VANTAGE POINT DENTAL PLANS

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TDA Total Dental Administrators

DENTAL PLAN CHANGE FORM

1. Policy Holders Information

Policy Holders Name: _____ ID#: _____ Date of Birth: _____
(Located on ID Card)

POLICY HOLDER CHANGES

2. Name Changed From: _____ To: _____ Marital Status ☐ Legally Married ☐ Divorced ☐ Death

New Address: _____ Unit / Apt #: _____

City: _____ State: _____ Zip: _____ New Ph#: _____

ADD DEPENDENTS

3. (USE THIS SECTION ONLY TO ADD AN ELIGIBLE NEWBORN DEPENDENT, ADOPTED CHILD, CHILDREN OR OPEN ENROLMENT. APPLICATION MUST BE MADE WITHIN 31 DAYS FROM THE CHID'S DATE OF BIRTH, ADOPTION OR PLACEMENT OPEN ENROLMENT IS THE MONTH PRIOR TO YOUR ANNIVERSARY DATE THIS IS THE DATE YOU POLICY BECAME EFFECTIVE)

Last Name:	First Name:	Sex: M/F	Relationship:	Date of Birth :	Social Security Number:
			☐ Natural ☐ Adopted		
			☐ Natural ☐ Adopted		
			☐ Natural ☐ Adopted		

DELETE DEPENDENTS

Last Name:	First Name:	Sex: M/F	Relationship:	Date of Birth :	Social Security Number:
			☐ Natural ☐ Adopted		
			☐ Natural ☐ Adopted		
			☐ Natural ☐ Adopted		

PLAN CHANGE

4. **CHANGES TO YOUR PLAN WILL NOT GO INTO EFFECT UNTIL THE 1ST OF THE FOLLOWING MONTH AFTER THE CHANGE HAS BEEN MADE TO YOUR PLAN. ALL CHANGES ARE SUBJECT TO REVIEW AND CAN BE DENIED. ALL PLAN CHANGES ARE SUBJECT TO A ONE YEAR CONTRACT FROM THE DATE OF CHANGE.**

Please mark you change below:

☐ Vantage Choice
☐ Vantage Care

Fax or e-mail this form to:

Fax: 801-983-8009
E-mail: apps@vpdental.com

Change of Dentist:
Provider Code:
(Vantage Care Plan Only)

Other changes please list below:

CHANGE IN PAYMENT

5. ☐ Please change my form of payment to:

☐ Credit Card ☐ Checking / Savings Account **(Please attache a voided check when you fax, mail or e-mail this form)**

☐ Visa ☐ Master Card ☐ Discover

Card #_____ Expiration Date _____ / _____

Account Holder Name (PLEASE PRINT)_____

DISCONTINUANCE OF DENTAL BENEFITS

6. ☐ I wish to discontinue my dental benefits that I have received under contract with Total Dental Administrators (TDA) and its affilates. I understand that **I must fufill my one year contract before the discontinuance of benefits will take effect.** Discontinuance of benefits will take effect on the last day of the month following receipt and approval of the request by Total Dental Administrators and Vantage Point Dental Plans. I understand that no cancellation will be made on a retroactive basis.

SIGNATURE

By signing, you agree that the changes requested above are correct and subject to approval by Total Dental Admin, (TDA) and its affilates.

Policy Holders Signature _____ Date_____