



INFORMATION CHANGE FORM

Please complete this form with all applicable information necessary to process your request. Submit by fax to 813-490-0093, mail to: 4010 W. State St., Tampa, FL 33609 or email to customer.care@argusdental.com.

Group Number: _____ Group Name: _____

Member ID Number: _____ Effective Date of Change: _____

Type of change: Name Address/Phone Dentist Termination Request Dependent coverage Other _____

Member Name: _____ Previous Name (if name change applies): _____

Current Address: _____

Current City, State and Zip: _____

Previous Address (if address change applies): _____

Previous City, State and Zip: _____

Current Telephone Number: () _____ - _____ Previous Telephone Number (if phone # change applies): () _____ - _____

IF CHANGING DENTAL OFFICES, PLEASE COMPLETE THE FOLLOWING:

Provider Number of New Dentist: _____ Dentist Name: _____

IF CHANGING DEPENDENT INFORMATION, PLEASE COMPLETE THE FOLLOWING:

Add or Remove	Last Name	First Name	Date of Birth	Relationship	Provider # of Dentist	Provider # of 2 nd choice Dentist