MEDICARE SUPPLEMENT PLANS

Optional Standard PPO Dental Plan Application

MONTHLY PLAN PREMIUM:
$19

Optional: Standard PPO Dental Plan

Please refer to the *Optional Standard PPO Dental Plan brochure* for detailed coverage and costs associated with the Optional Standard PPO Dental plan.

The premium for the Optional Standard PPO Dental Plan will be added to the current Medicare Supplement Health Plan billing statement and set up on the same premium payment mode (i.e., check, automatic bank draft) as your health plan.

In order to enroll in the Optional Standard PPO Dental Plan, you must enroll in, or be enrolled in, a Health Net Life Insurance Company Individual Medicare Supplement Plan and reside in the State of California. Please keep the yellow copy of this form as your proof of enrollment.

Your personal information (please print):

Last name:	First name:	MI:
Primary residence address (PO Box is not allowed):		
City:	State:	ZIP:
Mailing address (only if different from primary residence address):		
City:	State:	ZIP:
Subscriber/Reference ID #:	Medicare number:	
Home telephone #: (__ __ __) __ __ __ – __ __ __ __	Date of birth: __ __/__ __/__ __ __ __ M M/ D D/ Y Y Y Y	

Please check one of the following:

☐ I am enrolling in, or am currently enrolled in, a Health Net Life Individual Medicare Supplement Plan and wish to add/change to the Optional Standard PPO Dental Plan for an additional monthly premium of $19.

☐ Add Standard PPO Dental Plan ☐ Change to Standard PPO Dental Plan

Requested effective date: __ __/__ __/__ __ __ __
M M/ D D/ Y Y Y Y

I understand that my signature on this application means that I have read and understand the contents of this application.

Print name:	
Your signature[1]:	Date: __ __/__ __/__ __ __ __ M M/ D D/ Y Y Y Y

[1]Or the signature of the person authorized to act on behalf of the individual under the laws of the state where the individual resides. If signed by the authorized individual (as described above), this signature certifies that: (a) this person is authorized under state law to complete this enrollment, and (b) a copy of the authorization form, Durable Power of Attorney for Health Care or similar document is included with this application.

If you are the authorized representative, you must provide the following information:

Last name:	First name:	MI:
Address:		
City:	State:	ZIP:
Home telephone #: (__ __ __) __ __ __ – __ __ __ __	Relationship to enrollee:	

If you terminate coverage, you must wait 12 months until you may again apply for coverage.

Health Net Life Insurance Company (Health Net Life) will notify you when your effective date of coverage begins.

Mail this application to:

Health Net Life Insurance Company
PO Box 10420
Van Nuys, CA 91499-6208

Or you may fax it to **1-844-222-3180**.

Thank you for choosing Health Net Life. If you have any questions about enrolling in Health Net's Optional Standard PPO Dental Plan, call Health Net Life at **1-800-944-7287 (TTY: 711)**, Monday through Friday, 8:00 a.m. to 6:00 p.m., except holidays.

Dental services are offered by Health Net Dental, but are underwritten by Unimerica Life Insurance Company and administered by Dental Benefit Administrative Services.

Statement of Understanding

I have read this application and represent that the information shown on it is true and complete to the best of my knowledge or belief. I understand that: (a) no insurance will become effective unless my application is approved and the appropriate premium is received by Unimerica Life Insurance Company with this application; (b) if other dental insurance exists that duplicates coverage under the dental plan being applied for, the existing dental coverage must be terminated prior to the effective date of this coverage; (c) if coverage is issued, the coverage will not be a continuation of any prior coverage; and (d) the policy being applied for may contain waiting periods for certain benefits. Incorrect or incomplete information on this application may result in voidance of coverage and claim denial. The information provided in this application, and any supplement or amendments to it, will be made a part of any policy that may be issued. I understand that, for an application sent by mail or sent by any electronic means, insurance, if approved, will be effective the later of: (i) the requested effective date; or (ii) the effective date that Unimerica Life Insurance Company notifies me coverage begins; (e) for your protection California law requires the following to appear on this form: any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Print name:	
Proposed insured's signature:	Date: __ __/__ __/__ __ __ __ M M/ D D/ Y Y Y Y
Signature of authorized representative (if applicable):	

BROKER OFFICE USE ONLY	
Broker name:	
Phone #:	Health Net ID #:
Broker rep received date:	Broker email address:
FMO/GA/Agency name:	
Phone #:	Agency ID #:

HEALTH NET SALES REP OFFICE USE ONLY	
Sales rep name:	
Phone #:	Health Net ID #:
Sales rep received date:	Sales rep email address:

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