GEHA Connection Dental Plus

Change in Enrollment Form

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

Connection Dental Plus
P.O. Box 21542
Eagan, MN 55121-9930

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 from 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; and each unmarried child who is under age 26. All eligible dependents enrolled more than 31 days after the member's effective date will have a separate Effective Date 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:** _____