

DENTAL CHANGE REQUEST FORM

Participant's Name: _____

Telephone No.: _____

Social Security No.: _____

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)

Below please explain why you are requesting a dental change:

Signature: _____ Date _____

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