California DENTAL NETWORK, INC

CHANGE OF STATUS FORM

Please print or type

Effective Date: / /	Group #

Social Security No. | Last Name | First | Initial | Birthday | Home Phone No. ( )

Address | City | Zip Code | *Language

Employer's Name | Work Phone ( )

- ☐ **Cancel Coverage**
- ☐ **Add Coverage for One or More Family Members**
- ☐ **Cancel Coverage for One or More Family Members**
- ☐ **Change Dental Office**
- ☐ **Change of Address**

Last Name (If different)	First	Birthday	Language	Last Name (If different)	First	Birthday	Language
Spouse:		/ /		Child:		/ /	
Child:		/ /		Child:		/ /	
Child:		/ /		Child:		/ /	

Plan	On behalf of the above named individuals, I hereby apply for enrollment in CDN and certify that the above information is true and correct. NOTICE: BY SIGNING THIS APPLICATION YOU ARE AGREEING TO HAVE ANY DISPUTE WITH THE PLAN, INCLUDING MEDICAL MAL PRACTICE, DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR CONSTITUTIONAL RIGHT TO A JURY OR COURT TRIAL. SEE THE COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM FOR DETAILS.
Dental Office #	

Applicant's Signature **Date**