



<b>“Subscriber Change Form”</b>				Group #	<b>IMPORTANT</b>
Name Of Subscriber	Last Name	First Name	MI	Social Security or ID Number	
Present Home Address	No.	Street	City or Town		
	State	Zip Code	Telephone No.		
Change Of Address	New				
	New Telephone No.				
Change Of Provider	Name First Requested Provider		Provider's No.		
	<i>Please select a second provider in the event that your first choice is not accepting new patients or no longer participating on the panel</i>				
	Name Second Requested Provider		Provider's No.		
	Reason for Change				
Change Of Name	From:		To:		

If you wish to add or remove dependents, please complete section below. Give reason for change: for example, birth, adoption, marriage, death, separation, divorce, maturity (reaching 19 years), etc.

Please Check	First Name of Dependent	Birth Date			Relationship to Subscriber	Reason and Date of Occurrence
		Mo	Da.	Yr.		
Add <input type="checkbox"/>						
Remove <input type="checkbox"/>						
These Dependents						

Is person added a former or present member?

Yes  No

If yes, under what name? \_\_\_\_\_

I hereby apply to change my insurance coverage and/or records, as set forth herein. I understand such change(s) will not become effective until notification by the insurance company.

If a change in premium is required as a result of the changes requested herein, I agree to have my Remitting Agent deduct the changed premium.

If a change in dental provider is requested, I authorize my dentist with whom I have been enrolled to provide copies of my dental records or those of my dependents to the dentist I now select.

Date \_\_\_\_\_

Subscriber's Signature \_\_\_\_\_

**CHANGE REQUEST**

F-2017