Dental Plan Change Form

Group Name _____ Employee Last Name _____ First Name _____ Social Security Number ___-___-____

Section 1 – Change of Employee Information

Change Name:

From: Employee Last Name _____ First Name _____ M.I. _____

To: Employee Last Name _____ First Name _____ M.I. _____

Change Address to:

Employee Home Address _____

City _____ State _____ Zip Code _____

Section 2 – Change of Plan Option or Drop Coverage

☐ Drop all coverage for me and any covered dependents
Effective _____
State reason: _____

☐ Change of Plan Option
Change from Plan _____ to Plan _____

Section 3 – Add Dependent(s)

Dependent(s) are being added (check one):

☐ As dependents acquired through birth, marriage, or legal adoption. (Attach copy of birth certificate, marriage license, or adoption papers.)

☐ As late enrollments

☐ Due to loss of eligibility under another health plan (name, group number, and telephone number of the other plan must be written on the back of this form, or attach copy of other plan's ID card).

Dependent's Last Name	First Name	M.I.	Sex	Relation	Birth Date (MM/DD/YY)	Social Security Number
					/ /	- -
					/ /	- -
					/ /	- -

Section 4 – Drop Dependent(s)

Dependent(s) are being dropped (check one):

☐ Because the person(s) listed below no longer meet the requirements for being an eligible dependent under the plan, because of age, marriage, or divorce (please explain reason on the back of this form).

☐ Due to becoming eligible under another health plan (name, group number, and telephone number of the other plan must be written on the back of this form, or attach copy of other plan's ID card).

Dependent's Last Name	First Name	M.I.	Sex	Relation	Birth Date (MM/DD/YY)	Social Security Number
					/ /	- -
					/ /	- -
					/ /	- -

Section 5 – Other Changes

Describe any other requested changes below:

Section 6 – Employee Signature

I hereby request coverage as outlined above under the group dental plan offered by my employer and authorize my employer to deduct from my earnings, if applicable, including any future adjustments, and any required contributions. I reserve the right to revoke or change this authorization any written notice and understand that if I have declined any coverage on myself or an eligible dependent and wish to enroll at a later date, coverage will be deferred in accordance with the plan provisions. I understand and acknowledge that information concerning coverage, treatments, and services I may receive may be distributed and disclosed to my employer, and I hereby consent to the dissemination and disclosure of all information. I declare all answers to be true and complete

X _____
Employee Signature

Date signed ___/___/___

Office Use Only

Effective Date of Changes by Section #

Section 1 ___/___/___ Section 3 ___/___/___ Section 4 ___/___/___ Section 5 ___/___/___

X _____
Benefits Representative