



# 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	<b>Dental (DHMO)</b> <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	<b>Dental (DPPO)</b> <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 11 Unlimited <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 9 3000 <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.