

# Group Change Form

<b>Group Information</b> <input type="checkbox"/> Add <input type="checkbox"/> Terminate <input type="checkbox"/> Change	
Group Name	Group #
Effective Date of Change (MM/DD/YYYY)	

**Requested Change - Complete the applicable section below**

<b>Company Name Change</b>	From (Old or Current) Name:	To (New) Name:
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<b>Address Change</b>	<input type="checkbox"/> Mailing Address	New Street Address:
	<input type="checkbox"/> Physical Address	
New City/State/Zip:		Telephone:

<b>Contact Person Change</b>	From (Name):	To (Name):
	New Contact Person's Role (HR, Billing, etc.):	Phone:
	Email:	

<b>Add Additional Contact Person</b>	Additional Contact's Name:	
	New Contact Person's Role (HR, Billing, etc.):	Phone:
	Email:	

<b>New Hire Waiting Period</b>	From (MM/DD/YYYY):	To (MM/DD/YYYY):
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**Plan Termination - Complete for Each Plan Type**

Reason (Required for all requested terminations)	DENTAL	VISION
	<input type="checkbox"/> Company no longer offers benefits <input type="checkbox"/> Company Reorganization/Out of Business <input type="checkbox"/> Consolidating Medical/Dental benefits 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	<input type="checkbox"/> Company no longer offers benefits <input type="checkbox"/> Company Reorganization/Out of Business <input type="checkbox"/> Consolidating Medical/Dental benefits 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

<b>Signature Authorization</b>	Employer Name:	Title:
	Employer Signature:	Date Signed (MM/DD/YYYY):

**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 on this form, documentation will be required.**

**To Submit:**                      Mail: Dental Select ATTN: Eligibility, 75 W Towne Ridge Pkwy, Tower 2, Suite 500, Sandy, UT 84070  
 Fax: 801-290-5101 or 888-998-8704  
 Email: eligibility\_web@dentalselect.com (must be an attached PDF image of this form)