Florida Combined Life
Dental Division
P.O. Box 45132
Jacksonville, Florida 32232-9902

CHECKLIST for RELOCATION/CHANGE OF ADDRESS or REMOVING A LOCATION

Please complete all sections of the Relocation/Change of Address or Removing a Location package.
Applications submitted with incomplete and/or missing information will delay processing your request. The **Dentist's Signature** is required. Faxed, scanned or emailed forms are acceptable. Stamped signatures ***are not*** accepted.

☐ **Provider Information Change Form:**
Clearly print or type information in **each** section of the form.
Please include an explanation in the **Comment** Section for these changes.

☐ **IRS Form W-9:** Complete, sign and return, with the practice information.

Any questions may be directed to your **Provider Network Manager**. A letter will be sent to you confirming the effective date.

You may submit completed forms using **any** of the following methods:

Mail To: Florida Combined Life
Dental Division
P.O. Box 45132
Jacksonville, Florida 32232-9902

Email To: DentalProviderRelations@FCLife.com
Fax To: (904)866-4846