

Dental Source Dental Health Care Plans *Subsidiaries - SAFEGUARD - St. Louis Dental Service - Corporate Dental*
Membership Change Request Form

IMPORTANT - PLEASE READ Please complete the member information portion of this form regardless of your type of change. **Dental Source must receive all changes no later than the 25th of the month to be effective by the 1st of the following month.**

MEMBER INFORMATION:

Part 1	1. EMPLOYER NAME (if with a group plan) City of St. Louis		GROUP NUMBER	MEMBER NUMBER
	2. SOCIAL SECURITY NUMBER	3. NAME (LAST) (MI) (FIRST)		
	4. ADDRESS			
	(CITY)		(STATE)	(ZIP CODE)
	5. WORK PHONE	6. HOME PHONE	7. DATE OF BIRTH (month/day/year)	8. SEX <input type="checkbox"/> Female <input type="checkbox"/> Male

TYPE OF CHANGE:

- COBRA**
- DENTIST
- CONVERTING TO AN INDIVIDUAL PLAN
- ADDRESS
- DEPENDENT
- TERMINATION

OTHER (Explain)

REASON FOR CHANGE: - (Attach additional page if needed.)

DEPENDENT INFORMATION: (Dependents are defined as a spouse, legally dependent children to age 19 and full time college students to age 23.)

Part 2	NAME	DATE OF BIRTH	SEX	RELATION TO APPLICANT
	LAST FIRST MI			
<input type="checkbox"/> Add <input type="checkbox"/> Delete				
<input type="checkbox"/> Add <input type="checkbox"/> Delete				
<input type="checkbox"/> Add <input type="checkbox"/> Delete				

DENTIST INFORMATION:

Part 3	If changing dentists, please select a participating general dentist from the Dental Source network. Be sure that the dentist you select is accepting new patients. If you have questions regarding dentist in your area, please contact Dental Source at (816) 523-8900.	
	SELECTED DENTAL LOCATION NAME	OFFICE LOCATION NUMBER

Part 4	I HEREBY REQUEST THE ABOVE CHANGES BE MADE TO MY ACCOUNT WITH DENTAL SOURCE OF MISSOURI & KANSAS, INC.	
	SIGNATURE	DATE