Individual & Family Plan Change Form

DentalSelect

Subscriber Information - Please Print

Subscriber Name	SSN or Member #	Date of Birth (MM/DD/YYYY)

Request Change - Complete applicable section below

Surname Change	From (Name)	To (Name)
Address Change	New Address	
	City/State/Zip Code	Phone Number

Policy Change

☐ Plan Change (please complete both sections)

Current Plan	Requested Plan
Co-Insurance Platinum ☐ Opt 1 ☐ Opt 2 Co-Insurance Gold ☐ Opt 1 ☐ Opt 2 ☐ Co-Pay Platinum ☐ Co-Pay Gold ☐ Discount Silver	Co-Insurance Platinum ☐ Opt 1 ☐ Opt 2 Co-Insurance Gold ☐ Opt 1 ☐ Opt 2 ☐ Co-Pay Platinum ☐ Co-Pay Gold

☐ Delete / Add ONLY Dependents Listed Below

	Last Name	First Name	MI	Sex	Relationship	SSN	Birth Date
☐ Add ☐ Delete	Last Name	First Name	MI	Sex	Relationship	SSN	Birth Date
☐ Add ☐ Delete	Last Name	First Name	MI	Sex	Relationship	SSN	Birth Date
☐ Add ☐ Delete	Last Name	First Name	MI	Sex	Relationship	SSN	Birth Date
☐ Add ☐ Delete	Last Name	First Name	MI	Sex	Relationship	SSN	Birth Date

☐ Cancel Entire Policy (Subscriber/Family)

Billing Period Change ☐ Monthly (withdrawn on the 15th or next 2 business days) ☐ Annual (Check or Credit Card)

Reason/Status Change			
	☐ Marriage - Date: ___________________ ☐ Loss/Gain of Other Coverage - Date: ___________________ ☐ Divorce - Date: ___________________	☐ Death ☐ Birth ☐ Adoption	☐ Renewal Date ☐ Other (please explain) ____

Signature Authorization	Subscribers Signature	Date Signed (MM/DD/YYY)

Please Note That Changes May Result in Premium Adjustments

Mail: Dental Select (Attn: Eligibility) 75 W Towne Ridge Pkwy Tower 2, Suite 500, Sandy, UT 84070
Fax: (801) 290-5104 Toll Free Fax: (888) 998-8711
Email: idp@dentalselect.com (must be an attached pdf image of the enrollment form)