

**FLORIDA COMBINED LIFE INSURANCE COMPANY, INC.**

**BlueDental Choice & Freedom**

Membership Services, AZ-400; 7909 Parklane Road, Suite 350  
Columbia, SC 29223

**CHANGE NOTICE**

Fax No. 803-264-7358

<b>CHECK THOSE THAT APPLY AND COMPLETE THE LINES INDICATED:</b> <input type="checkbox"/> Employee name change                      Lines    1A, 1B, 2A, 10 <input type="checkbox"/> Employee social security correction        1A, 2A, 2B, 10 <input type="checkbox"/> Add dependent spouse                         1A, 2A, 3, 4, 8, 9, 10 <input type="checkbox"/> Add dependent child(ren)                    1A, 2A, 3, 5, 6, 7, 8, 9, 10 <input type="checkbox"/> Terminate dependent spouse                1A, 2A, 3, 4, 8, 10 <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 _____				<b>FOR EMPLOYER USE: (Required Information)</b>  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	Social Security 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 _____				