Florida Combined Life

An Independent Licensee of the Blue Cross and Blue Shield Association

BlueDental Care

Dental Service Administrator: P. O. Box 769569
Roswell, GA 30076-8223 Toll-Free Phone 877-325-3979

CHANGE FORM

CHECK THOSE THAT APPLY AND COMPLETE THE LINES INDICATED:

		Lines
☐	Employee name change	1, 2A, 3A, 10
☐	Employee social security correction	1, 2A, 2B, 10
☐	Add dependent spouse	1, 2A, 4, 5, 9, 10
☐	Add dependent child(ren)	1, 2A, 4, 6, 7, 8, 9, 10
☐	Terminate dependent spouse	1, 2A, 4, 5, 9, 10
☐	Terminate dependent child(ren)	1, 2A, 4, 6, 7, 8, 9, 10
☐	Terminate all coverage	1, 2A, 4, 9, 10
☐	Transfer provider	1, 2A, 3B, 10
☐	Address change	1, 2A, 4, 10

FOR EMPLOYER USE:

GROUP NUMBER:________________

GROUP NAME:________________

EFFECTIVE DATE:________________

POLICY TYPE:________________

REMARKS:________________

1	EMPLOYEE Last Name	First Name	Middle Initial			
2	Social Security Number		2B	Correct Social Security Number		
3	Previous name (if this is a Name Change)		3B	New Provider (Name and Provider Number)		
4	Street	City	State	Zip	Phone	
5	Last Name	First Name	Middle Initial	Date of Birth	Relation ☐ Husb	☐ Wife
6					☐ Son	☐ Dau
7					☐ Son	☐ Dau
8					☐ Son	☐ Dau
9	Reason: ☐ Marriage ☐ Age Limit ☐ Moved Out of Service Area ☐ Divorce ☐ Employment Termination ☐ Other (explain)					
10	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 Prepaid Dental Plan coverage, and I hereby authorize such a change.					

________________________ ____________
Employee Signature Date Signed

Copies to: Dental Service Administrator, Employer