

- Name/Address change: fill in Section 1
- Add/Terminated dependents: fill in Section 2
- Terminate/Reactivate coverage: fill in Section 3

SOCIAL SECURITY NUMBER _____	EMPLOYEE LAST NAME	FIRST NAME	MI
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EMPLOYER	GROUP NUMBER
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SECTION 1

ADDRESS CHANGE	NEW ADDRESS	CITY	STATE	ZIP CODE
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NAME CHANGE	THE REASON FOR THE CHANGE IS (CHECK ONE):	<input type="checkbox"/> MARRIAGE	<input type="checkbox"/> CORRECTION	<input type="checkbox"/> DIVORCE	<input type="checkbox"/> COURT ORDER
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CHANGE NAME FROM:	TO:
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SECTION 2

ADD DEPENDENT(S)

COMPLETE THE FOLLOWING INFORMATION FOR EACH DEPENDENT TO BE ADDED TO THE PLAN

	NAME(S) OF DEPENDENT(S) TO BE ADDED:	SEX	BIRTH DATE	EFFECTIVE DATE	RELATIONSHIP	REASON
01						
02						
03						
04						

Will you or any dependent be covered under another dental insurance plan while a member of Dental Care Plus Insurance Company?

Yes _____ No _____

If yes, name and address of other insurance company _____ Policy # _____

DELETE DEPENDENT(S)

COMPLETE THE FOLLOWING INFORMATION FOR EACH DEPENDENT TO BE REMOVED FROM THE PLAN

	NAME(S) OF DEPENDENT(S) TO BE DELETED:	SEX	BIRTH DATE	EFFECTIVE DATE	RELATIONSHIP	REASON
01						
02						
03						
04						

SECTION 3

TERMINATE COVERAGE

REASON: TERMINATED EMPLOYMENT NO LONGER ELIGIBLE COBRA ELIGIBILITY ENDED OPEN ENROLLMENT

DATE COVERAGE ENDS: _____

REACTIVATE COVERAGE

REASON: TERMINATED IN ERROR ELECTED COBRA REHIRED COURT ORDER

EFFECTIVE DATE: _____

OTHER

STATE CLEARLY THE REQUESTED CHANGE: _____

X ADMINISTRATOR/EMPLOYEE SIGNATURE _____ **DATE** _____