Primary applicant's Social Security number

Primary applicant's name: _____ ☐☐☐ ☐☐ ☐☐☐☐

Part III. Family member(s) to be enrolled (continued)

3. How to make different plan choices:

a. If you wish to choose different medical and Dental and Vision Plus coverage for each family member, please complete the Dental and Vision Plus coverage questions.[3]

b. Health Net bills to only one address per applicant. Therefore, to be processed under one applicant, all family members must be billed to the same address.

c. See Part VI to enroll in supplemental term life insurance.

Relation	Last name	First name	MI	Social Security number	Date of birth	Place of birth	Height/ weight (lbs.)
Dependent 1 ☐ Husband ☐ Wife ☐ Domestic partner ☐ Son ☐ Daughter							
Medical plan choice for each family member if different[3]						**Add Dental and Vision Plus**	
						☐ Yes ☐ No	
Relation	**Last name**	**First name**	**MI**	**Social Security number**	**Date of birth**	**Place of birth**	**Height/ weight (lbs.)**
Dependent 2 ☐ Son ☐ Daughter							
Medical plan choice for each family member if different[3]						**Add Dental and Vision Plus**	
						☐ Yes ☐ No	

For additional dependents, please complete the Statement of Health Addendum.

[3]Single rates apply when you enroll each family member in a different medical plan.

Part IV. Special enrollment for children under 19 years of age

	Your children under 19 years of age are eligible to enroll in an Individual & Family Plan during the following periods and cannot be declined due to a pre-existing medical condition. While coverage is guaranteed, the premium may vary due to health history or failure to maintain health insurance prior to open enrollment. Please complete one of the applicable sections below.	**Primary applicant** (complete primary applicant column for child-only apps.)	**Dependent 1**	**Dependent 2**
A.	**My child(ren) are applying during the month of their birthday (annual open enrollment).** (Proof of date of birth may be required. If late enrollee, see next page.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
B.	**My child(ren) are applying outside of an open enrollment period.**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	If "Yes" to A or B above: Throughout the previous 90 days, have your child(ren) been continuously covered by health insurance? If "Yes," proof of prior coverage is required.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Primary applicant name:	Insurer name:	Policyholder/member ID #:	Group #:
Plan name:	State:	Most recent coverage start date:	End date:

(continued)

Primary applicant's Social Security number

Primary applicant's name: _____ ☐☐☐ ☐☐ ☐☐☐☐

Part IV. Special enrollment for children under 19 years of age (continued)

	Dependent 1 name:	Insurer name:	Policyholder/member ID #:	Group #:
	Plan name:	State:	Most recent coverage start date:	End date:
	Dependent 2 name:	Insurer name:	Policyholder/member ID #:	Group #:
	Plan name:	State:	Most recent coverage start date:	End date:

		Primary applicant	Dependent 1	Dependent 2
C.	**My child(ren) are currently without coverage and are applying during a late enrollee period. Please select the appropriate qualifying event below.**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Qualifying events If your child(ren) did not enroll during an open enrollment period, they may enroll within 63 days after any of the following qualifying events. Please select the appropriate box and attach supporting documentation.			
	a) The child lost dependent coverage due to:			
	i) The termination or change in employment status of the child or the person through whom the child was covered. (Proof of loss of status, such as an employer letter or collateral showing dependent criteria, will be required.)	☐	☐	☐
	ii) The loss of an employer's contribution toward an employee's or dependent's coverage. (Proof of loss of contribution, such as an employer letter or collateral showing employer's contributions, will be required.)	☐	☐	☐
	iii) The death of the person through whom the child was covered as a dependent.	☐	☐	☐
	iv) Legal separation or divorce. (Proof of loss of coverage, such as a Certificate of Creditable Coverage or loss of coverage letter from the employer or insurer, will be required.)	☐	☐	☐
	v) The loss of coverage under the Healthy Families program, Access for Infants and Mothers (AIM) program or the Medi-Cal program. (Proof of loss of coverage, such as termination letter from these programs, will be required.)	☐	☐	☐
	b) The child became a resident of California during a month that was not the child's birth month.	☐	☐	☐
	c) The child was born as a resident of California and did not enroll in the month of birth.	☐	☐	☐
	d) The child is mandated to be covered pursuant to a valid state or federal court order. (As proof, a copy of the court order will be required.)	☐	☐	☐
	e) The child was adopted. (As proof, a copy of the legal adoption document will be required.)	☐	☐	☐
	f) The child exhausted COBRA or Cal-COBRA continuation coverage. (As proof, a Certificate of Creditable Coverage will be required.)	☐	☐	☐