

Must be completed in FULL – PLEASE PRINT – Change Form is not valid without signature(s)

Employer's Full Name		Employer's Address		
Group Number	Subgroup/Dept. #		Effective Date (MM/DD/YY)	
Subscribers Name			SSN/Member #	

Personal Information Selection - Change of name and/or Address.

Old Employee Name		New Employee Name		
New Address		City	State	Zip Code
				Phone #

Coverage Selection - Confirm available options with your employer. Check all that apply. Please note that changes may result in premium adjustments.

Requested Dental Plan			Requested Vision Plan		
<input type="checkbox"/> Discount - Silver	<input type="checkbox"/> Co-Insurance Indemnity - Platinum	<input type="checkbox"/> High <input type="checkbox"/> Low	<input type="checkbox"/> Vis 1	<input type="checkbox"/> Vis 2	<input type="checkbox"/> Vis 3
<input type="checkbox"/> Co-Pay - Gold	<input type="checkbox"/> Co-Insurance PPO/MAC - Platinum	Dual Options - If applicable, select High or Low to indicate plan type, otherwise leave blank.	<input type="checkbox"/> Vis 4	<input type="checkbox"/> Vis 5	<input type="checkbox"/> Vis 6
<input type="checkbox"/> Co-Pay - Platinum	<input type="checkbox"/> Co-Insurance Passive PPO - Platinum		<input type="checkbox"/> Vis 7	<input type="checkbox"/> Vis 8	<input type="checkbox"/> Vis 9
<input type="checkbox"/> Co-Insurance PPO* - Gold	<input type="checkbox"/> ACA EHB Child Only	* Where permitted by law	<input type="checkbox"/> Vis 10	<input type="checkbox"/> Vis 11	
<input type="checkbox"/> Co-Insurance PPO* - Platinum	<input type="checkbox"/> Other _____		<input type="checkbox"/> Other _____		

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

<input type="checkbox"/> Rehire Date of Layoff: ___/___/___ Rehire Date: ___/___/___ <input type="checkbox"/> Loss/Gain of Coverage - Employee and/or Dependent Date of Change: ___/___/___ Effective Date: ___/___/___ <input type="checkbox"/> Employee Part to Full Time Date of Change: ___/___/___ Effective Date: ___/___/___	<input type="checkbox"/> Other - Mark One <input type="checkbox"/> Marriage <input type="checkbox"/> Termination <input type="checkbox"/> Death <input type="checkbox"/> Divorce <input type="checkbox"/> Birth <input type="checkbox"/> Address Change <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Adoption <input type="checkbox"/> Name Change Date of Change: ___/___/___ Effective Date: ___/___/___ <input type="checkbox"/> COBRA - Mark One <input type="checkbox"/> 18 months - Termination <input type="checkbox"/> 36 months - Divorce. Loss of Subscriber, Etc. Effective Date: ___/___/___ Cancel Date: ___/___/___	(Cancel as indicated) <input type="checkbox"/> Entire Policy <input type="checkbox"/> Dependent (as indicated below) <input type="checkbox"/> Dental <input type="checkbox"/> Insured Vision <input type="checkbox"/> AD&D <input type="checkbox"/> COBRA <input type="checkbox"/> Cancel Date: ___/___/___
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Individuals Covered - List individuals for whom you are changing and/or terminating.

<input type="checkbox"/> Add <input type="checkbox"/> Terminate <input type="checkbox"/> Change	<input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> AD&D	<input type="checkbox"/> COBRA	Spouse Name - (Last, First, MI)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN	Date of Birth - (MM/DD/YYYY)
<input type="checkbox"/> Add <input type="checkbox"/> Terminate <input type="checkbox"/> Change	<input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> AD&D	<input type="checkbox"/> COBRA	Dependent Name - (Last, First, MI)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN	Date of Birth - (MM/DD/YYYY)
<input type="checkbox"/> Add <input type="checkbox"/> Terminate <input type="checkbox"/> Change	<input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> AD&D	<input type="checkbox"/> COBRA	Dependent Name - (Last, First, MI)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN	Date of Birth - (MM/DD/YYYY)
<input type="checkbox"/> Add <input type="checkbox"/> Terminate <input type="checkbox"/> Change	<input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> AD&D	<input type="checkbox"/> COBRA	Dependent Name - (Last, First, MI)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN	Date of Birth - (MM/DD/YYYY)

Authorization of Change - (Required for all requested changes - Notice must be given to Dental Select within 30 days)

_____ Employer Signature (Required)			_____ Title	_____ Date Signed (MM/DD/YYYY)
_____ Subscribers Signature			_____ Date Signed (MM/DD/YYYY)	

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.
 In the event there is a discrepancy regarding any information contained in this form, documentation will be required.