



CompBenefits

SUBSCRIBER/EMPLOYEE SERVICE FORM DENTAL and VISION PLAN

GENERAL INFORMATION

Subscriber (Employee) Name: _____

Social Security Number: _____ - _____ - _____ Group Name: City of Tallahassee

DENTAL FACILITY SELECTION

Please change my dental facility selection: Effective Date: _____

From Facility Number: _____ To Facility Number: _____

DEPENDENT INFORMATION - ADDITIONS/DELETIONS

Additions/Deletions to (please check box): DENTAL PLAN VISION PLAN

Add Dependent(s):

Spouse: _____ Eff. Date: _____ Date of Birth: _____ Facility #: _____

Child: _____ Eff. Date: _____ Date of Birth: _____ Facility #: _____

Child: _____ Eff. Date: _____ Date of Birth: _____ Facility #: _____

Delete Dependent(s):

Name: _____ Effective Date: _____

Name: _____ Effective Date: _____

CHANGE OF NAME, ADDRESS OR TELEPHONE

Plan Type (please check box(es)): DENTAL PLAN VISION PLAN

Name:

From: _____ To: _____

New Address:

Address: _____ Apt. #: _____

City: _____ ST: _____ Zip Code: _____

New Telephone Number(s): Home: () _____ Work: () _____

OTHER

Cancel (please check box): DENTAL PLAN VISION PLAN

Cancel Policy: Effective Date: _____ Reason: _____

Comments: _____

PERSON INITIATING REQUEST (Employee, Administrator, etc.)

Signature: _____ Date: _____

MAIL OR FAX TO:

P. O. Box 769649, Roswell, GA 30076-8225 - Phone: 800/633-1262 - Fax.: 770/998-6871