CompBenefits
P.O. Box 769769
Roswell, GA 30076-8228
FAX: 770-998-6871
Attn: Enrollment

FOR OFFICE USE ONLY

Group Number | Effective Date | Cov.

DENTAL CHANGE REQUEST FORM

INSTRUCTIONS

1. Please use pen: print clearly and press hard.
2. Complete all the information requested.
3. Sign and date this form - Section D.
4. Please forward completed form to your personnel office.

USE THIS FORM TO MAKE THE FOLLOWING CHANGES/
CHECK CHANGES DESIRED AND COMPLETE THE APPROPRIATE SECTION

- ❑ Name change of subscriber - complete Sections A & D.
- ❑ Change of address - complete Sections A & D.
- ❑ Change subscriber's Primary Care Dentist - Complete Sections A & D.
- ❑ Cancel coverage - complete sections A, B, C & D.
- ❑ Dependent Changes - Complete Sections A, C & D.
  - ❑ Add Dependents ❑ Remove Dependents
- ❑ Other - Complete Sections A, C & D.

Section A

SOCIAL SECURITY NUMBER	LAST NAME	FIRST NAME	INITIAL	HOME PHONE	BUSINESS PHONE

ADDRESS	CITY	STATE	ZIP CODE	COUNTY

Section B

❑ CANCEL COVERAGE ❑ Other_____

CHANGE COVERAGE TO:

❑ Single ❑ Family ❑ Cobra ❑ Other_____

Section C

		SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX	DEPENDENTS PRIMARY CARE DENTIST	PROVIDER NUMBER	STUDENT AGE 19-23	OTHER DENTAL COVERAGE
01	SPOUSE						YES NO	
02	DEPENDENT						YES NO	
03	DEPENDENT						YES NO	
04	DEPENDENT						YES NO	
05	DEPENDENT						YES NO	

* If the dependent is between ages 19 and 23, specify academic institution where enrolled:_____

** Explanation of other dental coverage:_____

If adding spouse,give date of marriage: ____ /____ /____ . If child is being adopted, give date of adoption. ____ /____ /____.

Give reason for adding or removing dependents if not Open Enrollment:_____

Section D

EFFECTIVE DATE OF COVERAGE | EMPLOYER NAME AND GROUP NO. | EMPLOYEE SIGNATURE | DATE