UFCW LOCAL 1776 AND PARTICIPATING EMPLOYERS
HEALTH AND WELFARE FUND

DENTAL CHANGE REQUEST FORM

Please Note: You may change your enrollment with a participating dentist only once every 12 months.

Participant's Name: _____

Telephone Number: _____

Social Security Number: _____

Employer: _____

Current Dentist: _____

Note: All Financial responsibilities must be paid in full with your current dentist before a Dental Change will be made.

New Dental Selection and #: _____

(Entire family will be changed collectively)

Please use the section below to explain why you are requesting a dental change:

_____

_____

_____

_____

_____

_____

Signature: _____ Date: _____

Walton Campus — 3031B Walton Road — Plymouth Meeting, PA 19462 Phone 610-941-9400 — FAX 610-941-9602
www.ufcw1776benefitfunds.org