



Change in Enrollment Form

4D

Elig: _____
 Date: _____
 Amt. Due: _____
 Initials _____
 CDPID _____
Internal Use Only

Please indicate change, sign and return this form by mail or fax to:

CONNECTION Dental Plus
 P O Box 400
 Independence, MO 64051-0400

Fax: (816) 257-3358

REQUEST TO CHANGE ADDRESS

To change your permanent address, please indicate your permanent physical address below:

(Street Address)

(Street Address)

(City)

(State)

(Zip Code)

If your mailing address is different than your physical address, please indicate your mailing address below:

(Street Address)

(Street Address)

(City)

(State)

(Zip Code)

REQUEST TO ADD DEPENDENT COVERAGE INFORMATION

(Relationship Codes: 1=spouse 2=natural child 3=other, specify)

To add or change dependent coverage information, please complete the section below. An eligible dependent is defined as your legally married spouse or each unmarried child who is under age 25. All eligible dependents enrolled more than 31 days after the member's effective date will have separate Effective Dates of Coverage and Waiting Periods as described in the brochure.

Relationship Code	First Name	Middle Initial	Last Name (If Different)	Gender M/F	Date Of Birth	Social Security Number

Member Signature: _____ **Date:** _____

CONNECTION Dental Plus ID Number: _____ **Phone:** _____