



Ancillary Add-On or Change Form

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 (renewal date):	
Dental			
<input type="checkbox"/> Voluntary	<input type="checkbox"/> Employer-paid	Dental (DHMO) <input type="checkbox"/> HN Plus 150 <input type="checkbox"/> HN Plus 225	Dental (DPPO) <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"/> Essential 6 1500
Vision			
<input type="checkbox"/> Voluntary	<input type="checkbox"/> Employer-paid	<input type="checkbox"/> Preferred 1025-2 <input type="checkbox"/> Supreme 010-2	<input type="checkbox"/> Preferred 1025-3 <input type="checkbox"/> Plus 20-1 <input type="checkbox"/> Preferred Value 10-3 <input type="checkbox"/> Exam only <input type="checkbox"/> Elite 1010-1
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: _____%	Employee Life: _____%
Dependent Dental: _____%		Dependent Vision: _____%	
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 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.