BlueDental Choice and Freedom
Employee Change Form

Florida Combined Life
An independent licensee of the Blue Cross and Blue Shield Association

Mail to:
Florida Combined Life
Membership Services
P.O. Box 44144
Jacksonville, FL 32232

Fax: 904-997-5471

For Employer Use: (Required Information)
Group Number: _____
Group Name: _____
Effective Date: _____ Plan Type: _____
Remarks: _____

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

☐ Address Change	From: _____ To: _____	
☐ Name Change	☐ Employee ☐ Dependent	From: _____ To: _____
☐ Social Security Number Correction	☐ Employee ☐ Dependent	From: _____ To: _____
☐ Terminate all coverage	Effective Date: _____	
☐ Other	☐ Employee ☐ Dependent	

List all eligible dependents to be covered. Children of a domestic partner may be covered when the domestic partner is also 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 *or* ☐DP	☐M ☐F
☐	☐						☐Child *or* ☐DP Child	☐M ☐F
☐	☐						☐Child *or* ☐DP Child	☐M ☐F
☐	☐						☐Child *or* ☐DP 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

Copies to: Membership Services, Employer