DENTALSELECT

Employee Change Form

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

Subscriber Information

Group Name:	Group #:	Sub-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 dependents as indicated
- ☐ Add or Change Dental Plan (request plan below)
- ☐ Add or Change Insured Vision (request plan below)
- ☐ AD&D (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

☐ Cancel as indicated

- ☐ Entire Policy
- ☐ Dependent (as indicated below)
- ☐ Dental
- ☐ Insured Vision
- ☐ AD&D
- ☐ COBRA
  Cancellation Date: _____

Requested Dental Plan:

- ☐ Indemnity - Platinum
- ☐ PPO - Platinum
- ☐ PPO - Gold
- ☐ Co-Pay - Platinum
- ☐ Co-Pay - Gold
- ☐ Discount - Silver
- ☐ Dual Option
  - ☐ High
  - ☐ Low
- ☐ Other _____

Requested Vision Plan:

- ☐ Access Value
- ☐ Access Classic

Access Choice

- ☐ Vis 4
- ☐ Vis 5
- ☐ Vis 6
- ☐ Vis 7
- ☐ Vis 8
- ☐ Vis 10

☐ **Delete / Add ONLY Dependants Listed Below** - Effective Date:_____

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

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

- ☐ Marriage - Date:_____
- ☐ Loss/Gain of Other Coverage - Date: _____
- ☐ Divorce - Date:_____
- ☐ Death
- ☐ Birth
- ☐ Adoption
- ☐ Renewal Date
- ☐ Terminated Employment Date: _____
- ☐ Full to Part-Time (will result in coverage termination)
- ☐ Court Ordered (Requires documentation)

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

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