Health Net®
A BETTER DECISION

EMPLOYER ACKNOWLEDGEMENT FORM

Application Date: ______________________________

Employer Name: ____

Employer Group Number (if applicable): ____

I understand that the Health Net HSA-Compatible or other high-deductible employer group plan I have selected is to be used as a stand-alone plan or in conjunction with a Health Savings Account (HSA) banking arrangement, where applicable.

I also understand that these plans are not to be combined with any form of partial self-funding or otherwise insuring of the deductible, whether in a wraparound, addition or companion capacity, including a partially self-funded Section 105 wraparound, now or in the future.

____
Signature of Company Officer

____
Please print name

____
Title

____
Date

CA33212 (9/06)
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