Medical and Dental Enrollment/Change Form

EVENT TYPE This form needs to be submitted within 30 days of your date of hire or life event. The update in insurance will take effect on the day of the life event.				
☐ New Hire/Rehire	Life Event (please check one) / Life Event Date:			
	☐ Marriage	☐ Birth/adoption	☐ Divorce	☐ Loss/Gain other coverage
☐ Update Personal Information (complete PERSONAL section)				

EMPLOYEE INFORMATION		
Name (Last, First)		A-Number
Gender	Birthdate	Date of Hire
Address, City, State, Zip		
Email Address	Phone	

Dual Coverage	
Do you have a spouse that is an employee of USU and you are electing a **DUAL** medical & dental plan? (If you are electing a **DUAL** plan please make sure to list your spouse's information, including A# below)	**Yes/No**

Medical Coverage Plan Election		Network Selection *If you do not make a selection you will automatically be enrolled into the Preferred ValueCare.	
Choice High Deductible Health Plan (HDHP) (not eligible for **DUAL**)	☐	Preferred ValueCare (PVC) Network	☐
Wellness Plan (White Plan)	☐	Participation (PAR) Network	☐
High Premium Plan (Blue Plan)	☐	**Medical Coverage - Level Election**	
WAIVE MEDICAL COVERAGE	☐	Employee Only	☐
		Employee + 1	☐
		Employee + 2 or more	☐

Coordination of Benefits – Will you or your dependents have other insurance while on the USU plan?		Dental Coverage – Level election	
Yes, Medical insurance	☐	Employee Only	☐
Yes, Dental insurance	☐	Employee + 1	☐
No other Medical or Dental insurance	☐	Employee + 2 or more	☐
		WAIVE DENTAL COVERAGE	

Dependents*

*Please provide proof of the relationship between the employee and dependent(s) listed below (e.g. birth certificate, marriage certificate or adoption documents.

Name	Dental	Medical	Gender	Birthdate	Social Security Number	A#	Relationship*
	☐	☐	M/ F				
	☐	☐	M/ F				
	☐	☐	M/ F				
	☐	☐	M/ F				
	☐	☐	M/ F				
	☐	☐	M/ F				

Signature:_____ **Date:**_____