

Group Information

Company Name (Please Print):	Group #:	Effective Date of Change (MM/DD/YYYY):
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Requested Change - Complete applicable section below

Company Name Change	From (Name):	To (Name):
Address Change	New Address:	
	City/State/Zip:	Telephone:
Contact Change	From (Name):	To (Name):
	Contact's Role (HR, Billing, etc):	Effective Date of Change (MM/DD/YYYY):
New Hire Waiting Period	From:	To:
	Effective Date of Change (MM/DD/YYYY):	
Group Termination	Effective Date of Change (MM/DD/YYYY):	
	Reason (Required for all requested terminations) <input type="checkbox"/> Company no longer offers benefits <input type="checkbox"/> Company Reorganization/Out of Business <input type="checkbox"/> Consolidating Medical/Dental New Carrier _____ <input type="checkbox"/> Lower Rates New Carrier _____ <input type="checkbox"/> Provider Network New Carrier _____ <input type="checkbox"/> Service Issues Explanation _____ <input type="checkbox"/> Under-enrolled	
Signature Authorization	Employer Name: _____ Title: _____	Date Signed (MM/DD/YYYY):
	Employer's Signature:	

Please Note That Changes May Result in Premium Adjustments

Any person 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
 Email: eligibility_web@dentalselect.com (must be an attached pdf image of the enrollment form)