Florida Combined Life

An Independent Licensee of the Blue Cross and Blue Shield Association

BlueDental Choice & Freedom Membership Services, 3060 Alpine Road, Mail Code AX-C02 Columbia, SC 29223 **CHANGE NOTICE** Fax No. 803-264-7358

CHECK THOSE THAT APPLY AND COMPLETE THE LINES INDICATED:	Lines	FOR EMPLOYER USE: (Required Information)
☐ Employee name change	1A, 1B, 2A, 10	GROUP NUMBER:__________
☐ Employee social security correction	1A, 2A, 2B, 10	GROUP NAME:__________
☐ Add dependent spouse	1A, 2A, 3, 4, 8, 9, 10	EFFECTIVE DATE:__________
☐ Add dependent child(ren)	1A, 2A, 3, 5, 6, 7, 8, 9, 10	POLICY TYPE:__________
☐ Terminate dependent spouse	1A, 2A, 3, 4, 8, 10	REMARKS:__________
☐ Terminate dependent child(ren)	1A, 2A, 3, 5, 6, 7, 8, 10	
☐ Terminate all coverage	1A, 2A, 3, 8, 10	
☐ Address change	1A, 2A, 3, 10	
☐ Other Dental Insurance	1A, 2A, 9, 10	
☐ Other __________		

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		

	Last Name First Name Middle Initial	Contract ID Number	Date of Birth	Relation	
4				☐ Husb	☐ Wife
5				☐ Son	☐ Dau
6				☐ Son	☐ Dau
7				☐ Son	☐ Dau

8 Reason: ☐ Marriage ☐ Divorce ☐ Age Limit ☐ Employment Termination ☐ Other

9 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

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 Dental Plan coverage, and I hereby authorize such a change.

____________________ ____________________
Employee Signature Date Signed

Copies to: Membership Services, Employer