Plans Underwritten by:

DENTCARE
DELIVERY SYSTEMS, INC.

Plans Administered by:

HEALTHPLEX
THE DENTAL BENEFIT EXPERTS℠

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

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
195 Montague Street
Brooklyn, NY 11201
Email: member.services@twulocal100.org -or- Fax: 347-643-8063