



Group number: _____ Effective Change Date: ____/____/____

Dental Change Form

Instructions: Please complete boxes outlined in **RED**.

A: Personal Information

Last Name: _____ Middle Initial: ____ First Name: _____
Date of Birth: ____/____/____ Social Security Number: _____
Street Address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____
Home Phone Number: _____ E-mail Address: _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Gender: ☐ Male ☐ Female

B: Type of Change

☐ Name Change:
Previous Name: _____
New Name: _____

☐ Address Change:
Previous Address: _____
New Address: _____

☐ Dependent Changes:

Dependent 1

Last Name: _____ Middle Initial: ____ First Name: _____
Date of Birth: ____/____/____ Social Security Number: _____
Gender: ☐ Male ☐ Female ☐ Enroll ☐ Delete

Dependent 2

Last Name: _____ Middle Initial: ____ First Name: _____
Date of Birth: ____/____/____ Social Security Number: _____
Gender: ☐ Male ☐ Female ☐ Enroll ☐ Delete

Dependent 3

Last Name: _____ Middle Initial: ____ First Name: _____
Date of Birth: ____/____/____ Social Security Number: _____
Gender: ☐ Male ☐ Female ☐ Enroll ☐ Delete

Dependent 4

Last Name: _____ Middle Initial: ____ First Name: _____
Date of Birth: ____/____/____ Social Security Number: _____
Gender: ☐ Male ☐ Female ☐ Enroll ☐ Delete

C: Acknowledgement of Coverage and Signature

Name Printed: _____

Signature Date: ____/____/____

Signature: **X** _____