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* ( )	

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)***