

GroupLink, Inc.

PO Box 20593, Indianapolis, IN 46220 (317) 578-7128

DENTAL PLAN CHANGE FORM

(This application should be used to report enrollment changes for all GroupLink administered dental plans)

EMPLOYER INFORMATION

Employer Name: _____ Location: _____ Group Number: _____

EMPLOYEE INFORMATION

Last Name: _____ First: _____ Initial: _____ Social Security Number: _____ - _____ - _____

TERMINATION

Date Employment Ends: _____ / _____ / _____ Date Coverage Ends: _____ / _____ / _____

Voluntary Drop of Employee Coverage - Date Coverage Ends: _____ / _____ / _____

ADDRESS CHANGE

Old Address: _____
No. & Street City State Zip

New Address: _____
No. & Street City State Zip

NAME CHANGE

From: _____
Last Name First Middle Initial

To: _____
Last Name First Middle Initial

LOCATION CHANGE

From: _____ To: _____
Name and/or Number Name and/or Number

DEPENDENT CHANGE - Change Information Below

Add Dependent(s) to Coverage - Reason: _____ Requested Effective Date: _____ / _____ / _____

Delete Dependent(s) from Coverage- Reason: _____ Requested Effective Date: _____ / _____ / _____

| Family Members | | | | | Please check if dependent child is: | | | Please check if child is full time student |
|--------------------------------|---------------------|---------------|------------------|---------|-------------------------------------|---------|------|--|
| Name: First, Mid Initial, Last | Social Security No. | Date of Birth | Date of Marriage | Sex M/F | Natural | Adopted | Step | |
| Spouse: | - - | | | | | | | |
| Dependent: | - - | | | | | | | |
| Dependent: | - - | | | | | | | |
| Dependent: | - - | | | | | | | |

PRIOR COVERAGE

Name of Insurance Carrier(s) or Plan: _____

Address of Carrier: _____

Phone Number of Carrier or Plan: _____ Policy Number: _____ Effective Date: _____ / _____ / _____ Termination Date _____ / _____ / _____

SIGNATURE

I hereby request coverage as outlined above under the group dental plan offered by my employer and authorize my employer to deduct from my earnings, if applicable, including any future adjustments, and any required contributions. I reserve the right to revoke or change this authorization by written notice and understand that if I have declined any coverage on myself or an eligible dependent and wish to enroll at a later date, coverage will be deferred in accordance with the plan provisions. I understand and acknowledge that information concerning coverage, treatments, and services I may receive may be distributed and disclosed to my employer, and I hereby consent to the dissemination and disclosure of all information. I declare all answers to be true and complete.

DATE: _____ / _____ / _____ SIGNATURE: _____