City of Tallahassee Delta Dental
Retiree Member Status Change Form

Employee Number	Last Name	First Name

Please change my current dental plan to:	
	PPO COPAY
	PPO PREMIER
	PPO PLUS

Please delete the following dependents from my dental plan:		
Relationship	**Last, First Name**	**Date of Birth**
Spouse		
Child		
Child		
Child		

I hereby authorize any payroll deduction that may be required towards the cost of this coverage.

	Please cancel coverage for myself and all dependents (if any).

_____ _____

Signature Date