Delta Dental of Wyoming
6234 Yellowstone Rd
Cheyenne, WY 82009
307-632-3313 * 800-735-3379
FAX 307-632-7309

Add/Delete/Change/Termination Form

Last Name First Name Middle Initial	Social Security Number	Group Name

Mailing Address	City	State	Zip

Changes to be made to coverage:

☐ Name Change:	☐ Change in type of coverage:
Previous/Former Name: _____	Reason for change: _____
Date Name Change effective: _____	Effective date of change: _____

☐ Termination: Effective date of termination: _____

If adding or removing Dependents – please list below (please attach another page for additional names)

Last Name First Name Middle Initial		Date of Birth
Relationship	☐ Add ☐ Delete	Effective Date
Last Name First Name Middle Initial		Date of Birth
Relationship	☐ Add ☐ Delete	Effective Date
Last Name First Name Middle Initial		Date of Birth
Relationship	☐ Add ☐ Delete	Effective Date
Last Name First Name Middle Initial		Date of Birth
Relationship	☐ Add ☐ Delete	Effective Date

Additional Information

Is your spouse employed? ☐ Yes ☐ No If Yes, where? _____	Does your spouse have a dental plan through their employer? ☐ Yes ☐ No

I hereby authorize my employer to make the necessary change(s) in my contributions under the Group Dental Contract issued to my employer resulting from the change above indicated. Under penalties of perjury, I declare that the information furnished above, to the best of my knowledge and belief is true, correct and complete.

Signature of Employee: _____ Date: _____