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	Tel Number

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

◯ Add	◯ Delete	Name (Last, First, Middle Initial)	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
		Relation	Date of Birth

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.

3. Signature Authorization

Subscriber's Signature	Date Signed