DentalSelect

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 #

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

Requested Dental Plan

- ☐ 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

Requested Vision Plan

- ☐ Vis 6 ☐ Vis 8
- ☐ Vis 12 ☐ Vis 21
- ☐ Other ____________

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

- ☐ Open Enrollment
- ☐ 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
  - ☐ Divorce
  - ☐ Leave of Absence
  - ☐ Termination
  - ☐ Birth
  - ☐ Adoption
  - ☐ Address Change
  - ☐ 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 ☐ COBRA ☐ Vision ☐ AD&D	Spouse Name – (Last, First, MI)	Gender ☐ Male ☐ Female	SSN	Date of Birth (MM/DD/YYYY)
☐ Add ☐ Terminate ☐ Change	☐ Dental ☐ COBRA ☐ Vision ☐ AD&D	Dependent Name – (Last, First, MI)	Gender ☐ Male ☐ Female	SSN	Date of Birth (MM/DD/YYYY)
☐ Add ☐ Terminate ☐ Change	☐ Dental ☐ COBRA ☐ Vision ☐ AD&D	Dependent Name – (Last, First, MI)	Gender ☐ Male ☐ Female	SSN	Date of Birth (MM/DD/YYYY)
☐ Add ☐ Terminate ☐ Change	☐ Dental ☐ COBRA ☐ Vision ☐ AD&D	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 (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.