DENTALSELECT

Individual & Family Plan Change Form

Toll Free: 800-999-9789 **Toll Free Fax:** 888-998-8711 **DentalSelect.com**

Subscriber Information – PLEASE PRINT

Subscriber Name:	SSN or Member #:	Date of Birth (MM/DD/YYYY):

Requested Change - Complete applicable section below

Surname Change

From (Name):	To (Name):

Address Change

New Address:	
City/State/Zip:	Telephone:

Policy Change

☐ **Plan Change** (Please complete both sections)

Current Plan:	Current Senior Plan:	Requested Plan:	Requested Senior Plan:
Co-Insurance Platinum ☐ Opt 1 ☐ Opt 2	Co-Insurance Platinum ☐ Opt 1 ☐ Opt 2	Co-Insurance Platinum ☐ Opt 1 ☐ Opt 2	Co-Insurance Platinum ☐ Opt 1 ☐ Opt 2
Co-Insurance Gold ☐ Opt 1 ☐ Opt 2	☐ Co-Pay Platinum	Co-Insurance Gold ☐ Opt 1 ☐ Opt 2	☐ Co-Pay Platinum
☐ Co-Pay Platinum	☐ Co-Pay Gold	☐ Co-Pay Platinum	☐ Co-Pay Gold
☐ Co-Pay Gold	☐ Discount Silver	☐ Co-Pay Gold	☐ Discount Silver
☐ Discount Silver		☐ Discount Silver	

☐ **Delete / Add ONLY Dependants Listed Below**

	Last Name:	First:	MI:	Relation:	Sex:	SSN:	Birth Date:
Add ☐ Delete ☐							
Add ☐ Delete ☐							
Add ☐ Delete ☐							
Add ☐ Delete ☐							

☐ **Cancel Entire Policy** (Subscriber/Family)

Reason/Status Change
(Required for all requested changes)
Notice must be given to Dental Select within 30 days

☐ Marriage - Date:_____	☐ Death	☐ Renewal Date
☐ Loss/Gain of Other Coverage - Date:_____	☐ Birth	☐ Other (Please explain)
☐ Divorce - Date:_____	☐ Adoption	_____

Signature Authorization

Subscribers Signature:	Date Signed (MM/DD/YYYY):

Please Note That Changes May Result in Premium Adjustments

Mail: Dental Select (Attn: Eligibility) 5373 S. Green Street, 4th Floor, Salt Lake City, UT 84123
Fax: (801) 290-5104 Toll Free Fax: (888) 998-8711
Email: idp@dentalselect.com (must be an attached pdf image of the enrollment form)