

CARE-PLUS DENTAL PLANS, INC. Coverage Status Change Form

Employee _____ **Social Security #** _____

Name Change _____ **New Address** _____

From _____

To _____

Single to Family

ADD: Spouse

Name _____

Date of Marriage _____

Birthdate _____

Maiden Name _____

Social Security # _____

Employer _____

ADD: Dependents

Name _____

Birthdate _____

Sex M F

Social Security # _____

Name _____

Birthdate _____

Sex M F

Social Security # _____

Is anyone named on this form covered by another group dental insurance plan? Yes No

Name of Policyholder

Policyholder's Employer

Name of Insurance Company

Policyholder's Identification Number

Family to Single

DELETE: Spouse

Name _____

Reason _____

DELETE: Dependent

Name _____

Reason _____

Terminate Coverage

- Lay Off
- Death
- Left Employment
- Retire
- Open Enrollment Drop

Reinstate Coverage

- Return to Work
- Cobra

X _____
INSURED'S SIGNATURE **DATE SIGNED**

FOR EMPLOYER USE ONLY

Employer _____ Department _____

Effective Date _____ Employer Representative _____