Class II (all other employees) – $15,000.

☐ **Option F** – Graded benefits by job title: Class I (officers, managers, supervisors) – $50,000; Class II (all other employees) – $25,000.

☐ **Option G** – Graded benefits by job title: Class I (officers, managers, supervisors) – $100,000; Class II (all other employees) – $50,000.

Dependent Life: (choose one)

☐ High: $5,000 spouse, $2,000 child, $200 infant (14 days–6 mos.)

☐ Low: $2,000 spouse, $1,000 child, $100 infant (14 days–6 mos.)

6. Pre-tax solutions *(E.g., IRS code sections 125 and 321; premium-only plans and Flex plans.)*

If you are interested in learning about the tax savings potential for your employees and company, please contact Total Administrative Services Corporation (TASC) at 1-800-422-4661.

7. Current carrier *(List current carrier if any.)*

Is your company currently active with other health insurance? ☐ Yes ☐ No

If so, will you be canceling your other health insurance if approved with Health Net? ☐ Yes ☐ No

Health and/or Life: ________________________ Worker's Compensation: ______________________________________

Will Health Net be the only carrier? ☐ Yes ☐ No If "No," name of other carrier: ______________________________

Plan(s) offered: ____

Number of enrollees not covered by Worker's Compensation: ______________________________________

(Employers required to have Worker's Compensation must have a policy in effect to be eligible with Health Net.)

8. Health Questionnaire *(For new groups only.)*

All employer groups must answer "Yes" or "No" to the following questions. Employer groups of 6–9 enrolling employees must have each employee complete the Health Questionnaire with the Enrollment form.

Genetic Information Non-discrimination Act of 2008 (GINA) Compliance Statement: This is not a request for genetic information. In answering this Health Questionnaire on behalf of your employees, employees' dependents and/or persons to be covered, you should not include any genetic information. That is, please do not include any family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which you believe your employees, employees' dependents or other persons to be covered may be at risk.

1. To your knowledge is there any employee, dependent of an employee, or person to be covered who has received more than $5,000 of medical care in the past two (2) years? ☐ Yes ☐ No
2. To your knowledge is any employee, dependent of an employee, or person to be covered unable to work due to injury or illness? ☐ Yes ☐ No
3. To your knowledge are there any current pregnancies or recent hospitalizations for any employee, dependent of an employee, or person to be covered? ☐ Yes ☐ No
4. To your knowledge has any employee, dependent of an employee, or person to be covered ever had, consulted for, had treatment rendered, been advised to have treatment or received treatment, or been hospitalized for any of the following conditions: Cardiovascular disease or heart attack; disorder of the kidney, stomach, intestines or liver; mental or nervous condition; central nervous system disorders; diabetes; respiratory disorders or cancer? ☐ Yes ☐ No
5. To your knowledge has any employee, dependent of an employee, or person to be covered ever been diagnosed as having AIDS or AIDS-related complex (ARC) by a medical professional? ☐ Yes ☐ No

For each "Yes" answer, please provide the person(s) name and submit their completed employee "Health Questionnaire."

____

____

9. Off-cycle dental/vision plan addition renewal cycle

Please complete this section to indicate your preferred renewal date for your dental and/or vision plan addition. If you do not indicate your preference, your dental and/or vision plan addition will be coordinated with your Medical Plan renewal date.

☐ Policy renewal date to coincide with medical plan (foregoing 12-month rate guarantee). Effective: __________

☐ Policy renewal date to follow 12-month rate guarantee. Effective: __________

10. Mailing methods

Where would you want your ID cards mailed? ☐ Member ☐ Employer

Where would you like your Administration Kit mailed? ☐ Broker ☐ Employer

11. Underwriting criteria

General conditions

The issuance of coverage and a Group Service Agreement/Group Policy is subject to underwriting review and approval by the Health Net Entities, the DBP Entities and/or the Fidelity Entities and receipt of the first month's premium. The initial quoted rates are subject to the Health Net Entities, the DBP Entities and/or the Fidelity Entities' review and revision based on actual enrollment and any other variations in the group from conditions outlined in the Underwriting Assumptions.

Coverage will be effective on the noted effective date if the application is accepted and approved by the Health Net Entities, the DBP Entities and/or the Fidelity Entities as appropriate within specified time requirements.

12. Arbitration agreement and other important terms

Please complete all of the information requested before signing this application. Please initial any changes.

This is an application only. Coverage and the issuance of a Group Service Agreement/Group Policy is subject to review and approval by the Health Net Entities, the DBP Entities and/or the Fidelity Entities and receipt of the first month's premium.

The undersigned, on behalf of Group Applicant, understands and agrees that the employer Group Policy(s) applied for, except for the HRA 3000 and HRA 5000 HRA-compatible plans outlined in the "Health plan information" section of this Small Business Application for Group Service Agreement/Group Policy, is intended to be issued as a stand-alone plan(s) only or in conjunction with a Health Savings Account (HSA) banking arrangement, where applicable. Such plan(s), except for the HRA 3000 and HRA 5000 HRA-compatible plans specified above, may not be combined with any form of partial self-funding or otherwise insuring of the deductible, whether in a wraparound, addition or companion capacity, including a partially self-funded Section 105 wraparound, at any time during which the Group Policy(s) is in force. Failure to comply is a breach of the Group Policy(s) and Underwriting Assumptions and will result in Health Net Life Insurance Company canceling the health insurance plan coverage initially issued, and replacing it with the most similar plan from the HRA 3000 and HRA 5000 HRA-compatible plan suite offered by Health Net Life Insurance Company and available for purchase at the time of the breach. The replacement health insurance plan will be issued at the applicable premium rates in effect at that time.

The undersigned hereby acknowledge that the preceding information constitutes true and complete representations to the Health Net Entities, the DBP Entities and/or the Fidelity Entities. Should it be determined at the time of enrollment and/or at a future date that there are misstatements in this application, the Health Net Entities, the DBP Entities and/or the Fidelity Entities may at their respective sole options either rescind the quote or initiate termination of the respective group contract(s).

Upon policy anniversary date, submission of renewal premium will confirm acceptance of that renewal and subsequent premium year.

Applicant, in the event this application is accepted, agrees to make authorized payroll dues deductions for such eligible employees who enroll under the Group Service Agreement/Group Policy and to forward such amounts in advance of the due date to the Health Net Entities, the DBP Entities and/or the Fidelity Entities, together with the reports necessary to maintain accurate and complete membership records. Furthermore, applicant agrees to comply with the applicable regulations pertaining to membership requirements, additions to the group, and deletions from the group. Please return this application to your Health Net of California, Inc. and/or Health Net Life Insurance Company Account Executive or Broker as specified.

This Small Business Application for Group Service Agreement/Group Policy and any attached Addendum, together with the Health Net Entities, the DBP Entities and/or the Fidelity Entities Group Policies (as referenced herein), and the employee enrollment forms form the entire agreement between the parties.

For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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

12. Arbitration agreement and other important terms *(continued)*

Arbitration Agreement: On behalf of Group Applicant, I understand and agree that any and all disputes or disagreements between Group (or enrolled members) and the Health Net Entities, the DBP Entities and/or the Fidelity Entities regarding the construction, interpretation, performance or breach of the Health Net Entities, the DBP Entities and/or the Fidelity Entities Group Policies, or regarding other matters relating to or arising out of the Health Net Entities, the DBP Entities and/or the Fidelity Entities Group Policies, whether stated in tort, contract or otherwise, must be submitted to final and binding arbitration in lieu of a jury or court trial. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties, including the Health Net Entities, the DBP Entities and/or the Fidelity Entities, are giving up their constitutional rights to the extent permitted by law to have their dispute decided in a court of law before a jury. I also understand that disputes with the Health Net Entities, the DBP Entities and/or the Fidelity Entities involving claims for medical services 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. A more detailed arbitration provision is included in the Health Net Entities, the DBP Entities and/or the Fidelity Entities Group Policies.

Effective July 1, 2002, members who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. § 1001 et seq., a federal law regulating benefit plans, are not required to submit disputes about certain "adverse benefit determinations" made by Health Net Entities, the DBP Entities and/or the Fidelity Entities to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by the Health Net Entities, the DBP Entities and/or the Fidelity Entities to deny, reduce, terminate or not pay for all or a part of a benefit. However, members and the Health Net Entities, the DBP Entities and/or the Fidelity Entities may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

Officer of the company signature:	Officer title:	Date:

13. Broker information

Broker name:	Health Net Broker ID #:	Broker Lic. #:		Date submitted:
Agency name:	Telephone #:	Fax #:		Email address:
Address:	City:		State:	ZIP:
Broker/consultant signature:	Date:	General Agent / ID #:		
Account Executive name:				Date:

14. For Health Net use only

Underwriter signature:	Date:	Approved: ☐ Medical ☐ Dental ☐ Vision Declined: ☐ Medical ☐ Dental ☐ Vision		Billing #:	Effective date:
SBG representative signature:	Date:	Group # (Health):	Policyholder # (Life):		Medical plan:

Health Net of California, Inc. offers the following products: Elect Open Access, HMO, Select POS, Salud con Health Net® HMO y Más.SM

Health Net Life Insurance Company offers the following products: Flex Net, PPO, Salud con Health Net EPO and PPO, Life and AD&D insurance.

Unimerica Life Insurance Company offers the following products: Dental PPO and Dental Indemnity.

Dental Benefit Providers of California, Inc. offers the following product: Dental HMO.

Fidelity Security Life Insurance Company offers the following product serviced by EyeMed Vision Care, LLC: Vision PPO.

Small Business Group submission checklist

To ensure prompt processing, please make sure to include the following documents.

Groups applying for a 1st-of-the-month effective date must be submitted to Health Net by the 5th of the month. Paperwork must be completed by the 20th of the month, otherwise the group will be rolled to the following month.

- ☐ A signed original application for Group Service Agreement (GSA)/Group Policy
- ☐ A complete employee application for each eligible employee enrolling/waiving coverage
- ☐ A check or a Check-by-Fax form for the first month's premium drawn from the group account
- ☐ A Health Questionnaire is required for:
  - All groups of 6–9 employees enrolling.
  - Groups of 1–5 enrolling employees that are eligible for an industry discount.
  - Any employee referenced on the GSA with a known medical condition.
  - Non-guaranteed issue groups.
  - All carve-out groups.
- ☐ The latest quarter DE-6, reconciled:
  - If the group has not been in business long enough to have a DE-6, six weeks of payroll, including withholdings, may be submitted.
  - 2 week payroll is required for all employees that don't appear on the current DE-6.
  - For wages exceeding part-time and wages below full-time status, payroll will be required.
  - To reconcile the DE-6, please indicate next to each employee's name one of the following:

    T – Terminated (including termination date)

    E – Eligible and enrolling

    W – Eligible and waiving coverage

    S – Seasonal

    WP – Waiting period (include date of hire for those in waiting period)

    TEMP – Temporary employees

    PT – Part-time

    Covered by another carrier – add carrier name.
- ☐ Ownership paperwork (required if owner/partners' names do not appear on the DE-6 or payroll records). Must list each person's first and last name. Paperwork must be filed with the state or county. Documentation may include:

  For sole proprietor:
  - California Business License
  - Fictitious Business Name Statement
  - Schedule C Tax Form

  For partnership:
  - California Business License (showing both names)
  - Fictitious Business Name Statement (showing both names)
  - Schedule K Tax Form (for all eligible owners)
  - Tax certificate (showing both names)

  For corporation:
  - Articles of Incorporation
  - Statement of Information
  - Tax Form 1120

  Note: Please consult your sales representative for acceptable ownership documentation for other business structures.

For PPO plans:

- ☐ Copies of EOBs for employees requesting Deductible Credit from prior carrier
- ☐ Groups enrolling in the HSA EZAccess Program:
  - Completed Bank of America Employer Enrollment Forms
  - Health Net Authorization Form (1 page)
  - Bank of America Employer Group Set-Up Form (2 pages)
  - Bank of America Services Agreement (3 pages)

Employees can easily enroll online for The HSA for Life from Bank of America by following these simple steps:

1. Visit www.bankofamerica.com/benefitslogin.[13]
2. Under "New User," click *Continue.*
3. Enter the Group ID provided to them by the employer.
4. Follow the prompts to complete and submit the application.

Send all completed paperwork to your designated Account Executive or Broker.

[1] HSA-compatible.

[2] Available in Orange County and select ZIP codes of Los Angeles, Riverside, San Diego and San Bernardino counties.

[3] Available in Los Angeles, Orange and Ventura counties.

[4] Available in select ZIP codes of San Diego and Imperial counties.

[5] Available in all or parts of Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Francisco, Santa Clara, Stanislaus and Ventura counties.

[6] Available in select ZIP codes of Los Angeles, San Bernardino and San Diego counties.

[7] All riders for HMO, Salud HMO y Más, EOA and POS only.

[8] Groups may only select one tailored network offering alongside the full network Dual Plans. Silver and Bronze may not be offered together.

[9] Enhanced Choice, Silver Choice, H^n Options, H^n Options Silver and H^n Options Bronze require 50% of the lowest cost plan (excluding Salud) or $100 minimum.

[10] Flat dollar contribution applies to Enhanced Choice, Silver Choice, H^n Options, H^n Options Silver and H^n Options Bronze only.

[11] Note: Generally, employers who normally employed 20 or more employees during the previous calendar year are subject to federal COBRA. Employers who employed 2–19 employees on at least 50% of its working days the previous calendar year are subject to Cal-COBRA. Please consult your legal counsel if you need help determining which law applies to you.

[12] If a DE-6 is not available, please provide a letter of explanation and supporting documentation, subject to underwriting approval, with this group service agreement application.

[13] If the employees do not have online access, contact your authorized Health Net Agent or Broker.

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