

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 Health Insurance Company of America, New York, Inc.
P.O. Box 1064
Schenectady, NY 12301**

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

(877) 230-1024 (toll free)

PrimeStar Dental Plan				Change Request Form		
Underwritten by: Security Health Insurance Company of America, New York, Inc.						
Submit completed form to: PO Box 1064 - Schenectady - NY - 12301 - (877) 230-1024 (toll free)						
INSURED INFORMATION						
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 ()	
FAMILY INFORMATION List only those eligible family members who are enrolling.						
Relationship	Last Name	First Name	M. I.	Birth date	Sex	Full-Time Student?
I authorize Security Health Insurance Company of America, New York, Inc. or its designee, to make the changes requested above.						
Signature: _____				Date: _____		
Form #S10673						