Florida Combined Life
An Independent Licensee of the Blue Cross and Blue Shield Association

Employee Change Form for Group BlueDental Choice and Freedom

Mail to:
Membership Services
3060 Alpine Road, Mail Code AX-C02
Alpine , SC 29223
Fax No. 803-264-7358

CHECK THOSE THAT APPLY AND COMPLETE THE LINES INDICATED:	**Lines**
☐ Employee name change	1A, 1B, 2A, 18
☐ Employee social security correction	1A, 2A, 2B, 18
☐ Add spouse	1A, 2A, 3-18
☐ Add domestic partner (DP)	1A, 2A, 3-18
☐ Add child(ren)	1A, 2A, 3-18
☐ Add child(ren) of DP	1A, 2A, 3-18
☐ Terminate spouse	1A, 2A, 3-5, 8, 16, 18
☐ Terminate domestic partner (DP)	1A, 2A, 3-5, 8, 16, 18
☐ Terminate child(ren)	1A, 2A, 3-5, 8, 16, 18
☐ Terminate child (ren) of DP	1A, 2A, 3-5, 8, 16, 18
☐ Terminate all coverage	1A, 2A, 3, 16, 18
☐ Address change	1A, 2A, 3, 18
☐ Other Dental Insurance	1A, 2A, 17, 18
☐ Other _____	

FOR EMPLOYER USE: (Required Information)

GROUP NUMBER: _____

GROUP NAME: _____

EFFECTIVE DATE: _____

PLAN TYPE: _____

REMARKS: _____

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		

List All Eligible Dependents To Be Covered. Children of a domestic partner may be covered when the domestic partner is also covered. Attach additional sheet of paper, if necessary. Sign and date it. Check all that apply.

4 Last Name, First Name, M.I. (Please provide information in the corresponding numbered spaces below.) 5 Social Security Number (Please provide in spaces below.)	6 Relation to You (DP = Domestic Partner)	7 Marital Status: Married	7 Marital Status: Unmarried No Children	8 Gender (M/F)	9 Birthdate mm/dd/yyyy	10 Disabled	11 Lives with You	12 You Support Financially	13 Student FT/PT	14 Florida Resident	15 Covered by Medicaid
4 5 ___ ___ ___ - ___ ___ - ___ ___ ___ ___	☐ Spouse *or* ☐ DP										
4 5 ___ ___ ___ - ___ ___ - ___ ___ ___ ___	☐ Child *or* ☐ DP Child	☐	☐			☐	☐	☐	☐	☐	☐
4 5 ___ ___ ___ - ___ ___ - ___ ___ ___ ___	☐ Child *or* ☐ DP Child	☐	☐			☐	☐	☐	☐	☐	☐
4 5 ___ ___ ___ - ___ ___ - ___ ___ ___ ___	☐ Child *or* ☐ DP Child	☐	☐			☐	☐	☐	☐	☐	☐

16 Reason: ☐ Marriage ☐ Divorce ☐ Age Limit ☐ Employment Termination ☐ Other

17 Do you or any of your dependents have other Dental insurance under a group plan? ☐ Yes ☐ No
If "Yes," complete the following sections:

Name of Person	Group Plan	Policy Number	Insurance Company and Address

18 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.

_____ _____
Employee Signature Date Signed

Copies to: Membership Services, Employer