



MADA
MADA DENTAL PLAN
MEMBER CHANGE FORM

Name of Employee: (Last, First, MI) _____

SSN: _____ DOB: _____ Male Female

JOB TITLE: _____ FULL-TIME HIRE DATE: _____

Name of Employer: _____ DIV #: _____

Your Address: **Complete only if new address:** _____

City: _____ State: _____ Zip: _____ Home Phone: _____

CHANGE TYPE OF COVERAGE:

I am changing to: _____ **GOLD** Plan* _____ **PLATINUM** Plan*

*Changing from Gold to Platinum is only an option during Open Enrollment

Employee Only Employee + 1 Employee + 2 FAMILY

Please provide the following information for each dependent:

Check One:

Add / Delete / Change

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Does anyone being added above have any other group Dental Insurance? (Circle) **Yes** **No**

If yes, please specify group name: _____

Name of Spouse's Employer: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone # _____

Reason for change(s) (check all that apply):

Subscriber's marriage Add newborn child Adoption/legal custody of child (attach documentation)

Subscriber's divorce Child reached dependent age limit Child's marriage

Open Enrollment Other (explain): _____

Date of the Event you checked: _____

Effective Date: _____ Termination Date: _____

Date: _____ Signature: _____

No action requested can be taken without your signature.