

# EXECUTIVE DENTAL & VISION

The Dental and Vision Plan Everyone Is Seeing Clearly To Smile About



## CHANGE FORM

Company Name _____	Policy # _____
Employee Name _____	Social Security # _____

<b>EMPLOYER CHANGES</b>	<b>EFFECTIVE:</b>
Change Company Name:	
Change Company Address:	
Change Company Contact:	
Change Phone Number:	
Change Fax Number:	
Change Waiting Period To:	

<b>EMPLOYEE CHANGES</b>	<b>EFFECTIVE:</b>
Change Employee Name To:	
Change Employee Address To:	
<input type="checkbox"/> Change Coverage From Single To Family	<input type="checkbox"/> Change Coverage From Family To Single
<input type="checkbox"/> Add/ <input type="checkbox"/> Remove Dependent	Name: _____ DOB: _____
<input type="checkbox"/> Add/ <input type="checkbox"/> Remove Dependent	Name: _____ DOB: _____
<input type="checkbox"/> Add/ <input type="checkbox"/> Remove Dependent	Name: _____ DOB: _____
Terminate Employee as of:	
Reason For Coverage Changes:	
<input type="checkbox"/> Change Dentist	New Dentist Name: _____ I.D.# _____
Reason For Change of Dentist:	
<input type="checkbox"/> *Change From Managed Care Option To PPO Option	
<input type="checkbox"/> *Change From PPO Option To Managed Care Option	Dentist Name _____ I.D.# _____
Employee Signature _____	Date: ___/___/___
Employer Signature _____	Title _____ Date: ___/___/___

Revised 05/05

\*These Changes Can Only Be Made On the Policy Anniversary (Renewal Date).

**IMPORTANT** Please Type Or Write Application Neatly. Any Missing Information Will Delay Processing Your Application.