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

CHANGE REQUEST FORM

- ☐ 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.

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