CARE-PLUS DENTAL PLANS, INC.
Coverage Status Change Form

Employee ____________ **Social Security #** ____________

Name Change **New Address**

From ____________ ____________

To ____________ ____________

Change:

❑ ADD: Spouse

Name ____________

Date of Marriage ____________

Birthdate ____________

Maiden Name ____________

Social Security # ____________

Employer ____________

❑ ADD: Dependents

Name ____________

Birthdate ____________

Sex ❑ M ❑ F

Social Security # ____________

Name ____________

Birthdate ____________

Sex ❑ M ❑ F

Social Security #

Is anyone named on this form covered by another group dental insurance plan? ❑ Yes ❑ No

____________ Name of Policyholder

____________ Policyholder's Employer

____________ Name of Insurance Company

____________ Policyholder's Identification Number

Change in Coverage

❑ **DELETE:** Spouse

Name ____________

Reason ____________

❑ **DELETE:** Dependent

Name ____________

Reason ____________

Terminate Coverage

- ❑ Lay Off
- ❑ Deceased
- ❑ Left Employment
- ❑ Retired
- ❑ Ineligible – Drop
- ❑ Over Age Dependent
- ❑ Other Coverage
- ❑ Leave of Absence
- ❑ COBRA Termination
- ❑ Open Enrollment Drop

Reinstate Coverage

- ❑ Return to Work
- ❑ COBRA
- ❑ Change Subgroup ____________

X ____________ **INSURED'S SIGNATURE**

____________ **DATE SIGNED**

For Employer Use Only

Employer ____________ Department ____________

Effective Date ____________ Employer Representative ____________