DentalSelect

Utah Certified Dental Plan Employee Change Form

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 #

Requested Coverage Selection - Confirm available options with your employer. Check all that apply. Please note that changes may result in premium adjustments.

Traditional Plan Options:

- ☐ 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
- ☐ Other _____

☐ High ☐ Low

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

* Where permitted by law

Certified Plan Options:

Opt 1 Family	Opt 1 Child Only Enhanced	Opt 1 Child Only
☐ Plat PPO 85	☐ Plat PPO 85	☐ Plat PPO 85
☐ Plat PPO 70	☐ Plat PPO 70	☐ Plat PPO 70
☐ Gold Co-Pay 85	☐ Gold Co-Pay 85	☐ Gold Co-Pay 85
Opt 3 Family	**Opt 3 Child Only Enhanced**	**Opt 3 Child Only**
☐ Plat PPO 85	☐ Plat PPO 85	☐ Plat PPO 85
☐ Plat PPO 70	☐ Plat PPO 70	☐ Plat PPO 70
☐ Gold Co-Pay 70	☐ Gold Co-Pay 70	☐ Gold Co-Pay 70

Opt 2 Family	Opt 2 Child Only Enhanced
☐ Plat PPO 85	☐ Plat PPO 85
☐ Plat PPO 70	☐ Plat PPO 70

Vision Plan Options:

☐ Vis 1 ☐ Vis2 ☐ 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 ☐ Vision ☐ AD&D ☐ COBRA	Spouse Name - (Last, First, MI)	**Gender** ☐ Male ☐ Female	SSN	Date of Birth - (MM/DD/YYYY)
☐ Add ☐ Terminate ☐ Change	☐ Dental ☐ Vision ☐ AD&D ☐ COBRA	Dependent Name - (Last, First, MI)	**Gender** ☐ Male ☐ Female	SSN	Date of Birth - (MM/DD/YYYY)
☐ Add ☐ Terminate ☐ Change	☐ Dental ☐ Vision ☐ AD&D ☐ COBRA	Dependent Name - (Last, First, MI)	**Gender** ☐ Male ☐ Female	SSN	Date of Birth - (MM/DD/YYYY)
☐ Add ☐ Terminate ☐ Change	☐ Dental ☐ Vision ☐ AD&D ☐ COBRA	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	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) 75 W Towne Bridge Parkway, Tower 2, Suite 500, Sandy, UT 84070 Fax: (801) 290-5101 Toll Free Fax: (888) 998-8704

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