

- This form indicates changes for the employee's DENTAL coverage.
- This form indicates changes for the employee's VISION coverage.

**EMPLOYER INFORMATION**

Employer Name: \_\_\_\_\_ Location: \_\_\_\_\_ Group Number: \_\_\_\_\_

**EMPLOYEE INFORMATION**

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Initial: \_\_\_\_\_ ID Number \_\_\_\_\_

**TERMINATION**

Date Employment Ends \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Date Coverage Ends \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Continuation Begins \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**ADDRESS CHANGE**

Old Address: \_\_\_\_\_  
No & Street City State Zip

New Address: \_\_\_\_\_  
No & Street City State Zip

**NAME CHANGE**

From: \_\_\_\_\_  
Last Name First Middle Initial

To: \_\_\_\_\_  
Last Name First Middle Initial

**DEPENDENT CHANGE**

Add Dependent(s) to Coverage Reason: \_\_\_\_\_ Requested Effective Date: \_\_\_\_\_

Delete Dependent(s) from Coverage Reason: \_\_\_\_\_ Requested Effective Date: \_\_\_\_\_

Name: First, Mid Initial, Last	Date of Birth	Date of Marriage	Sex M/F
Spouse:			
Dependent:			
Dependent:			

**SIGNATURE**

I hereby request coverage as outlined above under the group dental plan offered by my employer and authorized my employer to deduct from my earnings, including any future adjustments, any required contributions. I reserve the right to revoke or change this authorization by written notice and understand that if I have declined any coverage on myself or eligible dependent and wish to enroll at a later date, coverage will be deferred in accordance with the plan provisions. I understand and acknowledge that information concerning coverage's, treatments and services I may receive may be distributed and disclosed to my employer, and I hereby consent to the dissemination and disclosure of all information. I declare all answers true and complete.

DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SIGNATURE: \_\_\_\_\_