



GROUP EMPLOYEE / DEPENDENT ENROLLMENT AND CHANGE FORM

Enrollment
 Change

Life Membership Accounting & Eligibility
 Post Office Box 9103 • Van Nuys, California 91409-9103

Missing information will delay the processing of this enrollment form.

EMPLOYER			
POLICY HOLDER NAME			POLICY #
EMPLOYEE OCCUPATION TITLE	DATE OF HIRE	COVERAGE EFFECTIVE DATE	EMPLOYEE SALARY
EMPLOYEE CLASS (IF APPLICABLE)		# OF HOURS WORKED PER WEEK	\$ _____ <div style="float: right; font-size: small;"> <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly </div>

Employer: Send copy to Health Net Life Insurance Company at the above address.

EMPLOYEE							
A. GENERAL INFORMATION							
EMPLOYEE LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY #	DATE OF BIRTH	SEX	MARITAL STATUS	
STREET ADDRESS			CITY	STATE	ZIP CODE	TELEPHONE NUMBER () -	
Spouse	LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY #	DATE OF BIRTH	SEX	
Child							
Child							

Note: Additional children should be listed on a separate sheet attached to this form.

B. COVERAGE INFORMATION			
<input type="checkbox"/> Basic Amount (Employee) (includes AD&D)	\$ _____	<input type="checkbox"/> Supplemental Life Amount	\$ _____
<input type="checkbox"/> Dependent Life	\$ _____	<input type="checkbox"/> Supplemental AD&D Amount	\$ _____
Spouse Amount -	\$ _____	<input type="checkbox"/> Spouse Amount -	\$ _____
Child Amount -	\$ _____	<input type="checkbox"/> Child Amount -	\$ _____
Note - Infant Amount = 10% of Child Amount			

C. BENEFICIARY DESIGNATION (Required with Life and AD&D coverages.)							
LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY #	RELATIONSHIP TO EMPLOYEE			
STREET ADDRESS			CITY	STATE	ZIP CODE	TELEPHONE NUMBER () -	

Spouse Signature: _____ (Only necessary when named beneficiary is other than spouse.)

If none of the above is living, then pay:

NOTE: Additional or contingent Beneficiaries should be indicated on a separate sheet attached to this form.

D. STATEMENTS	
<p>I request coverage under my employer's group insurance plan as noted and also verify the accuracy of the employee section. Furthermore, I authorize my employer to deduct from my earnings any payments, if applicable, for this coverage.</p> <p>If I have checked NO to any or all of the above life and/or dependant coverages, I understand that Health Net Life Insurance Company may not approve my request to change this decision unless I provide satisfactory evidence of insurability.</p>	
SIGNATURE	DATE
X	

GROUP EMPLOYEE / DEPENDENT ENROLLMENT

INSTRUCTIONS FOR COMPLETING THE ENROLLMENT FORM

Employers	Complete Employer section
Employees	Complete sections A through D.

SECTION A

- Eligible dependents include your husband or wife and unmarried children under age 21 or under the age specified in the plan for students.

SECTION B

- Check Yes / No for each coverage option and identify the amount of coverage. (If you are unsure of the benefits for which you are eligible, please ask your Employer's Benefit Administrator.)
- Indicate whether your coverage is a flat dollar amount or based on a multiple of your salary. (If you are unsure of your benefit design or the amounts of coverage that you are eligible for, please ask your Employer's Benefit Administrator.)
- If Supplemental Life and Supplemental AD&D coverage is elected above the guaranteed issue amount, you are required to submit Evidence of Insurability (EOI).

SECTION C

- Beneficiaries are required for Life and AD&D coverage.

Please use the full name of the beneficiary (e.g., Smith, Mary J., not Smith, Mrs. John T.)

If you have indicated that your beneficiary is a trust or last will we will send you special forms to complete. You will also need to complete special forms if you don't want your beneficiaries to receive payment in a lump sum.

If beneficiaries are trustees of a Pension Plan, please provide the name of the plan.

We will pay all your beneficiaries equally unless you indicate that we should pay them in different percentages.

SECTION D

- You must sign this section, but a witness signature is required only if you have declined any of the coverages.
- The last copy of the completed form is for your records.