

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 _____