Dental Change Form (PLEASE PRINT)

EMPLOYER NAME	GROUP NUMBER	EMPLOYEE DATE OF HIRE	LOCATION
ET Investments, LLC	**76-411628**		

SOCIAL SECURITY NUMBER			**EMAIL ADDRESS**
NAME: LAST		**FIRST**	**M.I.**
ADDRESS		**CITY**	**STATE ZIP**
DATE OF BIRTH	**GENDER**	**MARITAL STATUS**	**HOME TELEPHONE NUMBER**
	.	.	

PLEASE SELECT DENTAL OPTION and COVERAGE TYPE BELOW:

☐ **DENTAL** ☐ EE only ☐ EE + spouse ☐ EE + child(ren) ☐ Family ☐ Waive

COMPLETE THIS SECTION IF ELECTING DEPENDENT COVERAGE

Spouse Name **First MI Last**	**SS#**	**BIRTH DATE**	**GENDER**	**RELATIONSHIP TO EMPLOYEE**
_____	_____-_____-_____	_____/_____/_____	☐ M ☐ F	____SPOUSE_____ (Child/Step-child/Adopted child/ Foster/ Legal guardianship /QMCSO)
Child/ren				
1_____	_____-____-_____	_____/_____/_____	☐ M ☐ F	_____
2_____	_____-____-_____	_____/_____/_____	☐ M ☐ F	_____
3_____	_____-____-_____	_____/_____/_____	☐ M ☐ F	_____
4_____	_____-____-_____	_____/_____/_____	☐ M ☐ F	_____
5_____	_____-____-_____	_____/_____/_____	☐ M ☐ F	_____

COMPLETE THIS SECTION IF MAKING CHANGES

Effective date of change: _____ Please specify change reason and update in appropriate section.

Qualifying event reason:

☐ Date of Loss of Prior Insurance Coverage _____

☐ Employee name change

☐ Employee address change

☐ Date of marriage_____

☐ Date of Divorce_____

☐ Eligible for Medicaid/CHIP subsidy

☐ Loss of Eligibility for Medicaid/CHIP subsidy

☐ Add dependents

☐ Remove dependents (list names) _____ Reason: _____

As of the effective date of this insurance (UMR), will you or any member of your family being covered under this Dental insurance (UMR), continue to be covered under another Dental insurance plan including Medicare.

☐ Yes, single ☐ Yes, Spouse/Children ☐ Yes, Family ☐ Yes, Children ☐ No

If YES to the above question, complete the following:

Person's name _____ Employer Name _____

Carrier Name_____ Plan Number_____

I hereby certify that all of the above information is true and correct. I understand that coverage will not be effective until all questions regarding eligibility for coverage have been satisfactorily resolved.
I understand that I may not change the coverage elections that I make on the Employee Enrollment/Change Form until the plan's next open/annual enrollment period or unless otherwise permitted by the Plan.

Please refer to your Employee Benefit Booklet for specific detail of your benefit plan.

☐ I hereby apply for coverage and authorize deductions from my earnings for the amount required, if any, to cover any contribution for coverage.

_____ _____

EMPLOYEE SIGNATURE **DATE**