



Individual Change Form

Employers Dental Services

Mailing Address:
3430 E. Sunrise Dr. #160
Tucson, AZ 85718

Please print legibly.

- Change of dependent status
Change payment method
Change bank information (Attach Bank Draft Authorization)
Cancel coverage

Your name (last, first, middle initial)
Mailing address
City
Date of birth
Daytime telephone
Social Security number
State
ZIP code

Dependents - List all eligible dependents you wish to Add or Delete: (see definition of eligible dependent below)

Table with columns: Spouse, Domestic Partner, First name, Initial, Date of birth, Add, Delete. Rows for 1. Child, 2. Child, 3. Child.

Eligibility:

Eligible dependents include lawful spouse, domestic partner and children to age 26. Domestic Partners are required to sign an Affidavit of Domestic Partners (call EDS to obtain a form). Members may add dependents mid-year if a marriage occurs. Dependent's newborn or adopted children will be eligible immediately upon birth or placement of adoption. All newly eligible dependents must be added within 31 days of change. Dependent children must be removed when they are no longer eligible. Benefits are available at your selected contracted dental facility only.

I hereby agree to be bound by the terms of the EDS Individual Pre-paid Plan as set forth in the Dental Enrollment & Coverage Guide for EDS Individuals. I certify that the above information is correct.

Cancel coverage (Cancellation of coverage is effective the last day of your current contract year):

Reason for cancellation
Termination date

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

Signature required for all changes X
Date

All changes are effective on the first of the current month, if this change form is received by EDS on or before the 5th.

Mailing Address: EDS, 3430 E. Sunrise Dr. #160, Tucson AZ 85718 EDSCS@principal.com

1-800-722-9772 Fax: 1-866-814-8023

Return this form to EDS

Bank Draft Authorization

Employers Dental Services

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Bank Draft Authorization:

Monthly payments by credit card are not available.

Please complete this section to initiate monthly deduction from your bank account.

Bank name _____ Checking account Savings account

Routing number (Transit/ABA number) _____

Account number _____

ACH Debits: Employers Dental Services ID Number: 1860328922

I (we) hereby authorize Employers Dental Services, hereinafter called COMPANY, to initiate debit entries to my (our) bank account indicated above and the depository named above, hereinafter called DEPOSITORY, to debit the same to such account.

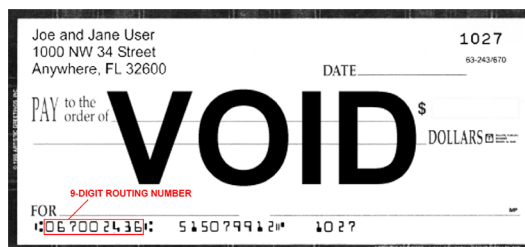
This authority is to remain in full force and effect until COMPANY and DEPOSITORY has received written notification from me (or either of us) of its termination in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it. I (or either of us) have the right to stop payment of a debit entry by notification to DEPOSITORY at such time as to afford DEPOSITORY a reasonable opportunity to act on it prior to charging account. After account has been charged, I have the right to have the amount of an erroneous debit immediately credited to my account by DEPOSITORY, provided I (we) send written notice of such debit entry in error to DEPOSITORY within 15 days following issuance of the account statement or 45 days after posting, whichever occurs first. **All deductions will be made from your savings or checking account between the 15th and 20th of each month.** A return item charge will be assessed if an automatic deduction is returned unpaid; the amount of the charge will be at the rate in effect at the time the item is returned to EDS.

Signature _____ Date _____

Print Name _____ Phone _____

Please write VOID on a blank check and attach here

Example



For assistance call Customer Service at 800-722-9772