

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
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2 I would like to change...

Name Change

From (Last Name, First Name)	To (Last Name, First Name)
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Address Change

New Address	City	State	Zip Code	Telephone Number
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Delete / Add Dependents Below Requested Effective Date: _____

<input type="checkbox"/> Add <input type="checkbox"/> Delete	Name (Last, First, Middle Initial)	Relation	Gender
		Date of Birth	SSN
<input type="checkbox"/> Add <input type="checkbox"/> Delete	Name (Last, First, Middle Initial)	Relation	Gender
		Date of Birth	SSN
<input type="checkbox"/> Add <input type="checkbox"/> Delete	Name (Last, First, Middle Initial)	Relation	Gender
		Date of Birth	SSN

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 Group.

3 Signature Authorization

Subscriber's Signature	Date Signed
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