Health Net®
LIFE INSURANCE COMPANY

CALIFORNIA FARM BUREAU FEDERATION

California Farm Bureau Federation Members' Application *for a Health Net Life Insurance Company Medicare Supplement Plan*

1. You do not need more than one Medicare Supplement plan.
2. If you purchase this plan, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medi-Cal and may not need a Medicare Supplement plan.
4. If, after purchasing this plan, you become eligible for Medi-Cal, the benefits and premiums under your Medicare Supplement plan can be suspended, if requested, during your entitlement to benefits under Medi-Cal for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal. If you are no longer entitled to Medi-Cal, your suspended Medicare Supplement plan, or if that is no longer available, a substantially equivalent plan, will be reinstituted if requested within 90 days of losing Medi-Cal eligibility. If the Medicare Supplement plan provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your plan was suspended, the reinstituted plan will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
5. If you are eligible for, and have enrolled in, a Medicare Supplement plan by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement plan can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement plan under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare Supplement plan, or if that is no longer available, a substantially equivalent plan, will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement plan provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your plan was suspended, the reinstituted plan will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
6. Counseling services are available in this state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the Medi-Cal program, including benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB). If you want to discuss buying Medicare Supplement insurance with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Insurance consumer toll-free telephone number (1-800-927-HELP), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free number (1-800-434-0222), or by accessing the Department of Insurance Internet website (www.insurance.ca.gov).

Health Net® LIFE INSURANCE COMPANY

CALIFORNIA FARM BUREAU FEDERATION

California Farm Bureau Federation Members' Application *for a Health Net Life Insurance Company Medicare Supplement Plan*

Please follow these application instructions:

1. Complete your application, provide any supporting information requested, sign and date it where indicated.
2. Mail your application in the prepaid envelope provided.
3. Please include your first payment. Your payment will be returned if your application is denied.
4. **NOTE:** If you do not choose an effective date and your plan is approved, your coverage will begin on the first day of the month following receipt of your application by Health Net Life.

If you have any questions regarding your enrollment, please call 1-800-944-7287 or TTY/TDD 1-800-929-9955.

Section I: Your personal information

Last name:	First name:	MI:

Primary residence address (PO Box is not allowed):

City:	State:	ZIP:	County:

Mailing address (only if different from primary residence address):

City:	State:	ZIP:

Home telephone #: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___	Email address:	Gender: ☐ Male ☐ Female
Date of birth: ___ ___/___ ___/___ ___ ___ ___ M M / D D / Y Y Y Y	Preferred language: ☐ English ☐ Other: _____	

Please indicate the type of Medicare plan you currently have?
☐ Medicare only ☐ Medicare Advantage HMO ☐ Medicare Advantage PDP
☐ Medicare Advantage PPO ☐ Medicare Advantage Private Fee-for-Service

Which Health Net Life Medicare Supplement Plan are you applying for? ☐ A ☐ C ☐ F ☐ F+ (high deductible) ☐ G	Your requested start date: The 1st of month ___ ___/___ ___/___ ___ ___ ___ M M / D D / Y Y Y Y

California Farm Bureau Membership # (for existing California Farm Bureau members):
_____

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Please provide your medicare insurance information

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card.

– OR –

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Medicare claim #:

_____

HOSPITAL (Part A) effective date:

___ ___/___ ___/___ ___ ___ ___
M M / D D / Y Y Y Y

MEDICAL (Part B) effective date:

___ ___/___ ___/___ ___ ___ ___
M M / D D / Y Y Y Y

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY
JANE DOE

MEDICARE CLAIM NUMBER
000-00-0000-A

SEX
FEMALE

IS ENTITLED TO
HOSPITAL (PART A)
MEDICAL (PART B)

EFFECTIVE DATE
00-00-2012
00-00-2012

Section II: Medicare prescription drug plan information

Have you purchased a Medicare Prescription Drug Plan? ☐ Yes ☐ No

If you have answered "Yes" to the above question, answer the following two questions:

a. Which company did you purchase it from? _____

b. What was the effective date? ___ ___/___ ___/___ ___ ___ ___
M M / D D / Y Y Y Y

Section III: Current health plan information

If you have recently lost, or will be losing, another health plan's coverage and received their notice stating that you are eligible for guaranteed issue of Medicare Supplemental Coverage stating that you have certain rights to purchase a Medicare Supplement plan, you may be guaranteed acceptance in one or more of Health Net Life's Medicare Supplement plans. Please include a copy of that notice with this application.

PLEASE ANSWER ALL OF THE QUESTIONS BELOW BY MARKING "Yes" OR "No" WITH AN "X" TO THE BEST OF YOUR KNOWLEDGE:

1. a. Did you turn 65 years of age in the last six months? ☐ Yes ☐ No

   b. Did you enroll in Medicare Part B (Medical) in the last 6 months? ☐ Yes ☐ No

   If "Yes," what was the effective date? ___ ___/___ ___/___ ___ ___ ___
   M M / D D / Y Y Y Y

2. Are you covered for medical assistance through California's Medi-Cal program? ☐ Yes ☐ No
   NOTE TO APPLICANT: If you are eligible for Medi-Cal benefits with a "share of cost" and have not met your share of cost, please answer "No" to this question.

   If you have answered "Yes" to the above question, answer the following two questions:

   a. Will Medi-Cal pay your premiums for this Medicare Supplement plan? ☐ Yes ☐ No

   b. Do you receive benefits from Medi-Cal OTHER THAN payment toward your Medicare Part B premium? ☐ Yes ☐ No

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Section III: Current health plan information (continued)

3. a. If you have had coverage from any Medicare plan other than Medicare within the past 63 days (for example, a Medicare Advantage plan or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under the plan, leave the END DATE blank. Start date: ___ ___/___ ___/___ ___ ___ ___ (M M / D D / Y Y Y Y) End date: ___ ___/___ ___/___ ___ ___ ___ (M M / D D / Y Y Y Y)	☐ Yes ☐ No
b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this Health Net Life Medicare Supplement plan?	☐ Yes ☐ No
If "Yes," have you received and completed the Notice to Applicant Regarding Replacement of Medicare Supplement Coverage or Medicare Advantage form?	☐ Yes ☐ No
c. Is this your first time in this type of Medicare plan?	☐ Yes ☐ No
d. Did you drop a Medicare Supplement plan to enroll in the Medicare Plan?	☐ Yes ☐ No
4. a. Do you have another Medicare Supplement plan in force?	☐ Yes ☐ No
b. If so, with what company and what plan do you have? _____	
c. If so, do you intend to replace your current Medicare Supplement plan with this plan?	☐ Yes ☐ No
If "Yes," have you received and completed the Notice to Applicant Regarding Replacement of Medicare Supplement Coverage or Medicare Advantage form?	☐ Yes ☐ No
5. a. Have you had coverage under any other health insurance coverage within the past 63 days (for example, an employer, union, or individual plan)?	☐ Yes ☐ No
b. If so, with what company and what kind of plan? _____	
c. What are your dates of coverage under the other plan? (If you are still covered under the other plan, leave "End date" blank.) Start date: ___ ___/___ ___/___ ___ ___ ___ (M M / D D / Y Y Y Y) End date: ___ ___/___ ___/___ ___ ___ ___ (M M / D D / Y Y Y Y)	
6. a. Are you under the age of 65?	☐ Yes ☐ No
b. If so, do you have end-stage renal disease (ESRD)?	☐ Yes ☐ No

Section IV: Guaranteed acceptance statement

If you think you qualify for guaranteed acceptance, please check the number of the qualifying criterion below as described in the accompanying Guaranteed Issue Guide. Please attach any supporting documents as outlined in the Guaranteed Issue Guide. **PLEASE NOTE:** If you are applying for coverage during a Medicare Supplement open enrollment or guaranteed issue period as specified in the accompanying Guaranteed Issue Guide, you do **NOT** need to complete the **Current Health Statement** portion of this application or sign a form required by the federal Health Insurance Portability and Accountability Act of 1996.

I qualify for guaranteed acceptance through an open enrollment or guaranteed issue period based on criterion number:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16

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Section V: Current health statement

If you qualify for Guaranteed Acceptance, you do not need to complete this section.

Genetic Information Nondiscrimination Act of 2008 (GINA) compliance statement: This Current Health Statement is not a request for genetic information. In answering these questions, 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 you may be at risk.

To the best of your knowledge, please answer "Yes," "No" or "Not sure" to each question in this section.

1. Are you currently hospitalized, confined to a nursing facility, or have you been hospitalized one or more times in the past two years?	☐ Yes ☐ No ☐ Not sure
2. Within the past year, have you had or been treated for internal cancer?	☐ Yes ☐ No ☐ Not sure
3. Within the past year, have you been advised to have joint replacement surgery that has not yet been performed?	☐ Yes ☐ No ☐ Not sure
4. Within the past two years, have you had an amputation caused by a disease, heart surgery, a cerebral vascular accident (stroke), liver disease, or kidney dialysis?	☐ Yes ☐ No ☐ Not sure
5. Do you have diabetes? Do you take insulin or oral medications for treatment of diabetes?	☐ Yes ☐ No ☐ Not sure ☐ Yes ☐ No ☐ Not sure
6. Are you presently receiving dialysis or have you ever had a kidney transplant?	☐ Yes ☐ No ☐ Not sure
7. Are you currently taking medication? **If you answered "Yes," please list on the following page all medications you are currently taking and the condition for which the medication is prescribed.**	☐ Yes ☐ No ☐ Not sure

If you answered "Yes" or "Not sure" to any of the questions above in Section V: Current Health Statement, please provide additional information and the dates associated with the condition, as well as current status of the condition in the space provided below. If additional space is required, please use additional sheets as necessary, then sign and date each sheet.

Condition, diagnosis or treatment date(s)	Explanation/current status

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Section V: Current health statement (continued)

Medications	Most recent refill date	Condition for which medication is prescribed

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

Section VI: Preferred payment information

Please include your first payment along with your application. To determine your total monthly payment amount, refer to the California Farm Bureau Federation Medicare Supplement Plan Outline of Coverage for your medical plan premium. If you are not already a County Farm Bureau member, you will also need to include the first year annual dues payment (refer to annual membership dues form).

If your application is approved, your check accompanying this application will be processed by Health Net Life electronically and will be shown as an Automated Clearing House (ACH) Debit on your bank statement. By signing this enrollment application, you agree to permit Health Net Life to process your check electronically. The payment will take 5–7 days to reflect in your Health Net Life account. You will receive a bill indicating the amount and the date your next payment is due. Health Net Life will also send you an approval letter, Certificate of Insurance and member identification card as proof of approval. If your application is not approved, Health Net Life will not process your check accompanying this application and will return it to you.

Health Net Life has two options for you to pay for this Certificate if you are approved. You may pay monthly by check or Automatic Bank Draft (ABD). An ABD form is included in the information packet for your convenience or you may contact Health Net Life and request one.

☐ I will pay monthly by check. (Make checks payable to Health Net Life.)

☐ I have completed the ABD form and attached a voided check. I understand that, by using Health Net Life's ABD, my bank account will be automatically debited on or about the sixth (6th) of each month.

Insufficient fund fees: Insufficient funds on Automatic Bank Drafts are subject to a $15.00 return fee. Insufficient funds on returned checks are subject to a $25.00 return fee.

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Section VII: Signature section

IT IS IMPORTANT THAT YOU READ and UNDERSTAND THE FOLLOWING BEFORE YOU SIGN.
By completing this application and applying for this coverage, I agree to or with the following:

1. I am age 65 or older, or under age 65 and entitled to Medicare on the basis of Social Security disability benefits and do not have end-stage renal disease (ESRD), enrolled in Medicare Parts A and B, and reside within the state of California.
2. I am a member of a County Farm Bureau of the California Farm Bureau Federation and its Rural Health Department.
3. I am not concurrently insured under any other California Farm Bureau Federation service to member health insurance program.
4. This application and the Statement of Health, together with the Health Net Life Certificate of Insurance (Certificate) and any endorsements, appendices and attachments thereto, will collectively constitute the entire agreement for coverage.
5. I will not receive coverage from Health Net Life unless they approve this application. Health Net Life is not liable for bills incurred before the effective date of coverage.
6. Only Health Net Life can approve this application. I understand that any insurance agent, broker or sales representative cannot grant approval, change terms or waive requirements.
7. I acknowledge receipt of the Outline of Coverage, the Guide to Health Insurance for People with Medicare and a copy of this application. I have read the Outline of Coverage and the terms, conditions and authorizations set forth herein. I certify that I meet the eligibility requirements set forth in the Outline of Coverage. I alone am responsible for the accuracy and completeness of this application and have answered all questions to the best of my knowledge and belief. I understand that I will not be eligible for coverage if any information is false or incomplete, and that coverage may be revoked based on such findings.
8. I authorize the United States Department of Health and Human Services, the Centers for Medicare & Medicaid Services, any health care provider, hospital or medical facility to furnish to any agent, designee, employee or representative of Health Net Life any and all records pertaining to claims payment or rejections, medical history, services rendered, or treatment given to myself for purposes of review, investigation or evaluation of this application **(except to those applicants eligible for guaranteed issue coverage, including applicants who are applying for coverage during an open enrollment period)** or a claim. I also authorize Health Net Life and its employees, participating providers, agents and representatives to disclose to any health care provider, health care service plan, insurer or self-insurer any such medical information obtained if such disclosure is necessary to allow the processing of a claim or if requested pursuant to legal process. This authorization shall become effective immediately and shall remain in effect for the term of coverage under the Certificate. I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an individual (as described previously), the signature certifies that:
   a. the person is authorized under state law to complete this enrollment form on behalf of the named applicant and,
   b. documentation of the authority is available upon request by Health Net Life Insurance Company or other authorized regulatory agencies.

Note: Health Net Life requests that a copy of the authorization form, Durable Power of Attorney for Health Care, or similar document, be included with this application.

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Section VII: Signature section (continued)

9. BINDING ARBITRATION AGREEMENT: I, the Applicant, understand and agree that any and all disputes between me (including any of my heirs or personal representatives) and Health Net Life , but not as to professional negligence (medical malpractice), 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 Certificate of Insurance or my Health Net Life 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 Life are giving up their constitutional right to have their dispute decided in a court of law by a jury. 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 name: _____

Signature: _____ Date: ___ ___/___ ___/___ ___ ___ ___
M M / D D / Y Y Y Y

If you are the legally authorized representative, authorized to act on behalf of the individual under the laws of the state where the individual resides, you must provide a copy of the authorization form, Durable Power of Attorney for Health Care, or similar document and provide the following information:

Last name:	First name:	MI:

Address:		

City:	State:	ZIP:

Relationship to applicant:	Phone #: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

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Section VIII: Broker information section only

The following items have been included with the application. Check all that apply:

☐ Proof of guaranteed issue ☐ Notice to Applicant Regarding Replacement of Coverage Form (RMSC)

Note: Applications received without the required documentation will not be processed. You will have 30 calendar days from the date of the Health Net Life notification letter to submit the documentation. Applications will be denied if the missing documentation is not received within this time frame.

A broker who assists an applicant in submitting an application to a health plan or insurer has a duty to assist the applicant in providing answers to health questions accurately and completely.

Broker Attestation

I, _____ (Name of broker)

(Note: You must select the appropriate box below. You may only select one box.)

☐ did not assist the applicant in any way in completing or submitting this application. All information was completed by the applicant with no assistance or advice of any kind from me.

☐ assisted the applicant in submitting this application. All information in the health questionnaire was completed by the applicant. I advised the applicant that he or she should answer all questions completely and truthfully and that no information requested on the application should be withheld. I explained that withholding information could result in cancellation of coverage in the future. The applicant indicated to me that he or she understood these instructions and warnings. To the best of my knowledge, the information on the application is complete and accurate. I understand that, if any portion of this statement by me is false, I may be subject to civil penalties of up to $10,000.

Today's date (required): ___ ___/___ ___/___ ___ ___ ___
M M / D D / Y Y Y Y

Broker signature (required): _____

Print broker name: _____

Phone #: _____ ID #: _____

FMO/GA/Agency name: _____

Phone #: _____ ID #: _____

Broker rep received date: _____ Broker email address: _____

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Section IX: Health Net sales rep section only

The following items have been included with the application. Check all that apply:

☐ Proof of guaranteed issue ☐ Notice to Applicant Regarding Replacement of Coverage Form (RMSC)

Note: Applications received without the required documentation will not be processed. You will have 30 calendar days from the date of the Health Net Life notification letter to submit the documentation. Applications will be denied if the missing documentation is not received within this time frame.

Sales rep name: _____

Phone #: _____ ID #: _____

Sales rep received date: _____ Sales rep email address: _____

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