

Dental Wellness Plan (DWP): Plan Change Form

Only fill out this form if you want to change your dental plan.

If you are satisfied with your current plans, you do not need to complete this form.

Fields marked * are required.

Name of Person	Date of Birth* (MM/DD/YY)	ID Number*	Check One Dental Plan
			<input type="checkbox"/> Delta Dental of Iowa <input type="checkbox"/> DentaQuest
			<input type="checkbox"/> Delta Dental of Iowa <input type="checkbox"/> DentaQuest
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			<input type="checkbox"/> Delta Dental of Iowa <input type="checkbox"/> DentaQuest
			<input type="checkbox"/> Delta Dental of Iowa <input type="checkbox"/> DentaQuest

Reason for changing your dental plan: _____

Your name*

Your address: Street, City, Zip Code*

Your phone number

***YES I am authorized to make changes on this account. I understand that by completing this form and submitting it to Member Services, I am changing the plans for the person(s) listed above.**

If you have questions about how to complete this form, call Member Services at 1-800-338-8366 or locally in the Des Moines area at 515-256-4606, Monday through Friday from 8 a.m. – 5 p.m.