Administrative Services Only Dental Change Request

ASSURANT Employee Benefits

Plan number K1900450 Date _____

Employer name VICTOR TREATMENT CENTERS, INC. Telephone number _____

1. **EMPLOYEE TERMINATION OF EMPLOYMENT**

Employee SSN	Employee Name	Reason for Termination	Last Day Worked Mo	Day	Yr	Continuation Elected	COBRA Election Form Attached

2. **EMPLOYEE CHANGE OF NAME** *(Please print or type.)*

Old name _____ Effective date _____

New name _____ Employee Social Security no. _____

Reason: ☐ Married ☐ Divorced ☐ Other _____

3. **NEW ADDRESS**

Employee name _____ Employee Social Security no. _____

Street address _____ City, state, zip code _____

4. **REQUEST FOR COVERAGE STATUS CHANGE**

Employee name _____ Effective date _____

Employee Social Security no. _____

Add

Dependent name	Relationship	Date of Birth

If spouse being added due to marriage, date of marriage _____

***Delete:** ☐ Spouse Date of death or divorce _____ ☐ Children only ☐ All dependents

*Waiver (below) **must** be completed and signed by the employee for deletions.

5. **WAIVER OF DENTAL COVERAGE** *(Please print or type.)*

Effective _____, I _____ Social Security no. _____, wish to waive the following benefits to which I am eligible:

	Dental
Myself	
My spouse	
My child(ren)	

Because: ☐ Covered by spouse's employer ☐ Other *(Explain.)* _____

Name of spouse's employer _____ Name of spouse's insurance company _____

_____ _____

EMPLOYEE SIGNATURE DATE

_____ _____

EMPLOYER/ADMINISTRATOR SIGNATURE DATE

Products and services marketed by Assurant Employee Benefits are underwritten and/or provided by Union Security Insurance Company.

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