

Subscriber Information

Group Name:	Group #:
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Subscriber Name (Please Print):	SSN or Member #:
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Requested Change - Complete applicable section below

Name Change	From (Name):	To (Name): William J. Christensen
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Address Change	New Address:	Telephone:
	City/State/Zip:	

Policy Change	Plan Change Effective Date: 9/1/2012 <input type="checkbox"/> Add as indicated <input checked="" type="checkbox"/> Subscriber <input type="checkbox"/> Subscriber + Dependent <input type="checkbox"/> Cancel as indicated <input type="checkbox"/> Entire Policy <input type="checkbox"/> Dependent (as indicated below)	Add to Current Dental Plan: <input checked="" type="checkbox"/> Change Dental Plan (request plan below) <input type="checkbox"/> Insured Vision (request plan below) <input type="checkbox"/> AD&D (A beneficiary change requires a Beneficiary Designation Form which is submitted to and kept by the employer.) <input type="checkbox"/> COBRA Effective Date: _____ <input type="checkbox"/> 18 Months – Termination or from Full to Part-time <input type="checkbox"/> 36 Months – Divorce, loss of Subscriber or loss of dependent child status	Cancel <input type="checkbox"/> Dental <input type="checkbox"/> Insured Vision <input type="checkbox"/> AD&D <input type="checkbox"/> COBRA Cancellation Date: _____
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Requested Dental Plan: <input type="checkbox"/> Platinum Indemnity <input type="checkbox"/> Platinum PPO <input type="checkbox"/> Gold PPO <input type="checkbox"/> Co-Pay Platinum <input type="checkbox"/> Co-Pay Gold <input type="checkbox"/> Discount Silver <input checked="" type="checkbox"/> Other PPO Classic	Requested Vision Plan: <input type="checkbox"/> Access Value <input type="checkbox"/> Access Classic Access Choice <input type="checkbox"/> Vis 4 – Red <input type="checkbox"/> Vis 8 – Green <input type="checkbox"/> Vis 5 – Orange <input type="checkbox"/> Vis 7 – Blue <input type="checkbox"/> Vis 6 – Yellow <input type="checkbox"/> Vis 10 – Purple
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<input type="checkbox"/> Delete / Add ONLY Dependants Listed Below - Effective Date: _____									
<input type="checkbox"/> Add <input type="checkbox"/> Delete	Last Name:	First:	MI:	Relation:	Sex:	Birth Date:	SSN:	<input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> AD&D <input type="checkbox"/> COBRA
<input type="checkbox"/> Add <input type="checkbox"/> Delete	Last Name:	First:	MI:	Relation:	Sex:	Birth Date:	SSN:	<input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> AD&D <input type="checkbox"/> COBRA
<input type="checkbox"/> Add <input type="checkbox"/> Delete	Last Name:	First:	MI:	Relation:	Sex:	Birth Date:	SSN:	<input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> AD&D <input type="checkbox"/> COBRA
<input type="checkbox"/> Add <input type="checkbox"/> Delete	Last Name:	First:	MI:	Relation:	Sex:	Birth Date:	SSN:	<input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> AD&D <input type="checkbox"/> COBRA
<input type="checkbox"/> Add <input type="checkbox"/> Delete	Last Name:	First:	MI:	Relation:	Sex:	Birth Date:	SSN:	<input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> AD&D <input type="checkbox"/> COBRA

Reason/Status Change <small>(Required for all requested changes) Notice must be given to Dental Select within 30 days</small>	<input type="checkbox"/> Marriage - Date: _____ <small>(Requires Subscribers Signature)</small>	<input type="checkbox"/> Death	<input type="checkbox"/> Terminated Employment Date: _____
	<input type="checkbox"/> Loss/Gain of Other Coverage - Date: _____	<input type="checkbox"/> Birth	<input type="checkbox"/> Full to Part-Time (will result in coverage termination)
	<input type="checkbox"/> Divorce - Date: _____ <small>(Requires Subscribers Signature)</small>	<input type="checkbox"/> Adoption	<input type="checkbox"/> Court Ordered
<input type="checkbox"/> Renewal Date			

Signature Authorization	Employer Name: _____ Title: _____	Date Signed (MM/DD/YYYY):
	Employer's Signature:	
	Subscribers Signature: William J Christensen	Date Signed (MM/DD/YYYY): 08/31/2012

Please Note That Changes May Result in Premium Adjustments

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.