Oleg Skurskiy Authorized Independent Agent, CA License 0E50389
licensed in State of California , Colorado , Texas , Virginia , Arizona ,
Nevada , Illinois , Ohio, Georgia, Connecticut, New Hampshire

Please print out the form below and mail your completed form to:

Oleg Skurskiy
18375 Ventura Blvd. # 226
Tarzana, CA 91356
or
By fax at 1-818-776-9865

Please do not send application to above fax or address the application if you are outside of the states below.

State of California , Colorado , Texas , Virginia , Arizona , Nevada , Illinois , Ohio, Georgia, Connecticut, New Hampshire .

all other states please call medicare at 1-800-medicare

2009

HEALTH NET ORANGE PRESCRIPTION DRUG PLAN

Why is choosing a health care company so complicated?
The simple truth is, it doesn't have to be.

Health Net Orange knows how challenging Medicare can be. We make enrolling simple and easy.

HOW TO ENROLL IN HEALTH NET'S ORANGE PRESCRIPTION DRUG PLAN:

- Clearly print all information and complete all sections of the enclosed enrollment application.
- If any information is missing, or if the name on your Medicare card does not match your enrollment application exactly, Health Net Orange will not be able to process your application.
- Please keep the **pink member copy** for your records. If you are completing this application yourself, please mail the top two copies to Health Net Orange in the enclosed postage-paid envelope.

After your application is received…

- Once Health Net Orange receives your application, a Customer Service Representative will call to follow-up. This call is to make sure that you understand how a Prescription Drug Plan works and to answer any questions that you have.
- Please allow two weeks to process your enrollment. In most cases, your coverage begins the first of day of the month following the date you submit your application. Health Net Orange will contact the Centers for Medicare & Medicaid (CMS) to verify your eligibility as well as confirm your effective date. For questions regarding benefits, how to enroll or how to complete this form, speak to your agent or call us before signing this form at 1-800-865-9431, TTD/TTY 1-800-929-9955.

Material ID# S5678-2009-06
CMS Approval (9/08)

6017014 (10/08)

Health Net® MEDICARE PROGRAMS

2009 HEALTH NET ORANGE MEDICARE PRESCRIPTION DRUG PLAN INDIVIDUAL ENROLLMENT FORM

TO ENROLL IN HEALTH NET ORANGE, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Please check which Health Net *Orange* plan you are eligible to enroll in:

Alabama/Tennessee
- ☐ Option 1-$25.10/month
- ☐ Option 2-$49.10/month

Alaska
- ☐ Option 1-$40.90/month
- ☐ Option 2-$45.60/month

Arizona
- ☐ Option 1-$14.10/month
- ☐ Option 2-$36.50/month

Arkansas
- ☐ Option 1-$33.70/month
- ☐ Option 2-$40.40/month

California
- ☐ Option 1-$24.00/month
- ☐ Option 2-$49.30/month

Central New England: (Connecticut/Massachusetts/ Rhode Island/Vermont)
- ☐ Option 1-$31.70/month
- ☐ Option 2-$46.20/month

Colorado
- ☐ Option 1-$45.30/month
- ☐ Option 2-$57.40/month

Florida
- ☐ Option 1-$29.70/month
- ☐ Option 2-$56.30/month

Georgia
- ☐ Option 1-$30.60/month
- ☐ Option 2-$45.20/month

Hawaii
- ☐ Option 1-$26.60/month
- ☐ Option 2-$36.90/month

Idaho/Utah
- ☐ Option 1-$40.20/month
- ☐ Option 2-$48.90/month

Illinois
- ☐ Option 1-$28.60/month
- ☐ Option 2-$53.00/month

Indiana/Kentucky
- ☐ Option 1-$34.80/month
- ☐ Option 2-$62.00/month

Kansas
- ☐ Option 1-$41.10/month
- ☐ Option 2-$52.00/month

Louisiana
- ☐ Option 1-$30.00/month
- ☐ Option 2-$40.30/month

Michigan
- ☐ Option 1-$33.60/month
- ☐ Option 2-$44.80/month

Mid-Atlantic: (Delaware/ District of Columbia/ Maryland)
- ☐ Option 1-$28.80/month
- ☐ Option 2-$39.90/month

Mississippi
- ☐ Option 1-$35.90/month
- ☐ Option 2-$44.40/month

Missouri
- ☐ Option 1-$39.00/month
- ☐ Option 2-$61.20/month

Nevada
- ☐ Option 1-$28.30/month
- ☐ Option 2-$49.10/month

New Jersey
- ☐ Option 1-$32.90/month
- ☐ Option 2-$52.10/month

New Mexico
- ☐ Option 1-$21.80/month
- ☐ Option 2-$41.20/month

New York
- ☐ Option 1-$28.50/month
- ☐ Option 2-$48.40/month

North Carolina
- ☐ Option 1-$35.80/month
- ☐ Option 2-$55.60/month

Northern New England: (Maine / New Hampshire)
- ☐ Option 1-$34.40/month
- ☐ Option 2-$47.40/month

Ohio
- ☐ Option 1-$30.90/month
- ☐ Option 2-$41.50/month

Oklahoma
- ☐ Option 1-$30.70/month
- ☐ Option 2-$43.20/month

Oregon/Washington
- ☐ Option 1-$32.30/month
- ☐ Option 2-$48.20/month

Pennsylvania/West Virginia
- ☐ Option 1-$35.30/month
- ☐ Option 2-$46.60/month

South Carolina
- ☐ Option 1-$33.30/month
- ☐ Option 2-$47.60/month

Texas
- ☐ Option 1-$22.40/month
- ☐ Option 2-$48.00/month

Upper Midwest & Northern Plains: (Iowa/Minnesota/ Montana/ Nebraska/North Dakota/ South Dakota/ Wyoming)
- ☐ Option 1-$41.60/month
- ☐ Option 2-$51.40/month

Virginia
- ☐ Option 1-$28.40/month
- ☐ Option 2-$40.90/month

Wisconsin
- ☐ Option 1-$35.00/month
- ☐ Option 2-$46.70/month

LAST Name:	FIRST Name:	Middle Initial:	☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex: ☐ M ☐ F	Email Address:	Home Phone Number: ( )
Permanent Residence Street Address:			County:
City:		State:	ZIP Code:
Mailing Address (only if different from your Permanent Residence Street Address): Street Address:			
City:		State:	ZIP Code:

Emergency Contact: ____________________ Phone Number: ____________________

Relationship to You: ____________________ E-mail Address: ____________________

Member last name:

White – Medicare Files Yellow – Medicare Programs Pink – Member

PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION:

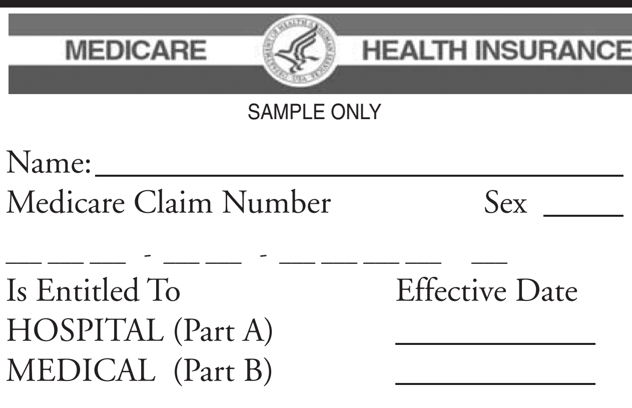
Please take out your Medicare Card to complete this section.

- 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 the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A or Part B (or both) to join a Medicare Prescription Drug Plan.



PAYING YOUR PLAN PREMIUM:

You can pay your monthly plan premium by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security Check each month.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover.

If you don't select a payment option, you will receive a bill each month.

Please select a premium payment option:

☐ Receive a bill

☐ Electronic funds transfer (EFT) from your bank account each month. Please complete an Automatic Bank Draft form and provide a voided check if your checking account is to be used.

☐ Automatic deduction from your monthly Social Security benefits check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point of withholding begins.)

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

   Will you have other prescription drug coverage in addition to Health Net *Orange*? ☐ Yes ☐ No

   If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

   Name of other coverage: ____________ ID # for this coverage: ____________ Group # for this coverage: ____________

2. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

   If "yes" please provide the following information: Name of Institution: ____________

   Address & Phone Number of Institution (number and street):

   ____

3. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

   If yes, please provide your Medicaid number: ____________

Please check one of the boxes below if you would prefer us to send you information in a language other than English:

☐ Spanish ☐ Chinese ☐ Vietnamese

Please contact Health Net Orange at 1-800-865-9431 (TTY users should call 1-800-929-9955) if you need information in another format or language. Our office hours are 8 am-8pm, 7 days a week.

Member last name:

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I understand that my signature on this enrollment form certifies that I have read and understand the information contained on **both sides** of this form. I agree to abide by Health Net Medicare Programs membership rules as outlined in the Evidence of Coverage **(please read your Evidence of Coverage document to know what rules you must follow in order to receive coverage with Health Net Medicare Programs).**

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 authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Health Net Orange or by Medicare.

X ______________________________ __________ ______________________

Signature of Enrollee — Date — Proposed Effective Date

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

Name: ______________________________

Address: ______________________________

Phone Number: (____) _____ - ________ **Relationship to Enrollee:** ______________________

Typically, you may enroll in a Medicare Prescription Drug Plan only during the annual open enrollment period between November 15 and December 31 of each year. Additionally, there are exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of the annual open enrollment period.

Please read the following statements carefully and please check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare
- ☐ I recently moved outside of the service area for my current plan.
- ☐ I recently moved and this plan is a new option for me.
- ☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- ☐ I receive extra help paying for Medicare prescription drug coverage.
- ☐ I am no longer eligible for extra help paying for my Medicare prescription drugs.
- ☐ I live in or recently moved out of a Long Term Care Facility (for example, a nursing home or long term care facility).
- ☐ I recently left a PACE program.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's).
- ☐ I am leaving employer or union coverage.
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ I recently returned to the United States after living permanently outside of the U.S.

If none of these statements apply to you or if you are not sure, please contact us to see if you are eligible to enroll.

Authorized Agent Use Only:

Broker Name: Oleg Skurskiy Broker Phone #: 818-654-4548 Broker HN ID#: W771

GA/FMO Name: ____________ GA/FMO Phone #: ____________ GA/FMO HN ID#: ______

Health Net Rep Name: ____________ Health Net Rep Phone #: ____________ Health Net Rep ID#: ______

MEDICARE PRESCRIPTION DRUG PLAN USE ONLY:			
Plan ID#:		Effective Date of Coverage:	
ICEP/IEP:	OEP:	AEP:	SEP (type):
Plan Representative/Agent/Broker Signature: ____________			

Member last name:

White – Medicare Files Yellow – Medicare Programs Pink – Member

PLEASE READ THIS IMPORTANT INFORMATION:

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have a prescription drug benefit from your Medicare Advantage plan that will meet your needs. By joining Health Net Orange, your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug benefits. Read the information that your Medicare Advantage plan sends you and if you have questions, contact your Medicare Advantage plan.

If you currently have health coverage from an employer or union, joining Health Net *Orange* could affect your employer or union health benefits. If you have health coverage from an employer or union, joining Health Net *Orange* may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

By completing this enrollment application, I agree to the following:

Health Net Orange is a Medicare drug plan and has a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare coverage. It is my responsibility to inform Health Net Orange of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time—if I am currently in a Medicare prescription drug plan, my enrollment in Health Net Orange will end that enrollment. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (November 15–December 31), unless I qualify for certain special circumstances.

Health Net Orange serves a specific area. If I move out of the area that Health Net Orange serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies to access Health Net Orange benefits, except under limited, non-routine circumstances when I cannot reasonably use Health Net Orange network pharmacies. Once I am a member of Health Net Orange, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Health Net Orange when I receive it to know which rules I must follow in order to receive coverage with this Medicare drug plan.

I understand that if I leave this plan and do not have or obtain other Medicare prescription drug coverage or creditable coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Health Net Orange, he/she may be compensated based on my enrollment in Health Net Orange. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

Release of Information: By joining this Medicare prescription drug plan, I acknowledge that Health Net Orange will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Health Net Orange will release my information, including my prescription drug event data to Medicare, who may release it for research and other purposed which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

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