

Underwritten by:  
**World Insurance Company**  
P.O. Box 3160  
Omaha, Nebraska 68103-0160

## Individual Dental Change Request Form

Administered by:  
**Meritain Health** – Eligibility Department  
P.O. Box 27810  
Minneapolis, MN 55427-0810  
(800) 765-4224 (Toll-Free)

### Insured Information

Reason for Change:  Dependent Addition  Dependent Termination  Name/Address Change  
 Termination – Reason \_\_\_\_\_  
Date of Birth, Adoption, Marriage, or Other Event: \_\_\_\_\_

Last Name	First Name	M.I.	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No.	Birth Date
Home Street Address				Home Phone ( )	
City	State	ZIP	Work Phone ( )		

### Family Information – List only those eligible family members who are enrolling.

Relationship	Last Name	First Name	M.I.	Birth Date	Sex	Full-Time Student?
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No

### Authorization

I authorize World Insurance Company, or its designee, to make the changes requested above.

Signature \_\_\_\_\_ Date \_\_\_\_\_

W1232 (3-08)

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