Delta Dental of Arkansas
P.O. Box 15965, Little Rock, AR 72231
individualservices@deltadentalar.com

REQUESTED EFFECTIVE DATE		
MONTH	DAY	YEAR
	1st	

Individual and Family Coverage Change Form

POLICY EFFECTIVE DATE: All Delta Dental policies will have an effective date of the first of the month following receipt of complete change form. Change form must be received in our offices by the 26th of the month prior to the requested effective date. (Example: Received by January 26th to be effective February 1st.) Change forms received after the 27th of the month will be made effective on the 1st of the following month. (Example: Received January 27th, will be effective March 1st.)

CURRENT POLICYHOLDER INFORMATION		
First Name:	M.I.:	Last Name:
Date of Birth: / /	Social Security Number:	Sex:
Mailing Address:		
City:	State:	ZIP:
Telephone:	Email:	

CHANGES TO BE MADE (please skip sections that do not apply to the change(s) you are making)			
NAME	First:	M.I.:	Last:
ADDRESS, EMAIL OR TELEPHONE NUMBER	Address:		
	City:	State:	ZIP:
	Email:	Telephone:	
To whom does this change apply?	☐ Policyholder	☐ Covered Dependent under age 18	☐ Covered Dependent age 18+
PLAN SELECTION CHANGE	**Please select the plan to which you wish to change.** ☐ Delta 500 (AR500) ☐ Delta 1000 (AR1000) ☐ Delta 1300 (AR1300) ☐ Add vision to my existing dental plan ☐ Remove vision from a dental plan		

COVERAGE LEVEL CHANGE (Please provide details for each member to be added or removed.)			
☐ Individual ☐ Individual and Spouse ☐ Individual and Child(ren) ☐ Family			
☐ Add ☐ Remove	Last (if different):	First:	M.I.:
	Relationship:	Sex:	Date of Birth: / /
☐ Add ☐ Remove	Last (if different):	First:	M.I.:
	Relationship:	Sex:	Date of Birth: / /
☐ Add ☐ Remove	Last (if different):	First:	M.I.:
	Relationship:	Sex:	Date of Birth: / /
☐ Add ☐ Remove	Last (if different):	First:	M.I.:
	Relationship:	Sex:	Date of Birth: / /
Do all proposed insured reside in Arkansas? ☐ YES ☐ NO. If no, provide reason:			
CANCEL COVERAGE	If you need to cancel your coverage, please check "Yes" and indicate the date your coverage is to be canceled. Cancel coverage? ☐ YES Date Coverage is to be Canceled: / /		

PAYMENT METHOD CHANGE

To make changes to your payment method, you can: (1) sign in to the Delta Dental of Arkansas Member Portal or (2) call our Individual Product Specialist Team at (844) 788-7627, Monday — Friday, 8 a.m. — 5:00 pm CST.

CERTIFICATION

I certify that the information supplied by me on this form is accurate to the best of my knowledge. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Policy Holder's Signature:____ Date: _____ / _____ / ________

OR

Parent/Legal Guardian's Signature:____ Date: _____ / _____ / ________
(If policy is for a minor)