

# CARE-PLUS DENTAL PLANS, INC.

## Coverage Status Change Form

Employee \_\_\_\_\_ Social Security # \_\_\_\_\_

Name Change \_\_\_\_\_ New Address \_\_\_\_\_  
 From \_\_\_\_\_  
 To \_\_\_\_\_

**Single to Family**

ADD:Spouse  
 Name \_\_\_\_\_  
 Date of Marriage \_\_\_\_\_  
 Birthdate \_\_\_\_\_  
 Maiden Name \_\_\_\_\_  
 Social Security # \_\_\_\_\_  
 Employer \_\_\_\_\_

ADD:Dependents  
 Name \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Sex M or F  
 Social Security # \_\_\_\_\_  
 Name \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Sex M or F  
 Social Security # \_\_\_\_\_

IS ANYONE NAMED ON THIS FORM COVERED BY ANOTHER GROUP DENTAL INSURANCE PLAN?  YES  NO

IF YES, \_\_\_\_\_  
 NAME OF POLICYHOLDER POLICYHOLDER'S EMPLOYER  
 \_\_\_\_\_  
 NAME OF INSURANCE COMPANY POLICYHOLDER'S IDENTIFICATION NUMBER

**Family to Single**

DELETE:Spouse  
 Name \_\_\_\_\_  
 Reason \_\_\_\_\_

DELETE:Dependent  
 Name \_\_\_\_\_  
 Reason \_\_\_\_\_

**Terminate Coverage**

- Lay Off
- Death
- Left Employment
- Retire
- Open Enrollment Drop

**Reinstate Coverage**

- Return to Work
- Cobra

X \_\_\_\_\_ DATE SIGNED

INSURED'S SIGNATURE

**FOR EMPLOYER USE ONLY**

Employer \_\_\_\_\_ Department \_\_\_\_\_  
 Effective Date \_\_\_\_\_ Employer Representative \_\_\_\_\_