DentalSelect

# Employee Change Form

**Toll Free:** 800-999-9789 **Toll Free Fax:** 888-998-8704 **DentalSelect**.com

## Must be completed in FULL – PLEASE PRINT – Change Form is not valid without signature(s)

| Employer's Full Name | Employer's Address | |
|---|---|---|
| Group Number | Subgroup/Dept. # | Effective Date (MM/DD/YY) |
| Subscribers Name | | SSN/Member # |

## Personal Information Selection - Change of name and/or Address.

| Old Employee Name | New Employee Name | | | |
|---|---|---|---|---|
| New Address | City | State | Zip Code | Phone # |

## Coverage Selection - Confirm available options with your employer. Check all that apply. Please note that changes may result in premium adjustments.

### Requested Dental Plan

- ☐ Discount - Silver
- ☐ Co-Pay - Gold
- ☐ Co-Pay - Platinum
- ☐ Co-Insurance PPO* - Gold
- ☐ Co-Insurance PPO* - Platinum
- ☐ Co-Insurance Indemnity - Platinum
- ☐ Co-Insurance PPO/MAC - Platinum
- ☐ Co-Insurance Passive PPO - Platinum
- ☐ ACA EHB Child Only
- ☐ Other ___________________

☐ High ☐ Low

Dual Options - If applicable, select High or Low to indicate plan type, otherwise leave blank.

* Where permitted by law

### Requested Vision Plan

☐ Vis 1 ☐ Vis 2 ☐ Vis 3
☐ Vis 4 ☐ Vis 5 ☐ Vis 6
☐ Vis 7 ☐ Vis 8 ☐ Vis 9
☐ Vis 10 ☐ Vis 11
☐ Other _____________

## Reason/Status - (Required for all requested changes - Notice must be given to Dental Select within 30 days)

☐ **Rehire**
Date of Layoff:____/____/_____ Rehire Date:____/____/_____

☐ **Loss/Gain of Coverage** - Employee and/or Dependent
Date of Change:____/____/_____ Effective Date:____/____/_____

☐ **Employee Part to Full Time**
Date of Change:____/____/_____ Effective Date:____/____/_____

☐ **Other** - Mark One
☐ Marriage ☐ Termination ☐ Death
☐ Divorce ☐ Birth ☐ Address Change
☐ Leave of Absence ☐ Adoption ☐ Name Change
Date of Change:____/____/_____ Effective Date:____/____/_____

☐ **COBRA** - Mark One
☐ 18 months - Termination ☐ 36 months - Divorce. Loss of Subscriber, Etc.
Effective Date:____/____/_____ Cancel Date:____/____/_____

**(Cancel as indicated)**
- ☐ Entire Policy
- ☐ Dependent (as indicated below)
- ☐ Dental
- ☐ Insured Vision
- ☐ AD&D
- ☐ COBRA
- ☐ Cancel Date:____/____/_____

## Individuals Covered - List individuals for whom you are changing and/or terminating.

| | | Name | Gender | SSN | Date of Birth - (MM/DD/YYYY) |
|---|---|---|---|---|---|
| ☐ Add ☐ Terminate ☐ Change | ☐ Dental ☐ COBRA ☐ Vision ☐ AD&D | **Spouse Name -** (Last, First, MI) | ☐ Male ☐ Female | | |
| ☐ Add ☐ Terminate ☐ Change | ☐ Dental ☐ COBRA ☐ Vision ☐ AD&D | **Dependent Name -** (Last, First, MI) | ☐ Male ☐ Female | | |
| ☐ Add ☐ Terminate ☐ Change | ☐ Dental ☐ COBRA ☐ Vision ☐ AD&D | **Dependent Name -** (Last, First, MI) | ☐ Male ☐ Female | | |
| ☐ Add ☐ Terminate ☐ Change | ☐ Dental ☐ COBRA ☐ Vision ☐ AD&D | **Dependent Name -** (Last, First, MI) | ☐ Male ☐ Female | | |

## Authorization of Change - (Required for all requested changes - Notice must be given to Dental Select within 30 days)

**Employer Signature** (Required) **Title** **Date Signed (MM/DD/YYYY)**

**Subscribers Signature** **Date Signed (MM/DD/YYYY)**

**WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.**
In the event there is a discrepancy regarding any information contained in this form, documentation will be required.

Mail: Dental Select (Attn: Eligibility) 5373 S. Green Street, 4th Floor, Salt Lake City, UT 84123 Fax: (801) 290-5101 Toll Free Fax: (888) 998-8704