Plans Underwritten by: Dentcare

Plans Administered by: healthplex

MEMBER/DEPENDENT CHANGE FORM

MEMBER INFORMATION

Member Name	Member BSC# (ID#)

☐ CHANGE OF PLAN

From	To	Effective Date of Plan Transfer
☐ Managed Care Plan ☐ PPO Plan	☐ Managed Care Plan ☐ PPO Plan	

☐ CHANGE OF NAME/ADDRESS

Last Name	First Name	M.I.

Address	Apt #	City

State	Zip Code	Phone Number

☐ DENTAL PROVIDER CHANGE *(MANAGED CARE PLAN ONLY)*

A second provider option has been provided in the event your first choice is not accepting new patients or no longer on the panel.

Dental Provider/Office Name - Selection 1	Provider ID Number

Dental Provider/Office Name - Selection 2	Provider ID Number

Reason for Change:

☐ CHANGE DEPENDENTS - SPOUSE/DOMESTIC PARTNER AND DEPENDENT CHILDREN *(COVERED UP TO THEIR 26TH BIRTHDAY).*

☐ Add Dependents		☐ Remove Dependents		☐ Reinstate Dependents	
Dependent (Last Name, First Name)	D.O.B.	Relationship to Member	Reason and Date of Occurrence		
Dependent (Last Name, First Name)	D.O.B.	Relationship to Member	Reason and Date of Occurrence		
Dependent (Last Name, First Name)	D.O.B.	Relationship to Member	Reason and Date of Occurrence		
Dependent (Last Name, First Name)	D.O.B.	Relationship to Member	Reason and Date of Occurrence		
Dependent (Last Name, First Name)	D.O.B.	Relationship to Member	Reason and Date of Occurrence		

I hereby apply to change my insurance coverage and/or records, as set forth herein.

If a change in dental provide is requested, I authorize my dentist with whom I have been enrolled to provide copies of my dental records or those of my dependents to the dentist I now select.

Member Signature	Date

Return completed form to:

TRANSPORT WORKERS UNION, LOCAL 100
180 Livingston Street, Suite 4017
Brooklyn, NY 11201
Email: member.services@twulocal100.org -or- Fax: 347-643-8063