Dental Source Dental Health Care Plans

Membership Change Request Form

Subsidiaries – SAFEGUARD - St. Louis Dental Service - Corporate Dental

IMPORTANT - PLEASE READ Please complete the member information portion of this form regardless of your type of change. If you are changing checking accounts, or are converting from your employer's plan to an Individual plan and wish to have your membership fees paid through monthly bank draft, please complete the authorization for electronic monthly installments on the back of this form. ***All changes must be received by Dental Source no later than the 25th of the month to be effective by the 5th of the following month.***

MEMBER INFORMATION:

Part 1

1. EMPLOYER NAME (if with a group plan)		GROUP NUMBER	MEMBER NUMBER
2. SOCIAL SECURITY NUMBER	3. NAME (MI)	(LAST)	(FIRST)
4. ADDRESS			
(CITY)		(STATE)	(ZIP CODE)
5. WORK PHONE	6 HOME PHONE	7. DATE OF BIRTH (month/day/year)	8. SEX ❑ Female ❑ Male

TYPE OF CHANGE:

- ❑ DENTIST
- ❑ CONVERTING TO AN INDIVIDUAL PLAN
- ❑ ADDRESS
- ❑ DEPENDENT
- ❑ CHANGING CHECKING ACCOUNTS
- ❑ TERMINATION
- ❑ OTHER (Explain)

REASON FOR CHANGE: - (Attach additional page if needed.)

DEPENDENT INFORMATION: (Dependents are defined as a spouse, legally dependent children to age 19 and full time college students to age 23.

Part 2

	NAME LAST FIRST MI	DATE OF BIRTH	SEX	RELATION TO APPLICANT
❑ Add ❑ Delete				
❑ Add ❑ Delete				
❑ Add ❑ Delete				
❑ Add ❑ Delete				

DENTIST INFORMATION:

Part 3

If changing dentists, please select a participating general dentist from the Dental Source network. Be sure that the dentist you select accepts the plan you select and is accepting new patients. If you have questions regarding dentist in your area, please contact Dental Source at (816) 523-8900.	
SELECTED DENTAL LOCATION NAME	OFFICE LOCATION NUMBER

Part 4

I HEREBY REQUEST THE ABOVE CHANGES BE MADE TO MY ACCOUNT WITH DENTAL SOURCE OF MISSOURI & KANSAS, INC.	
SIGNATURE	DATE

BANK ACCOUNT INFORMATION

Authorization For Electronic Monthly Installments:

Complete this portion of the change form **ONLY** if you wish to pay for membership through automatic monthly bank draft. The Automatic Bank drafts are processed on the 15th of every month. However, if the 15th falls on a Saturday, Sunday or bank holiday, the draft will be processed on the following business day.

PLEASE INCLUDE A VOIDED CHECK OR DEPOSIT SLIP

I hereby request and authorize Dental Source of Missouri & Kansas, Inc. to deduct a monthly membership fee from my account with the financial institution named below. This authority is to remain in effect until revoked by me in writing and until said written notice is actually received by Dental Source of Missouri & Kansas, Inc. I agree that Dental Source of Missouri & Kansas, Inc. shall be under no liability whatsoever upon processing these payments in accordance with said terms.

Bank Name Address City/State/Zip

_____ _____ _____

Routing Code Account Number Checking Savings

X_____

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MEMBER'S SIGNATURE DATE

ACH Electronic Draft Indemnification Agreement for your Financial Institution:

In consideration for your honoring pre-authorized payments drawn against depositors of your financial institution for the payment of membership fees to Dental Source of Missouri & Kansas, Inc. we agree that no liability or responsibility lapses shall be attached to your financial institution as a result of honoring such payments. We further agree to hold you harmless from and reimburse you for any loss resulting as a consequence to your agreement to honor such payments, and we shall defend any such action brought against you as a result of your agreement to honor such payments. This agreement was authorized in a resolution adopted by the Board of Directors of Dental Source of Missouri & Kansas, Inc.

CREDIT CARD INFORMATION

Authorization for Annual Credit Card Payment:

Complete this portion of the change form ONLY if you wish your membership fees to be charged to you and your **VISA** or **MASTERCARD.**

___**VISA** ___**MASTERCARD** Card Number:_____Expiration Date:_____

I hereby request and authorize Dental Source of Missouri & Kansas, Inc. to charge the credit card account listed above the annual membership fee to activate my membership with Dental Source of Missouri & Kansas, Inc. I understand that if, for whatever reason, the charge to the account listed above cannot be processed, benefits under the Dental Source program will not be activated and that I will be contacted by Dental Source for alternative payment options.

X_____

MEMBER'S SIGNATURE DATE