



Employee Change Form for Group BlueDental Choice and Freedom

Mail to: Membership Services 3060 Alpine Road, Mail Code AX-C02 Alpine, SC 29223 Fax No. 803-264-7358

CHECK THOSE THAT APPLY AND COMPLETE THE LINES INDICATED: FOR EMPLOYER USE: (Required Information)
Employee name change 1A, 1B, 2A, 18
Employee social security correction 1A, 2A, 2B, 18
Add spouse 1A, 2A, 3-18
Add domestic partner (DP) 1A, 2A, 3-18
Add child(ren) 1A, 2A, 3-18
Add child(ren) of DP 1A, 2A, 3-18
Terminate spouse 1A, 2A, 3-5, 8, 16, 18
Terminate domestic partner (DP) 1A, 2A, 3-5, 8, 16, 18
Terminate child(ren) 1A, 2A, 3-5, 8, 16, 18
Terminate child (ren) of DP 1A, 2A, 3-5, 8, 16, 18
Terminate all coverage 1A, 2A, 3, 16, 18
Address change 1A, 2A, 3, 18
Other Dental Insurance 1A, 2A, 17, 18
Other _____

1A EMPLOYEE Last Name First Name Middle Initial 1B Previous name (if this is a Name Change)
2A Social Security Number 2B Correct Social Security Number
3 Street City State Zip Phone

List All Eligible Dependents To Be Covered. Children of a domestic partner may be covered when the domestic partner is also covered. Attach additional sheet of paper, if necessary. Sign and date it. Check all that apply.

Table with 15 columns: 4 Last Name, First Name, M.I.; 5 Social Security Number; 6 Relation to You; 7 Marital Status; 8 Gender; 9 Birthdate; 10 Disabled; 11 Lives with You; 12 You Support Financially; 13 Student FT/PT; 14 Florida Resident; 15 Covered by Medicaid.

16 Reason: Marriage Divorce Age Limit Employment Termination Other
17 Do you or any of your dependents have other Dental insurance under a group plan? Yes No
Name of Person Group Plan Policy Number Insurance Company and Address

18 Membership granted to persons hereon shall be subject to all provisions and limitations of the group agreement. I am aware that a change in dependents may affect the amount deducted from any wages (if any) for Florida Combined Life Dental Plan coverage, and I hereby authorize such a change.
Employee Signature Date Signed