Employee Change Form

DentalSelect

Toll Free: 800-999-9789 **Toll Free Fax:** 888-998-8704 **DentalSelect**.com

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

- ☐ Discount - Silver
- ☐ Co-Pay - Gold
- ☐ Co-Pay - Platinum
- ☐ Co-Insurance PPO* - Gold
- ☐ Co-Insurance PPO* - Platinum
- ☐ Co-Insurance Indemnity - Platinum
- ☐ Co-Insurance PPO/MAC - Platinum
- ☐ Co-Insurance Passive PPO - Platinum
- ☐ ACA EHB Child Only
- ☐ Other ___________________

☐ High ☐ Low

Dual Options - If applicable, select High or Low to indicate plan type, otherwise leave blank.

* Where permitted by law

Requested Vision Plan

☐ Vis 1 ☐ Vis 2 ☐ Vis 3
☐ Vis 4 ☐ Vis 5 ☐ Vis 6
☐ Vis 7 ☐ Vis 8 ☐ Vis 9
☐ Vis 10 ☐ Vis 11
☐ Other _____________

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

☐ **Rehire**
Date of Layoff:____/____/_____ Rehire Date:____/____/_____

☐ **Loss/Gain of Coverage** - Employee and/or Dependent
Date of Change:____/____/_____ Effective Date:____/____/_____

☐ **Employee Part to Full Time**
Date of Change:____/____/_____ Effective Date:____/____/_____

☐ **Other** - Mark One
☐ Marriage ☐ Termination ☐ Death
☐ Divorce ☐ Birth ☐ Address Change
☐ Leave of Absence ☐ Adoption ☐ Name Change
Date of Change:____/____/_____ Effective Date:____/____/_____

☐ **COBRA** - Mark One
☐ 18 months - Termination ☐ 36 months - Divorce. Loss of Subscriber, Etc.
Effective Date:____/____/_____ Cancel Date:____/____/_____

(Cancel as indicated)
☐ Entire Policy
☐ Dependent (as indicated below)
☐ Dental
☐ Insured Vision
☐ AD&D
☐ COBRA
☐ Cancel Date:____/____/_____

Individuals Covered - List individuals for whom you are changing and/or terminating.

☐ Add ☐ Terminate ☐ Change	☐ Dental ☐ COBRA ☐ Vision ☐ AD&D	**Spouse Name** - (Last, First, MI)	**Gender** ☐ Male ☐ Female	**SSN**	**Date of Birth** - (MM/DD/YYYY)
☐ Add ☐ Terminate ☐ Change	☐ Dental ☐ COBRA ☐ Vision ☐ AD&D	**Dependent Name** - (Last, First, MI)	**Gender** ☐ Male ☐ Female	**SSN**	**Date of Birth** - (MM/DD/YYYY)
☐ Add ☐ Terminate ☐ Change	☐ Dental ☐ COBRA ☐ Vision ☐ AD&D	**Dependent Name** - (Last, First, MI)	**Gender** ☐ Male ☐ Female	**SSN**	**Date of Birth** - (MM/DD/YYYY)
☐ Add ☐ Terminate ☐ Change	☐ Dental ☐ COBRA ☐ Vision ☐ AD&D	**Dependent Name** - (Last, First, MI)	**Gender** ☐ Male ☐ 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.

Mail: Dental Select (Attn: Eligibility) 5373 S. Green Street, 4th Floor, Salt Lake City, UT 84123 Fax: (801) 290-5101 Toll Free Fax: (888) 998-8704