Florida Combined Life
An Independent Licensee of the Blue Cross and Blue Shield Association

Change Form for Individual BlueDental Choice

Mail to:
Membership Services
P. O. Box 37859
Jacksonville, FL 32236
Fax No. 904-425-7100

CHECK THOSE THAT APPLY AND COMPLETE THE LINES INDICATED:	**Lines**
☐ Name change	1A, 1B, 2A, 19
☐ Social Security Number correction	1A, 2A, 2B, 19
☐ Add spouse	1A, 2A, 3-16, 19
☐ Add domestic partner (DP)	1A, 2A, 3-16, 19
☐ Add child (ren)	1A, 2A, 3-16, 19
☐ Add child (ren) of DP	1A, 2A, 3-16, 19
☐ Terminate spouse	1A, 2A, 3-5, 9, 19
☐ Terminate domestic partner (DP)	1A, 2A, 3-5, 9, 19
☐ Terminate child (ren)	1A, 2A, 3-5, 9, 19
☐ Terminate child (ren) of DP	1A, 2A, 3-5, 9, 19
☐ Terminate all coverage	1A, 2A, 3, 19
☐ Address change	1A, 2A, 3, 19
☐ Other Dental Insurance	1A, 2A, 16, 19
☐ Bank Change (Bank Draft)	1A, 2A, 17, 19
☐ Credit Card Change	1A, 2A, 18, 19
☐ Other _____	

REQUIRED INFORMATION

Requested Effective Date of Change:_____

Contract Number:_____
(Located on your ID Card)

Remarks:_____

1A. Policyholder's Last Name | First Name | Middle Initial

1B. Previous name (if this is a Name Change)

2A. Social Security Number

2B. Correct Social Security Number

3. Policyholder's Street | City | State | Zip | Phone

List All Eligible Dependents To Be Covered. Children of a domestic partner may be covered when the domestic partner is also covered. Attach additional sheet of paper, if necessary. Sign and date it. Check all that apply.

4 Last Name, First Name, M.I. (Please provide information in the corresponding numbered spaces below.) 5 Social Security Number (Please provide in spaces below.)	6 Relation to You (DP = Domestic Partner)	7 Marital Status: Married	7 Marital Status: Unmarried No Children	8 Gender (M/F)	9 Birthdate mm/dd/yyyy	10 Disabled	11 Lives with You	12 You Support Financially	13 Student FT/PT	14 Florida Resident	15 Covered by Medicaid
4 5 ___-___-____	☐ Spouse *or* ☐ DP										
4 5 ___-___-____	☐ Child *or* ☐ DP Child	☐	☐			☐	☐	☐	☐	☐	☐
4 5 ___-___-____	☐ Child *or* ☐ DP Child	☐	☐			☐	☐	☐	☐	☐	☐
4 5 ___-___-____	☐ Child *or* ☐ DP Child	☐	☐			☐	☐	☐	☐	☐	☐

Insurance changes granted to persons hereon shall be subject to all provisions and limitations of the policy. I am aware that a change in dependent coverage may affect the amount of premium due to Florida Combined Life for the Individual Dental coverage, and I hereby authorize such a change. I understand the change requested will not become effective until FCL has approved the change.

Signature | Date Signed