compbenefits
vision
dental

Dental Plan Change Form

RETURN THIS FORM IF YOU ARE CURRENTLY ENROLLED AND WISH TO CHANGE YOUR COVERAGE.

EMPLOYEE INFORMATION (Please Print)

Employee's Name: **Employee's Social Security #:**

Last Name First MI

Employer's Name: **Shelby County Government**

EMPLOYEE CHANGES (Please Complete The Appropriate Items Below)

CHANGE OF ADDRESS:

Street Address Apt #:

City State Zip Code

PLEASE SELECT ONE:

- ☐ **Employee**
- ☐ **Employee + One**
- ☐ **Family**

CHANGE COVERAGE TO (Check One):

- ☐ **Option I:** Basic DHMO - Prestige 45
- ☐ **Option II:** Enhanced DHMO - Prestige 15
- ☐ **Option III:** Basic PPO - Elite Preferred 520
- ☐ **Option IV:** Enhanced PPO - Elite Preferred 510

FACILITY CHANGE:

If you are currently on Plan I or II and would like to change your facility selection, please note **new facility number**: _____

SELECT DENTIST FOR OPTION I (PST45) AND II (PST15) ONLY

If you are changing your coverage to the DHMO Plan, select a dentist from the list of Participating General Dentists, which is included in your enrollment packet. Write the Dental Facility Number of the dentist you have chosen for you and your family members in the space below.

CHANGE DEPENDENT COVERAGE

List dependents to be added or deleted. Please note it is the responsibility of the employee to inform the Shelby County Employee Benefits Office if a dependent has reached the maximum age limit or if their status has changed.

Last Name	First	M.I.	Relationship	Date of Birth	Sex	Facility #	Add	Delete
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CANCEL Coverage ☐

Check Box

Employee Signature: _____ Date: _____

Office Use Only:

Employee (EIN) Number: _____

Effective Date _____

Entered by _____

Comments _____