



Florida Combined Life Dental Change Form



**Florida
Combined Life**

An Independent Licensee of the
Blue Cross and Blue Shield Association

BlueDental Choice

OPEN ENROLLMENT

QUALIFYING LIFE EVENT

Employee Last Name:	First Name:	MI:	Social Security No.:
Home Address:	City:	State:	Zip Code: Phone Number:

Address Change	New Address: _____		
Name Change	<input type="checkbox"/> Employee <input type="checkbox"/> Dependent	From: _____	To: _____
Terminate all coverage	Effective Date: _____		
Plan Change	Effective Date: _____		
Coverage Selection:	Employee Yes No	Spouse Yes No	Child(ren) Yes No

Open Enrollment Plan Options Low Option Mid Option High Option
Select one (1) of the following:

List all eligible dependents to be covered. If necessary, attach an additional sheet of paper, sign and date it.

Add	Delete	Last Name	First Name	MI	Social Security Number	Birth Date <small>mm/dd/yyyy</small>	Relation to You	Gender
							Spouse	M F
							Child	M F
							Child	M F
							Child	M F

Membership granted to persons hereon shall be subject to all provisions and limitations of the group agreement. I am aware that a change in dependents may affect the amount deducted from any wages (if any) for Florida Combined Life Dental Plan coverage, and I hereby authorize such a change.

Employee Signature

Date Signed

For Employer Use: (Required Information)	NOTES:
Group Name: <u>Bay County Board of County Commissioners</u>	_____
HR Representative: _____ Date Entered: _____	_____
Effective Date: _____ Plan Type: _____	_____
Deductions will begin on Paycheck Date: _____	