

Individual & Family Plan Change Form

DentalSelect

Subscriber Information - Please Print		
Subscriber Name	SSN or Member #	Date of Birth (MM/DD/YYYY)

Request Change - Complete applicable section below

Surname Change	From (Name)	To (Name)				
Address Change	New Address					
	City/State/Zip Code	Phone Number				
Policy Change	<input type="checkbox"/> Plan Change (please complete both sections)					
	<table border="1"> <tr> <th>Current Plan</th> <th>Requested Plan</th> </tr> <tr> <td> Co-Insurance Platinum <input type="checkbox"/> Opt 1 <input type="checkbox"/> Opt 2 Co-Insurance Gold <input type="checkbox"/> Opt 1 <input type="checkbox"/> Opt 2 <input type="checkbox"/> Co-Pay Platinum <input type="checkbox"/> Co-Pay Gold <input type="checkbox"/> Discount Silver </td> <td> Co-Insurance Platinum <input type="checkbox"/> Opt 1 <input type="checkbox"/> Opt 2 Co-Insurance Gold <input type="checkbox"/> Opt 1 <input type="checkbox"/> Opt 2 <input type="checkbox"/> Co-Pay Platinum <input type="checkbox"/> Co-Pay Gold </td> </tr> </table>		Current Plan	Requested Plan	Co-Insurance Platinum <input type="checkbox"/> Opt 1 <input type="checkbox"/> Opt 2 Co-Insurance Gold <input type="checkbox"/> Opt 1 <input type="checkbox"/> Opt 2 <input type="checkbox"/> Co-Pay Platinum <input type="checkbox"/> Co-Pay Gold <input type="checkbox"/> Discount Silver	Co-Insurance Platinum <input type="checkbox"/> Opt 1 <input type="checkbox"/> Opt 2 Co-Insurance Gold <input type="checkbox"/> Opt 1 <input type="checkbox"/> Opt 2 <input type="checkbox"/> Co-Pay Platinum <input type="checkbox"/> Co-Pay Gold
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	<input type="checkbox"/> Delete / Add ONLY Dependents Listed Below					
	<input type="checkbox"/> Add <input type="checkbox"/> Delete	Last Name	First Name			
	<input type="checkbox"/> Add <input type="checkbox"/> Delete	Last Name	First Name			
	<input type="checkbox"/> Add <input type="checkbox"/> Delete	Last Name	First Name			
	<input type="checkbox"/> Add <input type="checkbox"/> Delete	Last Name	First Name			
	<input type="checkbox"/> Cancel Entire Policy (Subscriber/Family)					
Billing Period Change <input type="checkbox"/> Monthly (withdrawn on the 15th or next 2 business days) <input type="checkbox"/> Annual (Check or Credit Card)						
Reason/Status Change	<input type="checkbox"/> Marriage - Date: _____ <input type="checkbox"/> Loss/Gain of Other Coverage - Date: _____ <input type="checkbox"/> Divorce - Date: _____	<input type="checkbox"/> Death <input type="checkbox"/> Birth <input type="checkbox"/> Adoption				
		<input type="checkbox"/> Renewal Date <input type="checkbox"/> Other (please explain) _____				
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)



All plans of insurance are marketed by Dental Select, an insurance agency, and underwritten by Ameritas Life Insurance Corp.; both affiliates of Ameritas Mutual Holding Company. 5900 O Street / P.O. Box 81889 / Lincoln, NE 68501-1889