

EMPLOYEE CHANGE FORM

GROUP INFORMATION

COMPANY NAME _____ GROUP # _____

EMPLOYEE INFORMATION

EMPLOYEE NAME _____ SSN# OR MEMBER # _____

REQUESTED CHANGE Complete applicable section, below

NAME CHANGE

FROM (NAME) _____ TO (NAME) _____

COBRA CHANGE

- ENROLL ON COBRA EFFECTIVE DATE _____
 CANCEL COBRA EFFECTIVE DATE _____

ADDRESS CHANGE

 NEW ADDRESS _____
 CITY _____ STATE _____ ZIP _____ TEL _____

POLICY CHANGE

- PLAN CHANGE
 FROM (PLAN NAME) _____ TO (PLAN NAME) _____ EFFECTIVE DATE _____
 CANCEL ENTIRE POLICY (EMPLOYEE + FAMILY) EFFECTIVE DATE _____
 DELETE/ ADD ONLY DEPENDENTS LISTED BELOW EFFECTIVE DATE _____

	LAST NAME	FIRST NAME	INIT.	RELATION	SEX	BIRTHDATE
<input type="checkbox"/> ADD <input type="checkbox"/> DELETE						
<input type="checkbox"/> ADD <input type="checkbox"/> DELETE						
<input type="checkbox"/> ADD <input type="checkbox"/> DELETE						
<input type="checkbox"/> ADD <input type="checkbox"/> DELETE						

REASON/ STATUS CHANGE (REQUIRED FOR ALL REQUESTED CHANGES)

Notice must be given to Dental Select within 30 days

- MARRIAGE must enclose copy of marriage certificate
 DIVORCE must enclose copy of divorce decree
 ADOPTION must enclose copy of adoption certificate
 TERMINATED EMPLOYMENT Date: _____
 OPEN ENROLLMENT
 LOSS OF OTHER COVERAGE Date: _____
 FULL TO PART TIME will result in coverage termination
 OTHER _____
 BIRTH
 DEATH

EMPLOYER AUTHORIZATION SIGNATURE X _____
 NAME _____ TITLE _____ DATE _____

EMPLOYEE'S SIGNATURE X _____ DATE _____