

## Individual Plans Dental Change Form

**Before completing this form, please make note of the following information:**

- This form should be used to add, remove or change dental benefits.
- Changes will apply to all family members currently covered on your SelectHealth medical plan.
- You may not add dental coverage if you are not enrolled on a SelectHealth individual medical plan. Members with employer-sponsored medical coverage may not apply for individual dental plans.
- Dental plans can only be added or removed at the time of your annual medical plan renewal. Changes will be effective on the first day of the renewal period.
- To change or terminate medical benefits, add/remove dependents, change addresses or other personal information, please use the Individual Plans Change Form.

### A. SUBSCRIBER INFORMATION

Subscriber's Name \_\_\_\_\_ Subscriber ID \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(LOCATED ON ID CARD)

### B. DENTAL BENEFIT CHANGES

**Individual/Family Dental Coverage**

- I do not currently have dental coverage and would like to add it at this time.
- I currently have SelectHealth individual dental coverage and would like to change my benefits.

**Annual Maximum Benefit (select one)**

Individual/Family Deductible	<input type="checkbox"/> \$750 \$50/\$150	<input type="checkbox"/> \$1,000 \$50/\$150	<input type="checkbox"/> \$1,500 \$50/\$150
Participating Preventive Coverage	100%	100%	90%
Participating Basic Dental Coverage	80% after deductible	80% after deductible	70% after deductible
Participating Major Dental Coverage	50% after deductible	50% after deductible	50% after deductible
Orthodontia	Not covered	Not covered	Not covered

**Have you recently been insured by another dental carrier?**  Yes  No

If so, please provide the name of the dental insurance carrier. \_\_\_\_\_

### C. DISCONTINUANCE OF DENTAL BENEFITS

- I hereby request the discontinuance of dental benefits received under contract by SelectHealth. I understand that the discontinuance will be effective on the last day of the plan renewal period, and applies to all family members covered under my SelectHealth medical plan. Furthermore, I understand that no cancellation will be made on a retroactive basis.

### D. SIGNATURE

By signing, you agree to the changes requested above. To terminate coverage, please mark the box in section "C" above before signing.

Subscriber Signature \_\_\_\_\_ Date \_\_\_\_\_