EXECUTIVE DENTAL & VISION

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

Underwritten By

Co-Administered By

CHANGE FORM

Company Name____ Policy #________________

Employee Name____ Social Security # ________________

EMPLOYER CHANGES	**EFFECTIVE:**
Change Company Name:	
Change Company Address:	
Change Company Contact:	
Change Phone Number:	
Change Fax Number:	
Change Waiting Period To:	

EMPLOYEE CHANGES	**EFFECTIVE:**	
Change Employee Name To:		
Change Employee Address To:		
___ Change Current Coverage:	___To Single ____To Two Party _____ To Family	
___Add/__Remove Dependent	Name:	DOB:
___Add/__Remove Dependent	Name:	DOB:
___Add/__Remove Dependent	Name:	DOB:
Terminate Employee as of:		
Reason For Coverage Changes:		
__Change Dentist	New Dentist Name:________________________________	I.D.#_____________
Reason For Change of Dentist:		
*Change Current Coverage To PPO Option		
*Change Current Coverage To Managed Care Option	Dentist Name________________	I.D.#_________
*Change Current Coverage To Select Option	Dentist Name________________	I.D.#_________
Employee Signature____		Date: ____/ ____/ ____
Employer Signature____________________________	Title ____________________	Date: ____/ ____/ ____

Revised 10/19

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

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