



# Ancillary Add-On or Change Form

## For 2-100 Employees

Complete this form to add or change dental, vision, and/or life and AD&D coverage in conjunction with an existing medical plan. Complete the Employee Enrollment and Change form to add any new enrollees or dependents. **Note:** All medical plans include pediatric dental and pediatric vision coverage until the last day of the month in which the individual turns 19. For off-cycle dental/vision plan additions, your renewal date will be coordinated with your medical plan renewal date.

Employer group information			
Company Name:		Group #:	SIC code:
Tax ID number (TIN):		Effective date:	
Dental			
<input type="checkbox"/> Voluntary <input type="checkbox"/> Employer-paid <input type="checkbox"/> Bundled Rate <sup>1</sup>		<b>Dental (DHMO)</b> <input type="checkbox"/> HN Plus 150 <input type="checkbox"/> HN Plus 225	<b>Dental (DPPO)</b> <input type="checkbox"/> Classic 4 1500 <input type="checkbox"/> Essential 2 1000 <input type="checkbox"/> Classic 5 1500 (w/ortho) <input type="checkbox"/> Essential 5 1500 (w/ortho) <input type="checkbox"/> Classic 7 Unlimited <input type="checkbox"/> Essential 6 1500 <input type="checkbox"/> Classic 11 Unlimited (w/ortho) <input type="checkbox"/> Essential 9 3000 (w/ortho)
Vision			
<input type="checkbox"/> Voluntary <input type="checkbox"/> Employer-paid <input type="checkbox"/> Bundled Rate <sup>1</sup>		<input type="checkbox"/> Elite 1010-1 <input type="checkbox"/> Preferred 1025-2 <input type="checkbox"/> Preferred Value 10-3 <input type="checkbox"/> Exam only <input type="checkbox"/> Supreme 010-2 <input type="checkbox"/> Preferred 1025-3 <input type="checkbox"/> Plus 20-1	
Life and AD&D options (If Health Net Life is selected, all full-time employees are eligible.)			
<input type="checkbox"/> \$15,000 (2-100 employees) <input type="checkbox"/> \$25,000 (15-100 employees) <input type="checkbox"/> \$50,000 (25-100 employees)			
Employer contribution			
Employee Dental: _____%		Employee Vision: _____%	
Dependent Dental: _____%		Dependent Vision: _____%	
Employee Life: _____%			
Eligibility information			
	DENTAL	VISION	LIFE
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 signature:		General Agency:	

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.

<sup>1</sup>Groups adding new dental with new vision and/or life may be eligible to receive an additional 5% premium savings on each of the ancillary lines they add. Groups must qualify for employer paid rates on all selected products.