

Mail this report in the enclosed envelope labeled 'Membership Changes' or Fax this page to (630) 495-0575

Deliver to:
Data Management

DENTAL PROGRAM - MEMBERSHIP CHANGE REPORT

GROUP NAME: _____ SUBGROUP NO: _____
 GROUP NO: _____
 FOR NEW SUBSCRIBERS OR CHANGING DEPENDENT STATUS, PLEASE SUPPLY AN APPLICATION CONTAINING INFORMATION FOR THE SUBSCRIBER AND THE DEPENDENTS.
 PLEASE PRINT CLEARLY

Group Administrator's Change Codes:
 I- Subscriber Terminates/Ineligible
 S- Subscriber Subgroup Change
 A- Subscriber Address Change
 D- Dental Office Change **

Subscriber Identification Number As Identified on Invoice (required)	Subscriber's Name (required)	Subgroup Changes		Change Code	Change Effective Date	Change Data: (address, coverage, new dental office selection and #)	Reason for Cancel (1)
		Old Subgroup Number (as billed)	New Subgroup Number *				
	Last Name, First Name						1
	Last Name, First Name						2
	Last Name, First Name						3
	Last Name, First Name						4
	Last Name, First Name						5
	Last Name, First Name						6
	Last Name, First Name						7
	Last Name, First Name						8
	Last Name, First Name						9
	Last Name, First Name						10

(1) If subscriber cancelled, please indicate reason.

- 1 = Left employ
- 2 = Subscriber request
- 3 = Military Service
- 4 = Subscriber deceased
- 6 = Transfer out of state

* If Transferring, please indicate new subgroup number.
 ** Please attach dental office transfer form.

Administrator Signature: _____ Date: _____ Submitting _____ of _____ pages
 Processed by: _____ Date: _____ App: _____ Date: _____