

## 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 inforn	nation					
Company Name:			PHID#:	SIC code		
Tax ID number (TIN):			Effective date (renewal date):			
Dental						
□ Voluntary □ Employer-paid	Dental (DHMO)  HN Plus 85 HN Plus 100 HN Plus 150 HN Plus 185 HN Plus 225	Dental (DPPO)  □ Classic 1 1500 (w/ortho) □ Classic 2 1500 □ Classic 3 1500 (w/ortho) □ Classic 4 1500 □ Classic 5 1500 (w/ortho) □ Classic 6 1500 □ Classic 7 Unlimited □ Classic 11 Unlimited □ Classic Plus 1 2000 (w/ortho & Max Advantage) □ Classic Plus 2 2000 (w/ortho & Max Advantage) □ Essential 1 1000 (w/ortho) □ Essential 2 1000 □ Essential 3 1000 (w/ortho) □ Essential 4 1000 □ Essential 5 1500 (w/ortho) □ Essential 6 1500 □ Essential 10 3000 (w/ortho) □ Essential 11 5000 (w/ortho) □ Essential Value 1 1000 □ Basic 500 □ Custom Plan Code □ □ □				
Vision						
☐ Voluntary ☐ Employer-paid ☐ Preferred 1025-2 ☐ Preferred 1025-3 ☐ Preferred Value 10-3 ☐ Elite 1010-1 ☐ Supreme 010-2 ☐ Plus 20-1 ☐ Exam only ☐ Custom Plan Code						
Employer contribution						
Employee Dental:% Employee Vision:% Dependent Dental:% DependentVision:%						
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:			, , ,	, ,	cept as expl	ressly
emoor or the company eignature.	, .	s of the GS	, , ,	, ,	cept as expi	ressly Date:
Broker name:	, .	of the GS.	A and/or Group Po	, ,	cept as expi	<u> </u>
, , ,	, .	of the GS.  Of	A and/or Group Pe	, ,	ccept as expi	<u> </u>

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, LLC. Health Net Dental HMO and PPO plans are offered and serviced by Dental Benefit Providers of California, Inc. (DBP). Obligations of DBP are 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 and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All rights reserved.