Enrolling is Simple.
Just Follow These 3 Easy Steps…

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: 818-654-4548 fax: 818-776-9865

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly, quarterly, or semi-annual.

Step 3

SEND THE COMPLETED APPLICATION TO:

Oleg Skurskiy

18375 Ventura Blvd. # 226

Tarzana, CA 91356

Please make your check payable to: Health Net Life

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

If you have questions please contact our office at: 818-654-4548

Thank you for choosing...

Health Net

Please follow these application instructions:

Complete your application, provide any supporting information requested, sign and date it where indicated.
Mail your application in the prepaid envelope provided.
Please include your first payment. Your payment will be returned if your application is denied.
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 (800) 944-7287 or TTY/TDD (800) 929-9955.

Conditions of Membership in Health Net Life Insurance Company (Health Net Life) Medicare Supplement Plan:

1. You are age 65 or older or under age 65 and entitled to Medicare on the basis of Social Security disability benefits, enrolled in Medicare Parts A and B and you reside within the State of California.
2. You must be a member of a County Farm Bureau of the California Farm Bureau Federation and its Rural Health Department.
3. You are 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 and any endorsements, appendices, and attachments thereto, collectively constitute the entire agreement for coverage.
5. I will not receive coverage from Health Net Life unless it approves 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 finding.

Signature _____ Date _____

Your Personal Information

First Name:	Middle Initial:	Last Name:	
Home Address:			
City:		State:	Zip:
Mailing Address (if different from above)			
Home Telephone ( )	E-mail Address		Gender: ☐ Male ☐ Female
Date of Birth	Preferred Language: ☐ English ☐ Other _____		

Please indicate below the type of Medicare plan you currently have:
☐ Medicare Advantage HMO ☐ Medicare Advantage PDP ☐ Medicare Advantage PPO
☐ Medicare Advantage Private-Fee-For-Service ☐ Medicare

Which Health Net Life plan are you applying for? ☐ A ☐ C ☐ F ☐ F+ (High Ded.) ☐ G ☐ J
(Prescription drug benefits are not available with Health Net Life plans)

Your Requested Start Date: The 1st of _____	Medicare #	Social Security #

You are entitled to:
Medicare Part A (Hospital) Effective: _____ Medicare Part B (Medical) Effective: _____

California Farm Bureau Federation Membership Number:	California Farm Bureau Federation Membership County:

(continued on next page)

White – Medicare Files Yellow – Health Net Pink – Member

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Optional Supplemental Benefit Package Options

If you wish to enroll in an Optional Supplemental Benefit Package, please indicate your selection below:

You must be enrolled in a Health Net Life medical plan in order to enroll in an Optional Supplemental Benefit Package.

Choose one of the following:

☐ Package #1: $24 monthly premium includes HMO Preventive and Comprehensive Dental, PPO Vision, life management services (emotional and behavioral health, financial and legal support, elder care support, and other helpful resources) and Silver&Fit Basic Fitness Program

☐ Package #2: $26 monthly premium includes PPO Preventive and Comprehensive Dental, PPO Vision, life management services (emotional and behavioral health, financial and legal support, elder care support, and other helpful resources) and Silver&Fit Basic Fitness Program

Medicare Prescription Drug Plan Information

☐ YES ☐ NO	Have you purchased a Medicare Prescription Drug plan? If you have, please let us know: a. Which company did you purchase it from? _____ b. What was the effective date? _____ If you have not purchased a Medicare Part D plan, would you like information sent to you about Health Net Life's Medicare Prescription Drug plan, Health Net Orange? ☐ YES ☐ NO

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. ☐ YES ☐ NO 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?
   If YES, what was the effective date? _____

2. ☐ YES ☐ NO Are you covered for medical assistance through California's Medi-Cal program?
   Note to Applicant: If you have a "share of cost" under the Medi-Cal program, please answer "NO" to this question.

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

☐ YES ☐ NO 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 towards your Medicare Part B premium?

3. ☐ YES ☐ NO 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 ____/____/____ END DATE ____/____/____

   ☐ 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 plan?

   ☐ 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?

4. ☐ YES ☐ NO a. Do you have another Medicare Supplement plan in force?
   b. If so, with what company and what plan do you have?
   _____

   ☐ YES ☐ NO c. If so, do you intend to replace your current Medicare Supplement plan with this plan?

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Current Health Plan Information (continued)

5. ☐ YES ☐ NO a. Have you had coverage under any other health insurance coverage within the past 63 days (For example, an employer, union, or individual plan)?

b. If so with what companies 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 ____/____/____ END DATE ____/____/____

Guaranteed Acceptance Statement

If you think you qualify for guaranteed acceptance, please write the number of the qualifying criterion as described in the accompanying Guarantee Issue Guide on the line below. Please attach any supporting documents as outlined in the Guarantee Issue Guide. **PLEASE NOTE:** If you do qualify for Guaranteed Issue you do **NOT** need to complete the **Current Health Statement** portion of this application or to sign a form required by the federal Health Insurance Portability and Accountability Act of 1996.

I qualify for guaranteed acceptance based on criterion number _____

Current Health Statement – If you qualify for Guaranteed Acceptance, you do not need to complete this section.

Please answer "YES" or "NO" to each question in this section.

1. ☐ YES ☐ NO	Are you currently hospitalized, confined to a nursing facility, had any amputation caused by a disease, or have you been hospitalized two or more times in the past 12 months?
2. ☐ YES ☐ NO	Within the past year, have you had or been treated for internal cancer?
3. ☐ YES ☐ NO	Within the past year have you been advised to have joint replacement surgery that has not yet been performed?
4. ☐ YES ☐ NO	Within the past two years have you had heart surgery, a cerebral vascular accident (stroke), liver disease, or kidney dialysis?
5. ☐ YES ☐ NO	Do you have diabetes?
☐ YES ☐ NO	If so, have you ever used insulin or have you taken oral medications for diabetes for more than five years?
6. ☐ YES ☐ NO	Have you ever been diagnosed with End Stage Renal Disease (ESRD) or had a kidney transplant?
7. ☐ YES ☐ NO	Are you currently taking medication? If you answered "Yes," please list at the end of this section all medications you are currently taking and the condition for which the medication is prescribed.

If you answered "Yes" to any of the above questions, please provide additional information and dates associated with the condition, as well as current status of the condition. If additional space is required, please use additional sheets as necessary; please sign and date each sheet.

Condition or Medication	**Date**	**Explanation/Current Status**

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

(continued on next page)

Signature Section

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION

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) 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 of Insurance.

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:

1. The person is authorized under State law to complete this enrollment form on behalf of the named applicant and,
2. Documentation of the authority is available upon request by Health Net Life Insurance Company or other authorized regulatory agency.

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.

BINDING ARBITRATION

I, the applicant, understand and agree that any and all disputes or disagreements between me (including any of my heirs or personal representatives) and Health Net Life regarding the construction, interpretation, performance or breach of the Health Net Life Medicare Supplement Certificate of Insurance, but not as to professional negligence (medical malpractice), 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 Health Net Life, are giving up their constitutional right to the extent permitted by law to have their dispute decided in a court of law before a jury. A more detailed arbitration provision is included in the Certificate of Insurance. My signature below indicates that I understand the terms of this Binding Arbitration Clause and agree to submit disputes to binding arbitration.

Signature _____ Date: _____

If you are the authorized representative, you must provide the following information:

Name:	
Address:	
Relationship to Applicant:	Phone Number:

Agent/Broker Information – This section must be completed by Licensed Seller

FMO/GA Name:	FMO/GA ID Number:
Producer Name: Oleg Skurskiy	Producer ID Number: W771
Producer Phone Number: 818-654-4548	Producer Fax Number: 818-776-9865
Producer Address:	
Producer Signature:	

Office use only:	
Approval Date: _____	Guarantee Issue: _____
Effective Date: _____	ABD Included: ☐ Yes ☐ No
Plan/Group ID: _____	

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 plans 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 website (www.insurance.ca.gov).

CALIFORNIA FARM BUREAU FEDERATION

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Health Net®
LIFE INSURANCE COMPANY

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