Professional Musicians Local 47 Health and Welfare

Application and Enrollment Form

HEALTH NET PPO

Section A	**PLEASE SELECT THE BENEFITS IN WHICH YOU WANT TO ENROLL**	
❑ Single	❑ Employee and 1 Dependent	❑ Employee and Family

Section B	**TO BE COMPLETED BY ADMINISTRATOR**	
Group No.	Unit No.	Effective Date Of Coverage

Section C	**TO BE COMPLETED BY EMPLOYEE**			
Last Name	First Name	Middle Int.	Birth Date	Social Security No.
Address		Home Phone		Business Phone
City		State		Zip Code
Email Address				
Have you ever been a Member of Health Net before? □ Yes □ No				

Section D	**LIST BELOW ALL PERSONS TO BE COVERED BY THIS ENROLLMENT**						
Last Name	First Name	Social Security #	Date of Birth	M or F		Physician Name	
01 Self							
02 Spouse							
03 Dependent							
04 Dependent							
05 Dependent							

Section E	**OTHER MEDICAL AND HEALTH INSURANCE INFORMATION**					
	Primary Insured Name	Employed Y or N	Employer	City, State	Ins. Company Name	Policy #
01 Self						
02 Spouse						
03 Dependent						
04 Dependent						
05 Dependent						

Section F **PLEASE READ CAREFULLY AND SIGN BELOW**

I APPLY FOR BENEFITS FOR THE PERSONS LISTED AND I AGREE THAT MY FAMILY AND I SHALL ABIDE BY THE PROVISIONS OF SERVICE AGREEMENTS UNDER WHICH WE ARE ENROLLED.

I understand that misrepresentations in answering questions on this application or non-payment of premium may result in cancellation of membership. All benefits and exclusions are set forth in the Service Agreement of the Health or dental Plan. I understand that it is my responsibility to report to the Administrator any change in eligibility of my dependents. I agree to abide by the provisions as outlined.

AUTHORIZATION FOR DISCLOSURE OF PERSONAL INFORMATION: I authorize any "provider of care", insurer or health plan to disclose to the Health/Dental Plan (s) or their representatives all "medical information" (as those terms are defined in the California Civil Code), including any medical information regarding substance abuse or mental or emotional conditions, regarding me, my spouse, or my children. This medical review information is collected for the purpose of evaluating my employer's application, determining claims for benefits, or for quality assurance and peer review. This Authorization will remain valid for the term of coverage of the health/dental service contract. A photocopy of this authorization is as valid as the original. My authorized representative or I am entitled to receive a copy of this authorization.

Signature of Applicant X _____ Date _____