CONFIDENT℠ by cbg

Dental and Vision Change Form

Please Submit Completed Form to:
Matrix Insurance Marketing, Inc.
Phone: 206.521.9451 / Fax: 206.521.9554
Email: info@matrixinsurance.com

☐ This form indicates changes for the employee's DENTAL coverage.

☐ This form indicates changes for the employee's VISION coverage.

EMPLOYER INFORMATION

Employer Name:_____Location:_____ Group Number:_____

EMPLOYEE INFORMATION

Last Name:_____First:_____ Initial:____ ID Number_____

TERMINATION

Date Employment Ends ____/____/____ Date Coverage Ends ____/____/____ Continuation Begins ____/____/____

ADDRESS CHANGE

Old Address:_____
No & Street City State Zip

New Address:_____
No & Street City State Zip

NAME CHANGE

From:_____
Last Name First Middle Initial

To:_____
Last Name First Middle Initial

DEPENDENT CHANGE

Add Dependent(s) to Coverage Reason: _____Requested Effective Date: _____

Delete Dependent(s) from Coverage Reason:_____Requested Effective Date:_____

Name: First, Mid Initial, Last	Date of Birth	Date of Marriage	Sex M/F
Spouse:			
Dependent:			
Dependent:			

SIGNATURE

I herby request coverage as outlined above under the group dental plan offered by my employer ands authorized my employer to deduct from my earnings, including any future adjustments, any required contributions. I reserve the right to revoke or change this authorization by written notice and understand that if I have declined any coverage on myself or eligible dependent and wish to enroll at a later date, coverage will be deferred in accordance with the plan provisions. I understand and acknowledge that information concerning coverage's, treatments and services I may receive may be distributed and disclosed to my employer, and I herby consent to the dissemination and disclosure of all information. I declare all answers true and complete.

DATE: _____/____/____ SIGNATURE: _____