



## ***Dental & Vision Change Request Form***

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

e-mail: \_\_\_\_\_

### **DENTAL PLAN CHANGE SELECTIONS**

**From Old Plan Selection**

**Delta DHMO**

**Delta PPO**

**To New Plan Selection**

**Delta DHMO**

**Delta PPO**

### **DENTAL PLAN DEPENDENT SELECTIONS**

**Add Dependent**

**Name:** \_\_\_\_\_

**Social Sec #:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Delete Dependent**

**Name:** \_\_\_\_\_

**Social Sec #** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

### **VISION SERVICE PLAN CHANGE SELECTION**

**Add Dependent**

**Name:** \_\_\_\_\_

**Social Sec #:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Delete Dependent**

**Name:** \_\_\_\_\_

**Social Sec #** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

You can mail / fax / e-mail these documents to:

Vantage Business Support & Insurance Services  
CAFCC Benefits Program  
2363 Mariner Square Dr., Ste. 240  
Alameda, CA 94501

Fax: 510-595-0930

e-mail: [stevec@vantagebss.com](mailto:stevec@vantagebss.com)