



# 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