

# WESTERN DENTAL - CHANGE FORM

<b>FOR EMPLOYER USE ONLY:</b> EFFECTIVE DATE _____		<b>CHECK THOSE THAT APPLY AND COMPLETE ENTIRE FORM</b>					
GROUP # _____	MEMBER # _____	<input type="checkbox"/> Employee Name Change	<input type="checkbox"/> Terminate Coverage				
EMPLOYER NAME: _____	_____	<input type="checkbox"/> Address and/or Phone Change	<input type="checkbox"/> Add Dependent(s)				
EMPLOYEE Last Name _____	MI _____	<input type="checkbox"/> Dental Office Change	<input type="checkbox"/> Terminate Dependent(s)				
First Name _____	_____	<input type="checkbox"/> DENTAL OFFICE I.D. NO. _____	<input type="checkbox"/> COBRA Cobra Effective Date _____				
Street Address _____	Apt. No. _____	New Home Phone No. _____					
Social Security No. _____	City _____	State _____	Zip Code _____				
<b>DEPENDENT CHANGES</b>		ADD	TERM.	Husb./Sp.	Wid./Div.	Date of Birth	DATE OF MARRIAGE
SPOUSE (LAST NAME)		(FIRST NAME)					
CHILD							WDS USE
CHILD							
CHILD							

Western Dental reserves the right to transfer you to the nearest provider if your selected provider receives an insufficient enrollment or is no longer a participant in your program.

Employee Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

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