DENTALSELECT

Employee Change Form

Phone: 801-495-3000 **Toll Free:** 800-999-9789 **DentalSelect.com**

Subscriber Information

Group Name:	Group #:
Subscriber Name (Please Print):	SSN or Member #:

Requested Change - Complete applicable section below

Name Change

From (Name):	To (Name):

Address Change

New Address:

City/State/Zip:	Telephone:

Policy Change

Plan Change

Effective Date:________________________

- ☐ Add as indicated
  - ☐ Subscriber
  - ☐ Subscriber + Dependent
- ☐ Cancel as indicated
  - ☐ Entire Policy
  - ☐ Dependent (as indicated below)

Add to Current Dental Plan:

- ☐ Change Dental Plan (request plan below)
- ☐ Insured Vision (request plan below)
- ☐ AD&D (Adding Life coverage requires an enrollment form. A beneficiary change requires a Beneficiary Designation From which is submitted to and kept by the employer.)
- ☐ COBRA
  Effective Date: ________________________________
  - ☐ 18 Months – Termination or from Full to Part-time
  - ☐ 36 Months – Divorce, loss of Subscriber or loss of dependent child status

Cancel

- ☐ Dental
- ☐ Insured Vision
- ☐ AD&D
- ☐ COBRA
  Cancellation Date: ______________________

Requested Dental Plan:

- ☐ Platinum Indemnity
- ☐ Platinum PPO
- ☐ Gold PPO
- ☐ Co-Pay Platinum
- ☐ Co-Pay Gold
- ☐ Discount Silver
- ☐ Other ________________________

Requested Vision Plan:

- ☐ Access Value
- ☐ Access Classic
- Access Choice
  - ☐ Red ☐ Green
  - ☐ Orange ☐ Blue
  - ☐ Yellow ☐ Purple

☐ **Delete / Add <u>ONLY</u> Dependants Listed Below** - Effective Date:__________________________

☐ Add ☐ Delete	Last Name:	First:	MI:	Relation:	Sex:	Birth Date:	SSN:	☐ Dental ☐ Life ☐ COBRA ☐ Vision ☐ AD&D
☐ Add ☐ Delete	Last Name:	First:	MI:	Relation:	Sex:	Birth Date:	SSN	☐ Dental ☐ Life ☐ COBRA ☐ Vision ☐ AD&D
☐ Add ☐ Delete	Last Name:	First:	MI:	Relation:	Sex:	Birth Date:	SSN	☐ Dental ☐ Life ☐ COBRA ☐ Vision ☐ AD&D
☐ Add ☐ Delete	Last Name:	First:	MI:	Relation:	Sex:	Birth Date:	SSN	☐ Dental ☐ Life ☐ COBRA ☐ Vision ☐ AD&D
☐ Add ☐ Delete	Last Name:	First:	MI:	Relation:	Sex:	Birth Date:	SSN	☐ Dental ☐ Life ☐ COBRA ☐ Vision ☐ AD&D

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

- ☐ Marriage - Date:___________
  (Requires Subscribers Signature)
- ☐ Loss/Gain of Other Coverage - Date: __________
- ☐ Divorce - Date:____________
  (Requires Subscribers Signature)
- ☐ Death
- ☐ Birth
- ☐ Adoption
- ☐ Renewal Date
- ☐ Terminated Employment Date: _________________
- ☐ Full to Part-Time (will result in coverage termination)

Signature Authorization

Employer Name: ________________________________ Title:______________________ Employer's Signature:	Date Signed (MM/DD/YYYY):
Subscribers Signature:	Date Signed (MM/DD/YYYY):

Please Note That Changes May Result in Premium Adjustments

Any person who knowingly, and with intent to defraud or deceive Dental Select or any other person, makes a request for insurance containing any false, incomplete or misleading information may be guilty of a crime.

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