Individual & Family Plan Change Form

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Willamette Dental Group

Please print your answers clearly in ink and sign form at the bottom so we can process your changes quickly. Thank you.

1 My information is...

Self (Last, First, Middle Initial)	Date of Birth

2 I would like to change...

☐ **Name Change**

From (Last Name, First Name)	**To** (Last Name, First Name)

☐ **Address Change**

New Address	City	State	Zip Code	Telephone Number

☐ **Delete / Add Dependents Below** Requested Effective Date: _____

☐ Add ☐ Delete	**Name** (Last, First, Middle Initial)	Relation	Gender
		Date of Birth	SSN
☐ Add ☐ Delete	**Name** (Last, First, Middle Initial)	Relation	Gender
		Date of Birth	SSN
☐ Add ☐ Delete	**Name** (Last, First, Middle Initial)	Relation	Gender
		Date of Birth	SSN

Date of Qualifying Event (marriage, divorce, birth, adoption, death, loss/gain of other coverage): _____

Comments: _____

☐ **Cancel Entire Policy (Subscriber/Family)** Requested Effective Date: _____

Former enrollees must wait 12 months to enroll in any individual or family plan through Willamette Dental Group.

3 Signature Authorization

Subscriber's Signature	Date Signed