

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

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

<input type="checkbox"/> <b>Rehire</b> Date of Layoff: ___/___/___    Rehire Date: ___/___/___	<input type="checkbox"/> <b>Loss/Gain of Coverage</b> - Employee and/or Dependent Date of Change: ___/___/___    Effective Date: ___/___/___	<input type="checkbox"/> <b>Employee Part to Full Time</b> Date of Change: ___/___/___    Effective Date: ___/___/___	<input type="checkbox"/> <b>Other - Mark One</b> <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"/> <b>COBRA - Mark One</b> <input type="checkbox"/> 18 months - Termination <input type="checkbox"/> 36 months - Divorce. Loss of Subscriber, Etc. Effective Date: ___/___/___    Cancel Date: ___/___/___	<b>(Cancel as indicated)</b> <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.