DentalSelect

Individual & Family Plan Change Form

Subscriber Information – PLEASE PRINT

Subscriber Name:	SSN or Member #:	Date of Birth (MM/DD/YYYY):

Requested Change – Complete applicable section below

Surname Change

From (Name):	To (Name):

Address Change

New Address:	
City/State/Zip:	Telephone:

Policy Change

☐ **Plan Change** (Please complete both sections)

Current Plan:	Current Senior Plan:	Requested Plan:	Requested Senior Plan:
Co-Insurance Platinum ☐ Opt 1 ☐ Opt 2	Co-Insurance Platinum ☐ Opt 1 ☐ Opt 2	Co-Insurance Platinum ☐ Opt 1 ☐ Opt 2	Co-Insurance Platinum ☐ Opt 1 ☐ Opt 2
Co-Insurance Gold ☐ Opt 1 ☐ Opt 2	☐ Co-Pay Platinum	Co-Insurance Gold ☐ Opt 1 ☐ Opt 2	☐ Co-Pay Platinum
☐ Co-Pay Platinum	☐ Co-Pay Gold	☐ Co-Pay Platinum	☐ Co-Pay Gold
☐ Co-Pay Gold	☐ Discount Silver	☐ Co-Pay Gold	☐ Discount Silver
☐ Discount Silver		☐ Discount Silver	

☐ **Delete / Add ONLY Dependents Listed Below**

☐ Add ☐ Delete	Last Name: First: MI:	Relationship:	Sex:	SSN:	Birth Date:	
☐ Add ☐ Delete	Last Name: First: MI:	Relationship:	Sex:	SSN:	Birth Date:	
☐ Add ☐ Delete	Last Name: First: MI:	Relationship:	Sex:	SSN:	Birth Date:	
☐ Add ☐ Delete	Last Name: First: MI:	Relationship:	Sex:	SSN:	Birth Date:	

☐ **Cancel Entire Policy** (Subscriber/Family)

Billing Period Change: ☐ Monthly (Withdrawn on the 15th or next 2 business days) ☐ Annual (Check or Credit Card)

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

☐ Marriage - Date:_____	☐ Death	☐ Renewal Date
☐ Loss/Gain of Other Coverage - Date:_____	☐ Birth	☐ Other (Please explain) _____
☐ Divorce - Date:_____	☐ Adoption	

Signature Authorization

Subscribers Signature:	Date Signed (MM/DD/YYYY):

Please Note That Changes May Result in Premium Adjustments

Mail: Dental Select (Attn: Eligibility) 75 W Towne Ridge Pkwy Tower 2, Suite 500, Sandy, UT 84070
Fax: (801) 290-5104 Toll Free Fax: (888) 998-8711
Email: idp@dentalselect.com (must be an attached pdf image of the enrollment form)