

100 Crowne Point Place • Cincinnati, OH 45241
 Phone (513) 554-1100 • 1-800-367-9466

- 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
EMPLOYER		GROUP NUMBER	

SECTION 1

ADDRESS CHANGE NEW ADDRESS CITY STATE ZIP CODE

NAME CHANGE THE REASON FOR THE CHANGE IS (CHECK ONE):
 MARRIAGE CORRECTION DIVORCE COURT ORDER

CHANGE NAME FROM: _____ TO: _____

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	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** _____

Notice: The state of Ohio requires that we provide you with the following information: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.