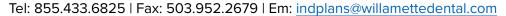
INDIVIDUAL & FAMILY PLAN CHANGE FORM

Willamette Dental of Washington, Inc. | 6950 NE Campus Way, Hillsboro, OR 97124





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	Tel Number	
	Delete / Add Dependents Below	Requested Effe	L ctive Date:			
	☐ Add ☐ Delete	Name (Last, First, Middle Initia		Gender		
		Relation		Date of Birth		
	☐ Add ☐ Delete	Name (Last, First, Middle Initial)		Gender		
	·	,	,			
		Relation		Date of Birth		
	☐ Add ☐ Delete	Name (Last, First, Middle Initial)		Gender		
	- rida - Belete	rvame (East, First, Whate Hittel)		- Contact		
		Relation		Date of Birth		
		Relation		Date of Birtin		
Date of Qualifying Event (marriage, divorce, birth, adoption, death, loss/gain of other coverage):						
Со	mments:					
□ 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.						
3. Signature Authorization						
Subscriber's Signature				Date Signed		