



# THE DENTAL NETWORK

"Plans to Make You Smile - Now and Into the Future"

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## INDEMNITY CHANGE IN COVERAGE FORM

GROUP NUMBER: \_\_\_\_\_ EFFECTIVE DATE OF CHANGE: \_\_\_\_\_

Employee's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

I.D. # or SS #: \_\_\_\_\_  
.....

### CHANGE OF ADDRESS:

Old Address: \_\_\_\_\_ New Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
.....  
.....

### CHANGE IN DEPENDENT COVERAGE:

NAME	SEX	BIRTH DATE	RELATIONSHIP	ADD	DROP

.....

Briefly Describe Reason for Change: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_

\*\*\*\* YOUR CHANGE MAY TAKE UP TO 30 DAYS TO PROCESS \*\*\*\*

Member's Signature: \_\_\_\_\_ Date: \_\_\_\_\_