



Florida Combined Life

An Independent Licensee of the Blue Cross and Blue Shield Association

BlueDental Choice & Freedom

Membership Services, 3060 Alpine Road, Mail Code AF-170
Columbia, SC 29223

CHANGE NOTICE

Fax No. 803-264-7358

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|------------------------------|----------------|-------------------------------|---|--|------------------------------|--|--|----------------|---|--|------------------------|---|--|------------------------------|---|--|---------------------|---|--|---------------------------|---|--|------------------|---|--|---------------|---|--|---------------|--------------------------------------|--|--|--|--|--|--|--|
| <p>CHECK THOSE THAT APPLY AND COMPLETE THE LINES INDICATED:</p> <table style="width:100%; border: none;"> <tr> <td style="width:30%;"><input type="checkbox"/> Employee name change</td> <td style="width:20%;">Lines</td> <td style="width:50%;">1A, 1B, 2A, 10</td> </tr> <tr> <td><input type="checkbox"/> Employee social security correction</td> <td></td> <td>1A, 2A, 2B, 10</td> </tr> <tr> <td><input type="checkbox"/> Add dependent spouse</td> <td></td> <td>1A, 2A, 3, 4, 8, 9, 10</td> </tr> <tr> <td><input type="checkbox"/> Add dependent child(ren)</td> <td></td> <td>1A, 2A, 3, 5, 6, 7, 8, 9, 10</td> </tr> <tr> <td><input type="checkbox"/> Terminate dependent spouse</td> <td></td> <td>1A, 2A, 3, 4, 8, 10</td> </tr> <tr> <td><input type="checkbox"/> Terminate dependent child(ren)</td> <td></td> <td>1A, 2A, 3, 5, 6, 7, 8, 10</td> </tr> <tr> <td><input type="checkbox"/> Terminate all coverage</td> <td></td> <td>1A, 2A, 3, 8, 10</td> </tr> <tr> <td><input type="checkbox"/> Address change</td> <td></td> <td>1A, 2A, 3, 10</td> </tr> <tr> <td><input type="checkbox"/> Other Dental Insurance</td> <td></td> <td>1A, 2A, 9, 10</td> </tr> <tr> <td><input type="checkbox"/> Other _____</td> <td></td> <td></td> </tr> </table> | | | | | <input type="checkbox"/> Employee name change | Lines | 1A, 1B, 2A, 10 | <input type="checkbox"/> Employee social security correction | | 1A, 2A, 2B, 10 | <input type="checkbox"/> Add dependent spouse | | 1A, 2A, 3, 4, 8, 9, 10 | <input type="checkbox"/> Add dependent child(ren) | | 1A, 2A, 3, 5, 6, 7, 8, 9, 10 | <input type="checkbox"/> Terminate dependent spouse | | 1A, 2A, 3, 4, 8, 10 | <input type="checkbox"/> Terminate dependent child(ren) | | 1A, 2A, 3, 5, 6, 7, 8, 10 | <input type="checkbox"/> Terminate all coverage | | 1A, 2A, 3, 8, 10 | <input type="checkbox"/> Address change | | 1A, 2A, 3, 10 | <input type="checkbox"/> Other Dental Insurance | | 1A, 2A, 9, 10 | <input type="checkbox"/> Other _____ | | | <p>FOR EMPLOYER USE: (Required Information)</p> <p>GROUP NUMBER: _____</p> <p>GROUP NAME: _____</p> <p>EFFECTIVE DATE: _____</p> <p>POLICY TYPE: _____</p> <p>REMARKS: _____</p> | | | | |
| <input type="checkbox"/> Employee name change | Lines | 1A, 1B, 2A, 10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Employee social security correction | | 1A, 2A, 2B, 10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Add dependent spouse | | 1A, 2A, 3, 4, 8, 9, 10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Add dependent child(ren) | | 1A, 2A, 3, 5, 6, 7, 8, 9, 10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Terminate dependent spouse | | 1A, 2A, 3, 4, 8, 10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Terminate dependent child(ren) | | 1A, 2A, 3, 5, 6, 7, 8, 10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Terminate all coverage | | 1A, 2A, 3, 8, 10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Address change | | 1A, 2A, 3, 10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Other Dental Insurance | | 1A, 2A, 9, 10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4 | Last Name | First Name | Middle Initial | Contract ID Number | Date of Birth | Relation <input type="checkbox"/> Husband <input type="checkbox"/> Wife | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5 | | | | | | <input type="checkbox"/> Son | <input type="checkbox"/> Dau | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6 | | | | | | <input type="checkbox"/> Son | <input type="checkbox"/> Dau | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7 | | | | | | <input type="checkbox"/> Son | <input type="checkbox"/> Dau | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8 | Reason: <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Age Limit <input type="checkbox"/> Employment Termination <input type="checkbox"/> Other | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9 | Do you or any of your dependents have other Dental insurance under a group plan? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | If "Yes," complete the following sections: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Name of Person | Group Plan | Policy Number | Insurance Company and Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10 | <p>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.</p> <p>_____</p> <p>Employee Signature Date Signed</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |