Health Net Health Plan of Oregon, Inc. (Health Net)

Ancillary Add-On or Change Form

For 1-51 Employees

Complete this form to add or change dental, and vision 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

☐ Plus D25-1855-2000 ☐ Preferred Plus DP50-1855-1500 ☐ Value D50-185-1500V
☐ Plus D50-185-1000 ☐ Plus D50-1855-1500 ☐ Essentials D50-16-500

Vision

☐ Elite 1010-1 ☐ Preferred 1025-2 ☐ Preferred 1025-3

Employer contribution

Employee Dental:_____% Employee Vision:_____% Employee Life:_____%
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 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.

FRM066045EP00 (9/25)
Ancillary Add On (1/26)