

SUBSCRIBER CHANGE FORM

GROUP INFORMATION					
Group Name			Group Number		
CURRENT POLICY INFORMATION					
Last Name			First Name		M.I.
Address		Apt #	City		
State	Zip Code	Phone Number		SSN/ID #	
<input type="checkbox"/> CHANGE OF NAME/ADDRESS					
Last Name			First Name		M.I.
Address		Apt #	City		
State	Zip Code	Phone Number			
<input type="checkbox"/> DENTAL PROVIDER CHANGE					
A second provider option has been provided in the event your first choice is not accepting new patients or no longer on the panel.					
Last Name, First Name/Office Name - Option 1			Provider ID Number		
Last Name, First Name/Office Name - Option 2			Provider ID Number		
Reason for Change:					
To enroll on the 1st day of a given month, change form must be received by the 15th day of the preceding month.					
<input type="checkbox"/> ADD/REMOVE DEPENDENTS					
<input type="checkbox"/> ADD DEPENDENTS			<input type="checkbox"/> REMOVE DEPENDENTS		
Dependent (Last Name, First Name)	D.O.B.	Relationship to Subscriber		Reason and Date of Occurrence	
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Is person added a former or present member? If yes, under what name? <input type="checkbox"/> Yes - Name: _____ <input type="checkbox"/> No					
I hereby apply to change my insurance coverage and/or records, as set forth herein. I understand such change(s) will not become effective until notification by the insurance company.					
If a change in premium is required as a result of the changes requested herein, I agree to have my Remitting Agent deduct the changed premium.					
If a change in dental provider is requested, I authorize my dentist with whom I have been enrolled to provide copies of my dental records or those of my dependents to the dentist I now select.					
Subscriber's Signature				Date	