

# 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 32231

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:

<input type="checkbox"/> Address Change	From: _____ To: _____
<input type="checkbox"/> Name Change	<input type="checkbox"/> Employee From: _____ To: _____ <input type="checkbox"/> Dependent
<input type="checkbox"/> Social Security Number Correction	<input type="checkbox"/> Employee From: _____ To: _____ <input type="checkbox"/> Dependent
<input type="checkbox"/> Terminate all coverage	Effective Date: _____
<input type="checkbox"/> Other	<input type="checkbox"/> Employee <input type="checkbox"/> 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
<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/> Spouse or <input type="checkbox"/> DP	<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/> Child or <input type="checkbox"/> DP Child	<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/> Child or <input type="checkbox"/> DP Child	<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/> Child or <input type="checkbox"/> DP Child	<input type="checkbox"/> M <input type="checkbox"/> 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