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.)<br>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<br>5 ___-___-____ | ☐ Spouse *or* ☐ DP | | | | | | | | | | |
| 4<br>5 ___-___-____ | ☐ Child *or* ☐ DP Child | ☐ | ☐ | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4<br>5 ___-___-____ | ☐ Child *or* ☐ DP Child | ☐ | ☐ | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4<br>5 ___-___-____ | ☐ Child *or* ☐ DP Child | ☐ | ☐ | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

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16. Do you or any of your dependents have other Dental insurance under a group or individual plan? ☐ Yes ☐ No
If "Yes," complete the following sections:

| Name of Person | Group Number | Policy/Certificate Number | Insurance Company and Address |
|---|---|---|---|
| | | | |
| | | | |

17. Bank Draft: You Must Include A Voided Check With This Change Form and Complete the Section Below.

I authorize _____ to make a bank draft of $_____
*(Financial Institution/Bank Name)*
from Account No. _____ Bank Routing No. _____
and to remit the amounts deducted to FCL, upon instructions from FCL. The amount of deduction indicated above is approximate and may be corrected as instructed by FCL. This authorization will remain in effect until: (a) I/we cancel it in writing; (b) the above account is closed; (c) the deduction and remittance arrangements between the above financial institution and FCL are discontinued; or (d) the insurance policy is cancelled. I understand that this authorization does not waive or change any of the payment provisions of the policy issued to me by FCL, and if this authorization terminates for any reason, any further payments required under the policy will be made as provided in the policy. I agree that the above financial institution is acting gratuitously and for my sole accommodation and not as an agent for FCL.

| 18. Credit Card: ☐ MasterCard ☐ Visa | Credit Card No.: | Exp. Date: |
|---|---|---|

19. Insurance changes granted to persons hereon shall be subject to all provisions and limitations of the individual 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

| **For Internal Use Only** | PSR No. | Date Processed | Group & Division No. | Change Effective Date |
|---|---|---|---|---|
| | | | | |