Group Change Form

DentalSelect

Group Information ☐ Add ☐ Terminate ☐ Change

Group Name	Group #
Effective Date of Change (MM/DD/YYYY)	

Requested Change - Complete the applicable section below

Company Name Change	From (Old or Current) Name:	To (New) Name:

Address Change	☐ Mailing Address ☐ Physical Address	New Street Address:
	New City/State/Zip:	Telephone:

Contact Person Change	From (Name):	To (Name):
	New Contact Person's Role (HR, Billing, etc.):	Phone:
	Email:	

Add Additional Contact Person	Additional Contact's Name:	
	New Contact Person's Role (HR, Billing, etc.):	Phone:
	Email:	

New Hire Wating Period	From (MM/DD/YYYY):	To (MM/DD/YYYY):

Plan Termination - Complete for Each Plan Type

Reason (Required for all requested terminations)	DENTAL	VISION
	☐ Company no longer offers benefits ☐ Company Reorganization/Out of Business ☐ Consolidating Medical/Dental benefits New Carrier: _____ ☐ Lower Rates New Carrier: _____ ☐ Provider Network New Carrier: _____ ☐ Service Issues Explanation: _____ ☐ Under Enrolled	☐ Company no longer offers benefits ☐ Company Reorganization/Out of Business ☐ Consolidating Medical/Dental benefits New Carrier: _____ ☐ Lower Rates New Carrier: _____ ☐ Provider Network New Carrier: _____ ☐ Service Issues Explanation: _____ ☐ Under Enrolled

Signature Authorization	Employer Name:	Title:
	Employer Signature:	Date Signed (MM/DD/YYYY):

Please Note that changes may result in premium adjustments. Any person knowingly and with intent to defraud or deceive Dental Select or any other person, makes a request for insurance containing any false, incomplete or misleading information may be guilty of a crime.

In the event there is a discrepancy regarding any information contained on this form, documentation will be required.

To Submit: Mail: Dental Select ATTN: Eligibility, 75 W Towne Ridge Pkwy, Tower 2, Suite 500, Sandy, UT 84070
Fax: 801-290-5101 or 888-998-8704
Email: eligibility_web@dentalselect.com (must be an attached PDF image of this form)

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