



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

CHECK THOSE THAT APPLY AND COMPLETE THE LINES INDICATED: <input type="checkbox"/> Employee name change <input type="checkbox"/> Employee social security correction <input type="checkbox"/> Add dependent spouse <input type="checkbox"/> Add dependent child(ren) <input type="checkbox"/> Terminate dependent spouse <input type="checkbox"/> Terminate dependent child(ren) <input type="checkbox"/> Terminate all coverage <input type="checkbox"/> Address change <input type="checkbox"/> Other Dental Insurance <input type="checkbox"/> Other _____				FOR EMPLOYER USE: (Required Information) GROUP NUMBER: _____ GROUP NAME: _____ EFFECTIVE DATE: _____ POLICY 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	
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		
10	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					