



Florida Combined Life

An Independent Licensee of the Blue Cross and Blue Shield Association

Employee Change Form for Group BlueDental Choice and BlueDental Freedom

Mail to Membership Service:
3060 Alpine Road, Mail Code AX-C07
Alpine, SC 29227
Fax No. 803-264-7840

CHECK THOSE THAT APPLY AND COMPLETE THE LINES INDICATED:

- | | | |
|--------------------------|-------------------------------------|------------------------|
| <input type="checkbox"/> | Employee name change | Lines 1A, 1B, 2A, 19 |
| <input type="checkbox"/> | Employee social security correction | 1A, 2A, 2B, 19 |
| <input type="checkbox"/> | Add spouse | 1A, 2A, 3-19 |
| <input type="checkbox"/> | Add child(ren) | 1A, 2A, 3-19 |
| <input type="checkbox"/> | Terminate spouse | 1A, 2A, 3-5, 8, 17, 19 |
| <input type="checkbox"/> | Terminate child(ren) | 1A, 2A, 3-5, 8, 17, 19 |
| <input type="checkbox"/> | Terminate all coverage | 1A, 2A, 3, 17, 19 |
| <input type="checkbox"/> | Address change | 1A, 2A, 3, 19 |
| <input type="checkbox"/> | Other Dental Insurance | 1A, 2A, 18, 19 |
| <input type="checkbox"/> | Other _____ | |

FOR EMPLOYER USE: (Required Information)

GROUP NUMBER: _____

GROUP NAME: _____

EFFECTIVE DATE: _____

PLAN TYPE: _____

REMARKS: _____

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

Identify each individual to be covered below. Attach additional sheet of paper, if necessary. Sign and date it. Check all that apply.

4 First Name, M.I., Last Name (Please provide information in the corresponding numbered spaces below.)	5 Social Security Number (Please provide in spaces below)	6 Relation to You (DP = Domestic Partner)	7 Gender (M/F)	8 Birthdate mm/dd/yyyy	9 Marital Status		10 Disabled	11 Lives With You	12 You Support Financially	13 Student FT/PT	14 Florida Resident	15 Covered By Medicaid	16 BlueDental Care Facility ID# Check box if a current patient (Select from provider directory)
					Married	Unmarried No Children							
Employee													
4		<input type="checkbox"/> Spouse or <input type="checkbox"/> DP											<input type="checkbox"/>
4		<input type="checkbox"/> Child or <input type="checkbox"/> DP Child				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4		<input type="checkbox"/> Child or <input type="checkbox"/> DP Child				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4		<input type="checkbox"/> Child or <input type="checkbox"/> DP Child				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17 Reason: Marriage Divorce Age Limit Employment Termination Other

18 Do you or any of your dependents have other Dental insurance under a group plan? Yes No
If "Yes," complete the following sections:

Name of Person	Group Plan	Policy Number	Insurance Company and Address

19 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 _____