GOLDEN WEST DENTAL & VISION

Fax Form To: (805) 987-7491 OR Mail To: Golden West Dental & Vision PO Box 5066 Oxnard CA 93031-5066

# EMPLOYEE CHANGE OF STATUS FORM

## To be completed by Employee

**Instructions:**

1. Complete Section 1 and any other applicable section(s), sign and date. Mail or fax this form along with any necessary supporting documentation to the address or number listed above.
2. If you are changing your name, please enter your prior name in Section 1 and your new name in Section 2 along with the reason for the name change.
3. If you are enrolled in the DHMO plan and are using this form to change or select a network provider for yourself and/or currently enrolled dependents, you only need to complete Section 1 and fill in names and provider numbers in Section 3. Please note that provider changes must be received by the 20th of the month in order to become effective the first of the following month. Each family member may select their own dentist, orthodontist, and vision provider (up to 3 providers of each type per family).

## 1. Employee Information

| Social Security/ID No | Last Name | First Name | MI | Effective Date of Change |
|---|---|---|---|---|
| | | | | / / |

| Name of Employer | Group No | Business Phone |
|---|---|---|
| Santa Barbara City College | 27167690001 | ( 805 ) 965-0581 |

## 2. Change Name/Address/Phone

| New Name | Reason for Name Change |
|---|---|
| | ☐ Marriage ☐ Divorce ☐ Other_____ |

| New Street Address | City/State/Zip | New Phone No |
|---|---|---|
| | | ( ) |

## 3. Add/Delete Dependent Coverage or Change/Select DHMO Providers (if employee is enrolled in the DHMO plan)

| Add/Delete | Last Name | First Name | MI | Gender | Date of Birth MM/DD/YY | Dentist# | Ortho# | Vision # |
|---|---|---|---|---|---|---|---|---|
| | Self | | | | | | | |
| ☐ Add ☐ Delete | Spouse/Domestic Partner | | | ☐ Male ☐ Female | | | | |
| ☐ Add ☐ Delete | Child | | | ☐ Male ☐ Female | | | | |
| ☐ Add ☐ Delete | Child | | | ☐ Male ☐ Female | | | | |
| ☐ Add ☐ Delete | Child | | | ☐ Male ☐ Female | | | | |

If adding spouse or domestic partner, please give reason: ☐ Marriage ☐ Domestic Partner Registration ☐ Court Order Date of Event: ___/___/___

☐ Birth/Adoption of Child ☐ Loss of Other Coverage ☐ Other (Please Explain) _____

If adding dependent child(ren), please give reason: ☐ Marriage ☐ Birth ☐ Adoption ☐ Court Order Date of Event: ___/___/___

☐ Other (Please Explain) _____

**Note: If dependent child is over the age of 19, a Dependent Verification Form will need to be completed and must accompany this form.**

If deleting dependent coverage, please give reason: ☐ Divorce ☐ Death ☐ Coverage Elsewhere Date of Event: ___/___/___

☐ Other (Please Explain) _____

## 4. Terminate Coverage While Actively Employed

I am actively employed and eligible for benefits through my employer named in Section 1. I wish to terminate the following coverage(s). I understand that coverage for any enrolled dependents will terminate on the same date. I understand that if I wish to re-enroll at a later date, I may be subject to waiting periods and/or reduced benefits, or my coverage could be denied. **Note: Coverage will be terminated on the last day of the month in which a completed request to terminate coverage is received.**

| Please terminate the following coverage(s): | Reason for termination: |
|---|---|
| ☐ Dental plan | ☐ I am covered under my spouse's employer-sponsored plan |
| ☐ Vision Plan 90GE or Vision Advantage | ☐ Other (please explain) _____ |

X_____ ___/___/___

*Signature of Employee* *Date (MM/DD/YY)*