SEIU 775
BENEFITS GROUP

Dental Change Form

To change your current dental carrier, please fill out and return the form below. If you have any questions, please contact the Member Resource Center at 1-866-371-3200.

Due: July 20, 2019: For coverage starting in August.

PERSONAL INFORMATION			
First Name	Last Name		
Street Address			
City	State	Zip	
Phone:	Social Security Number	☐ Male ☐ Female	Date of Birth (Month/Day/Year)
Agency / Payee Number			

I want to change my dental insurance carrier to: (check one)

☐ Delta Dental ☐ Willamette Dental

Your dental change will take place the first of the month following the date your change form is received by the Trust Office. You will not be able to change your dental carrier again until 12 months after your change has taken place.

Your Signature: _____ Date: _____

Please mail, fax or email your form to Zenith American Solutions, your benefits administrator by July 20th for August coverage.
If you have any questions, please call the Member Resource Center at 1-866-371-3200.

Mail to:
Zenith American Solutions, Inc
11724 NE 195th Street, Suite 300
Bothell, WA 98011-3145

Fax to:
(206) 298-3424

Email to:
SEIU-HBT@Zenith-American.com