



## Miami-Dade County MEDICAL, DENTAL & VISION PLANS STATUS CHANGE FORM

**For Office Use Only**  
 FLEX APPROVAL: YES NO  
 Effective Date: \_\_\_\_\_  
 Group #: \_\_\_\_\_

Employee's Last Name	First	MI	Social Security #
Medical Plan:			
Dental Plan:			
Vision Plan:			

ADDITIONS			
<b>SPOUSE</b> (check appropriate box) <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION	Name of spouse	Social Security #	Date of Birth
	Date of Marriage	Name of Spouse's Employer	
	Dentist Name and Facility #	PCP Name and Provider #	

<b>CHILD</b> (check appropriate box) <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION	Name	Sex	Social Security #	Date of Birth	Relationship	Dental Facility #	PCP Provider #
	1)						
	2)						
	3)						

DELETIONS					
COMPLETE FOR DELETIONS	Name(s) To Be Deleted (First, M., Last)	Medical/Dental/Vision	Date of Birth	Relationship	Sex
	1)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/> Male <input type="checkbox"/> Female
	2)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/> Male <input type="checkbox"/> Female
	3)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/> Male <input type="checkbox"/> Female
	4)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/> Male <input type="checkbox"/> Female
REASON FOR DELETION	<input type="checkbox"/> Age <input type="checkbox"/> Divorce <input type="checkbox"/> Marriage <input type="checkbox"/> Death <input type="checkbox"/> Other – Please explain:				

OTHER CHANGES	Name of Member	Date of Birth	Dental Facility #	PCP Provider #
<b>CHANGE OF PROVIDER</b>	1)			
	2)			
	3)			

CHANGE OF ADDRESS	New Address (Include Zip Code)	Home Phone Number
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CHANGE OF NAME	From:	To:
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Signature of Employee	Date
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