

DENTACARE CHANGE NOTICE

Dentacare

EMPLOYER INFORMATION	EMPLOYER NAME	GROUP NO.	SECTION NO.	PKG. CODE	EMPLOYER PHONE			
EMPLOYEE INFORMATION	LAST NAME	FIRST NAME	INITIAL	BIRTHDATE	SOCIAL SECURITY NUMBER			
<input type="checkbox"/> NAME CHANGE	PREVIOUS LAST NAME	FIRST NAME	INITIAL	IDENTIFICATION NUMBER				
<input type="checkbox"/> ADDRESS CHANGE	NEW ADDRESS (STREET)		(CITY)	(STATE)	(ZIP CODE) EFFECTIVE DATE			
<input type="checkbox"/> COVERAGE CHANGE INFORMATION	<input type="checkbox"/> ADD <input type="checkbox"/> TERMINATE <input type="checkbox"/> SPOUSE ONLY <input type="checkbox"/> CHILDREN ONLY <input type="checkbox"/> SPOUSE AND CHILDREN EFFECTIVE DATE: ___/___/___		REASON: <input type="checkbox"/> MARRIAGE <input type="checkbox"/> OTHER: _____ <input type="checkbox"/> DEATH OF SPOUSE <input type="checkbox"/> DIVORCE <input type="checkbox"/> NEW DEPENDENT					
RELATIONSHIP CODE	EMPLOYEE	LAST NAME	FIRST NAME / INITIAL	RELATIONSHIP	STUDENT	SEX	BIRTHDATE MO / DAY / YR	SOCIAL SECURITY NUMBER
		SAME AS	ABOVE				SAME	AS ABOVE
	SPOUSE							
	N=Natural Child	DEPENDENT			<input type="checkbox"/> YES <input type="checkbox"/> NO			
	A=Adopted Child	DEPENDENT			<input type="checkbox"/> YES <input type="checkbox"/> NO			
	S=Stepchild	DEPENDENT			<input type="checkbox"/> YES <input type="checkbox"/> NO			
O=Other	DEPENDENT			<input type="checkbox"/> YES <input type="checkbox"/> NO				
<input type="checkbox"/> DENTACARE CLINIC CHANGE	CURRENT CLINIC _____		NEW CLINIC _____		EFFECTIVE DATE ___/___/___			
<input type="checkbox"/> OTHER COVERAGE INFORMATION	Is anyone named on this notice covered by another group insurance program? <input type="checkbox"/> NO <input type="checkbox"/> YES → Complete information below.							
	Name under which policy is listed:			Type of Coverage			<input type="checkbox"/> Family Plan	Effective Date
				<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Drug			<input type="checkbox"/> Single Plan	
Name of other insurance company:			Policy I.D. Number			Group Number		
<input type="checkbox"/> MEDICARE INFORMATION	Is anyone named on this notice eligible for Medicare coverage? <input type="checkbox"/> NO <input type="checkbox"/> YES → Name of Person: _____			Reason <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled	Part A (Hospital) Effective Date	Part B (Medical) Effective Date	Medicare Card Number	
SIGNATURE	X							
				SIGNATURE OF INSURED		DATE		
<input type="checkbox"/> TRANSFER OF COVERAGE	Previous Medical Group	Previous Medical Section No.	Previous Dental Group No.	Previous Dental Section No.	Previous PKG Code			
EMPLOYER SIGNATURE	X							
				SIGNATURE OF EMPLOYER		DATE		
Effective Date of Change: ___/___/___								