Dental Change Form

Davidson County Schools

Ameritas Life Insurance Corp.

Social Security # _____

Name _____ 10-377272- _____

CHANGE PLAN ☐ Employee Only ☐ Employee/Child ☐ Employee/Spouse ☐ Employee/Family Effective Date _____

NAME CHANGE

Former Last Name _____ First Name _____ Middle Initial _____

Present Last Name _____ First Name _____ Middle Initial _____

Reason: _____ Effective Date _____

☐ **ADD** / ☐ **DROP DEPENDENT COVERAGE**

Name (Last, First, Middle)	Relationship	Sex	Date of Birth	Social Security #

Reason: ☐ Marriage ☐ Divorce ☐ Other _____ Effective Date _____

Was spouse covered for dental at his/her place of employment prior to request to be added? ☐ Yes ☐ No (If 'Yes', the following information is needed.)

Length of time spouse was insured under his/her employer's coverage: _____

Reason coverage stopped: _____ Date coverage stopped: _____

☐ **TERMINATE COVERAGE** Effective Date _____

EMPLOYEE _____ **DATE** _____ **SCHOOL** _____