

## PrimeStar Dental Plan Change Request Form

Use this form to notify us of a change in your coverage. A change of coverage can be:

- Dependent Termination or Dependent Addition
- Address Change
- Name Change
- Termination of Coverage

Complete the attached form and mail it to:

**Security Life Insurance Company of America  
P.O. Box 1064  
Schenectady, NY 12301**

If you have any questions concerning this form or making changes to your coverage call:

**(877) 862-8949 (toll free)**

PrimeStar Dental Plan				Change Request Form		
Underwritten by: Security Life Insurance Company of America - Minnetonka, MN						
Submit completed form to: PO Box 1064 - Schenectady - NY - 12301 - (877) 862-8949 (toll free)						
<b>INSURED INFORMATION</b>						
Reason for Change: <input type="checkbox"/> Dependent Addition <input type="checkbox"/> Dependent Termination <input type="checkbox"/> Name/Address Change <input type="checkbox"/> Termination - Reason:						
Date of Change: _____						
Last Name		First Name		M. I.	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth date
Home Street Address					Home Phone ( )	
City		State		Zip	Work Phone ( )	
<b>FAMILY INFORMATION List only those eligible family members who are enrolling.</b>						
Relationship	Last Name	First Name	M. I.	Birth date	Sex	Full-Time Student?
I authorize Security Life Insurance Company of America, or its designee, to make the changes requested above.						
Signature: _____				Date: _____		
Form #S10673				Rev 10/2010		