HEALTH NET FEDERAL SERVICES
A Wholly-Owned Subsidiary of Centene Corporation

CALIFORNIA CONSUMER PRIVACY RIGHTS REQUEST FORM

PRIVACY ACT STATEMENT

This statement serves to inform you of the purpose for collecting personal information required by Health Net Federal Services, LLC and how it will be used.

AUTHORITY: California Civ. Code §§1798.100-1799; 10 U.S.C. Chapter 55; 38 U.S.C. Chapter 17; 32 CFR Part 199, and E.O.9397 (SSN), as amended.

PURPOSE: Provides a California resident or his or her authorized representative with a means to request what personal information Health Net Federal Services collects, uses and discloses about the individual, request to opt-out of the sale of the individual's personal information, and/or request the deletion of the individual's personal information. Certain exemptions apply.

ROUTINE USES: The information you provide on this form may be disclosed in order to investigate waste, fraud and abuse, security, and privacy concerns. Use and disclosure of your records outside of DoD may occur in accordance with the DoD Blanket Routine Uses published at **http://dpclo.defense.gov/privacy/SORNs** and as permitted by the Privacy Act of 1974, as amended (5 U.S.C. 552a(b)). Health Net Federal Services does not sell personal information for money or other valuable consideration.

DISCLOSURE: Voluntary; if you choose not to provide your information on this form, no penalty will be imposed, but absence of the requested information may result in administrative delays or the inability to process this request.

Please submit the completed request to:

Health Net Federal Services, LLC
Attention: Privacy Compliance Office
4191 East Commerce Way
Sacramento, CA 95834
FAX: 1-844-813-7788

SECTION A: CALIFORNIA RESIDENT INFORMATION

First Name	Middle Initial	Last Name	Date of Birth (mm/dd/yyyy)

Select Identification Number Type Enter Identification Number	Select Program Type Select one:

Address	City	State	ZIP

Telephone Number ( )	Email Address

SECTION B: PLEASE SELECT A REQUEST OPTION

☐ Request to opt-out of the sale of my personal information.	☐ Request HNFS to disclose what personal information is collected.
☐ Request a deletion of my personal information.	☐ Request HNFS to disclose what personal information was collected/shared.

SECTION C: SIGNATURE: I have read and understand the information on this request.

1. California Consumer Privacy Act requests will be complete within 45 days of receiving a verifiable consumer request (Civ. Code § 1798.130).
2. Health Net Federal Services is not required to provide personal information to a consumer more than twice in a 12-month period (Civ. Code § 1798.100(d).).
3. The deletion of personal information required for the application of business programs is exempt from California Consumer Privacy Act compliance (Civ. Code § 1798.105(d)(1).).
4. Personal information in connection with protected health information collected or used in the course of its business is exempt from California Consumer Privacy Act compliance (Civ. Code § 1798.145(c)(1)(a).).
5. If your form is incomplete, you will be notified by mail and your request will not be considered until a completed form is received.
6. Verifiable requests apply only to the records maintained by Health Net Federal Services.
7. Documentation of authorized representative is required to determine the appropriate parties who are entitled to access or manage the individual's personal information. If you are a parent or guardian requesting personal information of a minor child, legal documentation showing parental rights is required.

I DECLARE UNDER PENALTY OF PERJURY THE INFORMATION ON THIS FORM OR ATTACHED IS TRUE AND CORRECT. ANY ATTEMPT TO FALSELY GAIN ACCESS TO PERSONAL INFORMATION IS SUBJECT TO LEGAL PENALTIES.

_____ _____

Signature(s) of the Requestor or Personal Representative(s)* Date (mm/dd/yyyy)

Print Name(s)/Relationship to the Requestor _____

*If this request is by a personal representative on behalf of the beneficiary, check the box that describes the relationship to the beneficiary and attach documentation of the representative's authority.

☐ Parent of Minor Child ☐ Legal Guardian ☐ Power of Attorney ☐ Executor ☐ Other (please explain) _____

Please retain a copy of this request for your records.