DENTAL CHANGE REQUEST FORM

Please Note: You may change your enrollment with a participating dentist only once every 12 months.

Participant's Name: ______________________________

Telephone Number: ______________________________

Social Security Number: ______________________________

Employer: ______________________________

Current Dentist: ______________________________

Note: All financial responsibilities must be paid in full with your current dentist before a Dental Change will be made.

New Dental Selection: ______________________________
(Entire family will be changed collectively)

Please use the section below to explain why you are requesting a dental change:
(Please use the other side of paper if necessary)

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Signature: ______________________________ Date: ______________

Walton Campus — 3031B Walton Road — Plymouth Meeting, PA 19462 Phone 610-941-9400 — FAX 610-941-9602
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