DENTALSELECT™

Employee Change Form

5373 S. Green Street, 4th Floor, Salt Lake City, UT 84123
Toll Free Phone: 800-999-9789 Toll Free Fax: 888-998-8704 DentalSelect.com

Subscriber Information

Group Name:	Group #:
Subscriber Name (Please Print):	SSN or Member #:

Requested Change - Complete applicable section below

Name Change

From (Name): | To (Name):

Address Change

New Address:

City/State/Zip: | Telephone:

Policy Change

☐ **Plan Change** - Effective Date:_____ (Please complete both sections)

Current Dental Plan:	Current Vision Plan:	Requested Dental Plan:	Requested Vision Plan:
☐ Platinum Indemnity	☐ Discount	☐ Platinum Indemnity	☐ Discount
☐ Platinum PPO	☐ Access Value	☐ Platinum PPO	☐ Access Value
☐ Gold PPO	☐ Access Classic	☐ Gold PPO	☐ Access Classic
☐ Co-Pay Platinum	Access Choice	☐ Co-Pay Platinum	Access Choice
☐ Co-Pay Gold	☐ Red ☐ Green	☐ Co-Pay Gold	☐ Red ☐ Green
☐ Discount Silver	☐ Orange ☐ Blue	☐ Discount Silver	☐ Orange ☐ Blue
☐ Other _____	☐ Yellow ☐ Purple	☐ Other _____	☐ Yellow ☐ Purple

☐ **Cancel Entire Policy** (Subscriber/Family) - Effective Date:_____

☐ **Add Life Plan (Adding life coverage requires an enrollment form)** A Beneficiary change requires a Beneficiary Designation Form which is submitted and kept by the employer.

☐ **Delete / Add <u>ONLY</u> Dependants Listed Below** - Effective Date:_____

	Last Name:	First:	MI:	Relation:	Sex:	Birth Date:	SSN:	
☐ Add ☐ Delete								☐ Dental ☐ Life ☐ Vision ☐ AD&D
☐ Add ☐ Delete								☐ Dental ☐ Life ☐ Vision ☐ AD&D
☐ Add ☐ Delete								☐ Dental ☐ Life ☐ Vision ☐ AD&D
☐ Add ☐ Delete								☐ Dental ☐ Life ☐ Vision ☐ AD&D

COBRA

☐ COBRA - Effective Date:_____

Type of COBRA (must choose one)

☐ 18 months – Termination or from full to part-time

☐ 36 months – Divorce, loss of Subscriber or loss of dependent child status

☐ Cancel COBRA - Effective Date:_____

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

☐ Marriage - Date:_____ (Requires Subscribers Signature)

☐ Loss/Gain of Other Coverage - Date: _____

☐ Divorce - Date:_____ (Requires Subscribers Signature)

☐ Death

☐ Birth

☐ Adoption

☐ Renewal Date

☐ Terminated Employment Date: _____

☐ Full to Part-Time (will result in coverage termination)

Signature Authorization

Employer Name: _____ Title:_____

Employer's Signature: | Date Signed (MM/DD/YYYY):

Subscribers Signature: | Date Signed (MM/DD/YYYY):

Please Note That Changes May Result in Premium Adjustments

Any person who knowingly, and with intent to defraud or deceive Dental Select or any other person, makes a request for insurance containing any false, incomplete or misleading information may be guilty of a crime.

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