

FLORIDA COMBINED LIFE INSURANCE COMPANY, INC.

BlueDental Choice & Freedom

Membership Services, 3060 Alpine Road, Mail Code AF-170

CHANGE NOTICE

Columbia, SC 29223

Fax No. 803-264-7358

CHECK THOSE THAT APPLY AND COMPLETE THE LINES INDICATED:				FOR EMPLOYER USE: (Required Information)			
<input type="checkbox"/>	Employee name change	Lines	1A, 1B, 2A, 10	GROUP NUMBER: _____			
<input type="checkbox"/>	Employee social security correction		1A, 2A, 2B, 10	GROUP NAME: _____			
<input type="checkbox"/>	Add dependent spouse		1A, 2A, 3, 4, 8, 9, 10	EFFECTIVE DATE: _____			
<input type="checkbox"/>	Add dependent child(ren)		1A, 2A, 3, 5, 6, 7, 8, 9, 10	POLICY TYPE: _____			
<input type="checkbox"/>	Terminate dependent spouse		1A, 2A, 3, 4, 8, 10	REMARKS: _____			
<input type="checkbox"/>	Terminate dependent child(ren)		1A, 2A, 3, 5, 6, 7, 8, 10				
<input type="checkbox"/>	Terminate all coverage		1A, 2A, 3, 8, 10				
<input type="checkbox"/>	Address change		1A, 2A, 3, 10				
<input type="checkbox"/>	Other Dental Insurance		1A, 2A, 9, 10				
<input type="checkbox"/>	Other _____						
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"/> Husb <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 _____			

50415-0404R SR

White Copy - Membership Services

Yellow Copy - Employer