



Dental and Vision Add-On or Change Form for Groups 101+

Complete this form to add or change dental, and/or vision coverage in conjunction with an existing medical plan. Complete the Employee Enrollment and Change form to add any new enrollees or dependents. For off-cycle dental/vision plan additions, your renewal date will be coordinated with your medical plan renewal date.

Employer group information		
Company Name:	PHID#:	SIC code:
Tax ID number (TIN):	Effective date (renewal date):	
Dental		
<input type="checkbox"/> Voluntary <input type="checkbox"/> Employer-paid	Dental (DHMO) <input type="checkbox"/> HN Plus 85 <input type="checkbox"/> HN Plus 100 <input type="checkbox"/> HN Plus 150 <input type="checkbox"/> HN Plus 185 <input type="checkbox"/> HN Plus 225	Dental (DPPO) <input type="checkbox"/> Classic 1 1500 (w/ortho) <input type="checkbox"/> Classic 2 1500 <input type="checkbox"/> Classic 3 1500 (w/ortho) <input type="checkbox"/> Classic 4 1500 <input type="checkbox"/> Classic 5 1500 (w/ortho) <input type="checkbox"/> Classic 6 1500 <input type="checkbox"/> Classic Plus 1 2000 (w/ortho & Max Advantage) <input type="checkbox"/> Classic Plus 2 2000 (w/ortho & Max Advantage) <input type="checkbox"/> Essential 1 1000 (w/ortho) <input type="checkbox"/> Essential 2 1000 <input type="checkbox"/> Essential 3 1000 (w/ortho) <input type="checkbox"/> Essential 4 1000 <input type="checkbox"/> Essential 5 1500 (w/ortho) <input type="checkbox"/> Essential 6 1500 <input type="checkbox"/> Essential Value 1 1000 <input type="checkbox"/> Basic 500 <input type="checkbox"/> Custom Plan Code _____
Vision		
<input type="checkbox"/> Voluntary <input type="checkbox"/> Employer-paid	<input type="checkbox"/> Preferred 1025-2 <input type="checkbox"/> Preferred 1025-3 <input type="checkbox"/> Preferred Value 10-3 <input type="checkbox"/> Elite 1010-1 <input type="checkbox"/> Supreme 010-2 <input type="checkbox"/> Plus 20-1 <input type="checkbox"/> Exam only <input type="checkbox"/> Custom Plan Code _____	
Employer contribution		
Employee Dental: _____% Employee Vision: _____% Dependent Dental: _____% Dependent Vision: _____%		
Eligibility information		
	DENTAL	VISION
Number of eligible employees (including eligible owner(s)):		
Total number of Health Net enrollees (excluding COBRA enrollees):		
Number of Health Net COBRA enrollees (applying for ancillary coverage):		
Number of waivers:		
I hereby authorize these changes to the Group Service Agreement (GSA) and/or Group Policy, and agree that, except as expressly modified by this form, all terms, limitations and conditions of the GSA and/or Group Policy remain in effect.		
Officer of the company signature:	Officer title:	Date:
Broker name:	Broker company:	
Broker ID/NPN:	Broker address:	
Broker or Employer signature:	General agent name:	

Applicant's signature above confirms to the best of their knowledge or belief the accuracy and completeness of the information that the applicant has entered in this application.

Health Net PPO Vision plans, other than pediatric vision, are underwritten by Health Net Life Insurance Company and serviced by EyeMed Vision Care, LLC ("EyeMed") and Envolve Vision, Inc. Health Net Dental HMO plans, other than pediatric dental, are offered and administered by Dental Benefit Providers of California, Inc. (DBP). Health Net Dental PPO and indemnity plans for adults are underwritten by Unimerica Life Insurance Company. Obligations of DBP and Unimerica Life Insurance Company are not the obligations of, nor guaranteed by, Health Net, LLC. or its affiliates. Health Net of California, Inc. and Health Net Life Insurance Company are subsidiaries of Health Net, LLC. Health Net is a registered service mark of Health Net, LLC. All rights reserved.