

Beta Health Association, Inc.

"Dental Plan Specialists since 1990"

EMPLOYEE CHANGE OF STATUS FORM

This is not an enrollment form, please call 303.744.3007 for enrollment packets!

Step #1 - Please check the appropriate plan:

Today's date (required): _____

- Alpha Dental Plan
- Choice Dental Plan
- CarePOS
- Vision Plan of Colorado

Step #2 - Other information:

A. Company name: _____ Group#: _____

(Please Print)

B. Employee name: _____

(Please Print)

C Member # _____ Employee Social Security # _____ - _____ - _____

Step #3 - Please check the following change(s) to be made to the above employee's coverage.

- Please cancel the above employee coverage effective:

____/____/1____

Reason for cancellation (required): _____

Please note: Employees are only allowed to cancel coverage at renewal, upon termination of employment, or if qualifying event occurs (they become covered by a plan through spouse).

- Please add the following dependent(s) to the above coverage

First and last name: _____ effective date: ____/____/1____ birth date: ____/____/____

First and last name: _____ effective date: ____/____/1____ birth date: ____/____/____

First and last name: _____ effective date: ____/____/1____ birth date: ____/____/____

- Please remove the following dependent(s) from the above coverage

Please note: Employees can only terminate dependent(s) on the annual anniversary date or if a qualifying event occurs (they become covered by a plan through spouse).

First and last name: _____ effective date: ____/____/1____ birth date: ____/____/____

First and last name: _____ effective date: ____/____/1____ birth date: ____/____/____

First and last name: _____ effective date: ____/____/1____ birth date: ____/____/____

- Any other change(s) needed:

- Signature: _____

Please fax this completed form to the number listed below **AS THEY ARE COMPLETED!**

Phone 303-744-3007 * Toll free 1-800-807-0706 * Fax 303-744-8608