

TO CHANGE DENTAL OR VISION PLAN, COMPLETE AND SIGN THIS FORM AND SEND TO HUMAN RESOURCES, BENEFITS COORDINATOR.

GENERAL INFORMATION

Subscriber (Employee) Name: _____
 Social Security Number: _____ - _____ - _____ Group Number: **DENTAL PREPAID: CP4067**
DENTAL INDEMNITY : CD4067
 Group Name: **CENTRAL FLORIDA COMMUNITY COLLEGE** **VISION PLAN:**

DENTAL FACILITY SELECTION

Please change my dental facility selection: Effective Date: _____
 From Facility Number: _____ To Facility Number: _____

DEPENDENT INFORMATION – ADDITIONS/DELECTIONS

Add Dependent(s):
 Spouse: _____ Eff. Date: _____ Date of Birth: _____
 Child: _____ Eff. Date: _____ Date of Birth: _____
 Child: _____ Eff. Date: _____ Date of Birth: _____

Delete Dependent(s):
 Name: _____ Eff. Date: _____
 Name: _____ Eff. Date: _____

CHANGE OF NAME, ADDRESS OR TELEPHONE

Name
 From: _____ To: _____
 Address
 Address: _____ Apt. No. _____
 City: _____ State: _____ Zip Code: _____
 Telephone Number(s) Home: () _____ Work: () _____

OTHER

Cancel Policy: Effective Date: _____ Reason: _____

 Comments: _____

PERSON INITIATING REQUEST (Employee, Administrator, Etc.)

Signature: _____ Date: _____