



Individual & Family Plan Change Form

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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...

<input type="checkbox"/>	Name change			
	From (Last, First):	To (Last, First):		
<input type="checkbox"/>	Address change			
	New Address:			
	City:	State:	Zip:	Tel:
<input type="checkbox"/>	Delete / Add Dependents below	Requested Effective Date:		
	<input type="checkbox"/> Add <input type="checkbox"/> Delete			
	Name (Last, First, MI):		Gender:	
	Relation:		DOB:	
	<input type="checkbox"/> Add <input type="checkbox"/> Delete			
	Name (Last, First, MI):		Gender:	
	Relation:		DOB:	
	<input type="checkbox"/> Add <input type="checkbox"/> Delete			
	Name (Last, First, MI):		Gender:	
	Relation:		DOB:	

Date of qualifying event (marriage, divorce, birth, adoption, death, loss/gain of other coverage): _____

Comments: _____

<input type="checkbox"/>	Cancel entire policy (subscriber / family)	Requested Effective Date:	
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3. Signature authorization

Subscriber's signature _____ Date signed _____