HEALTHPLEX
THE DENTAL BENEFIT EXPERTS™

Subscriber Change Form

Group Name and Number

Current Policy Information

Last Name		First Name	M.I.
Address	Apt.#	City	
State	Zip Code	Phone Number	SSN/ID #

☐ Change of Name/Address

Last Name		First Name	M.I.
Address	Apt.#	City	
State	Zip Code	Phone Number	

☐ Dental Provider Change

A second provider option has been provided in the event your first choice is not accepting new patients or no longer on the panel.

Last Name, First Name/Office Name - Option 1	Provider ID Number
Last Name, First Name/Office Name - Option 2	Provider ID Number

Reason for Change:

To enroll on the 1st day of a given month, change form must be received by the 15th day of the preceding month.

☐ Add /Remove Dependents

☐ Add Dependents		☐ Remove Dependents	
Dependent (Last Name, First Name)	D.O.B.	Relationship to Subscriber	Reason & Date of Occurrence
Dependent (Last Name, First Name)	D.O.B.	Relationship to Subscriber	Reason & Date of Occurrence
Dependent (Last Name, First Name)	D.O.B.	Relationship to Subscriber	Reason & Date of Occurrence
Dependent (Last Name, First Name)	D.O.B.	Relationship to Subscriber	Reason & Date of Occurrence
Dependent (Last Name, First Name)	D.O.B.	Relationship to Subscriber	Reason & Date of Occurrence

Is person added a former or present member? If yes, under what name? ☐ **Yes** ☐ **No** **Name:**_____

I hereby apply to change my insurance coverage and/or records, as set forth herein. I understand such change(s) will not become effective until notification by the insurance company.

If a change in premium is required as a result of the changes requested herein, I agree to have my Remitting Agent deduct the changed premium.

If a change in dental provider is requested, I authorize my dentist with whom I have been enrolled to provide copies of my dental records or those of my dependents to the dentist I now select.

Subscriber's Signature	Date

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"PLEASE PRINT OR TYPE ALL INFORMATION"