Employee Change Form

DentalSelect

Use the Employee Change Form to cancel or modify existing member and dependent plan options. For first time employees, please use the Employee Enrollment Form.

Must be completed in full - PLEASE PRINT. Change form is not valid without signature(s)

Name of Employer	Employer's Address	
Group Number	Subgroup/Dept #	
Subscriber's Name	SSN/Member #	Effective Date (MM/DD/YYYY)

Old Employee Name	New Employee Name	
New Address		
City	State	Zip Code
Phone Number	Email Address	

Plan/Coverage Selection – Confirm available options with your employer. Select all that apply.

Requested Dental Plan ☐ Copay† ☐ High Deductible Plan†	☐ PPO R&C ☐ PPO MAC	**Dual Option (PPO)** ☐ High ☐ Low	**Network** ☐ Gold ☐ Platinum	
Requested Vision Plan	☐ Vis 6 ☐ VIs 8 ☐ Vis 12 ☐ Vis 21 ☐ Other ________________________			
Requested AD&D Plan	☐ AD&D - Amount ____________________			

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

☐ Open Enrollment

☐ Rehire
Date of Layoff: ___/___/___ Date of Rehire: ___/___/___

☐ Loss/Gain of Coverage (Employee and/or Dependent)
Date of Change: ___/___/___ Effective Date: ___/___/___

☐ Employee Full Time Status Change (PT to FT)
Date of Change: ___/___/___ Effective Date: ___/___/___

☐ Other (Mark One)
Date of Change: ___/___/___ Effective Date: ___/___/___

☐ Marriage ☐ Termination
☐ Divorce ☐ Birth
☐ Leave of Absence ☐ Adoption
☐ Change of Address ☐ Name Change
☐ Death

☐ Cobra (Mark One)
Date of Change: ___/___/___ Effective Date: ___/___/___

☐ 18 months - Termination
☐ 36 months - Divorce, Loss of Subscriber, Etc.

Cancel (as Indicated)
☐ Entire Policy
☐ Dental
☐ Insured Vision
☐ AD&D
☐ COBRA
☐ Dependent (As indicated herein)

Cancel Date: ___/___/___

Individuals Covered – List individuals and select plan options.

☐ Add ☐ Terminate ☐ Change	☐ Dental ☐ Vision ☐ AD&D ☐ COBRA	Spouse Name (Last, First, M.I.)		
		Gender: ☐ Male ☐ Female	SSN	Date of Birth
☐ Add ☐ Terminate ☐ Change	☐ Dental ☐ Vision ☐ AD&D ☐ COBRA	Dependent Name (Last, First, M.I.)		
		Gender: ☐ Male ☐ Female	SSN	Date of Birth
☐ Add ☐ Terminate ☐ Change	☐ Dental ☐ Vision ☐ AD&D ☐ COBRA	Dependent Name (Last, First, M.I.)		
		Gender: ☐ Male ☐ Female	SSN	Date of Birth
☐ Add ☐ Terminate ☐ Change	☐ Dental ☐ Vision ☐ AD&D ☐ COBRA	Dependent Name (Last, First, M.I.)		
		Gender: ☐ Male ☐ Female	SSN	Date of Birth
☐ Add ☐ Terminate ☐ Change	☐ Dental ☐ Vision ☐ AD&D ☐ COBRA	Dependent Name (Last, First, M.I.)		
		Gender: ☐ Male ☐ Female	SSN	Date of Birth

Authorization of Change (Required for all requested changes. Notice must be given within 30 days.)

Please note that changes may result in premium adjustments.

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.

Employer Signature (Required) ____________ Title ____________ Date Signed (MM/DD/YYYY) ____________

Subscriber Signature ____________ Date Signed (MM/DD/YYYY) ____________

* Discount program is not underwritten by ACE American Insurance Company.
† Currently Available Only in TX and UT.

Dental Select 75 W Towne Ridge Parkway, Tower 2, Suite 500, Sandy, Utah 84070 · 800-999-9789
Toll Free Fax: 888-998-8704