



Dental Plan Change Request Form

If your group *does not* offer "All Dental Plans" and would like to add or change plans please refer to the instructions below.
FAX your completed form to 805-713-7024



Please tell us who you are and how we can reach you:

Group No.	Company Name
Phone	Contact Name
FAX	Email

Be sure to complete this section to authorize these changes:

I am an owner or officer of this company, and hereby authorize the following changes to our Blue Cross group dental coverage portfolio.

Signature _____ Printed Name _____

Date _____ Requested Effective Date _____

For each member who wishes to change plans:

Provide their name and identification number and mark the plan the member wishes to move to.

When adding **additional** dental products please provide:

- 1) Employer Application
- 2) Letter from the group on company letterhead and signed by officer
- 3) New enrollees or family additions must complete Dental Applications requesting or declining coverage

Member's Name	Member's Social Security or ID No.	High Option FFS PPO	Standard PPO Dental	Basic PPO Dental	Dental Net	Dental Select HMO	Platinum Preferred 2000	Platinum 2000	Gold Preferred 1500	Gold 1500	Silver 1000	Dental Net or Dental Select HMO <small>Provide the 6-digit Dental Office number here.</small>
1)												
2)												
3)												
4)												
5)												
6)												
7)												
8)												
9)												
10)												

Please photocopy form if additional rows are needed