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	☐ Employee ☐ 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
Select one (1) of the following: ☐ Low Option ☐ Mid Option ☐ High Option

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 mm/dd/yyyy	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)

Group Name: Bay County Board of County Commissioners

HR Representative: _____ Date Entered: _____

Effective Date: _____ Plan Type: _____

Deductions will begin on Paycheck Date: _____

NOTES: _____