



Medical and Dental Enrollment/Change Form

Employee Name: _____ A-Number: _____

Check the appropriate box(es) below and complete the required section(s).

- New/Open Enrollment** (complete ALL sections)
 Update Personal Information (complete PERSONAL section)
 Change Plan, Network, Coverage (complete CHANGE and PLAN section)
 Add or Update Dependents (complete DEPENDENTS section)

PERSONAL	Gender	Birthdate	Date of Hire
	Address, City, State, Zip		
	Email Address		Phone
CHANGE REASON	Circle One: New Employee Divorce Lost or Gained Other Coverage Court Order Birth or Adoption Death Marriage Other		This form needs to be submitted within 30 days of your date of hire or change reason. The update in insurance will take effect on the day of the change. Please Indicate Effective Date: _____

PLAN	<u>Medical Plan</u>	
	High Deductible Health Plan (HDHP)	_____
	Wellness Plan (White Plan)	_____
	High Premium Plan (Blue Plan)	_____
	WAIVE MEDICAL COVERAGE	_____
	<u>Will you or your dependents have other insurance while on the USU plan?</u>	
	Yes, Medical insurance	_____
	Yes, Dental insurance	_____
No other Medical or Dental insurance	_____	

<u>Network Selection</u>	
<i>(If you do not make a selection you will automatically be enrolled into the Preferred ValueCare network)</i>	
Preferred ValueCare (PVC) Network	_____
Participating (PAR) Network	_____
<u>Dental Plan</u>	
Employee Only	_____
Employee Plus One	_____
Employee Plus Two or More	_____
WAIVE DENTAL COVERAGE	_____

DEPENDENTS*	Name	Dental	Medical	Gender	Birthdate	Social Security Number	Relationship*
		<input type="checkbox"/>	<input type="checkbox"/>	M/ F			
		<input type="checkbox"/>	<input type="checkbox"/>	M/ F			
		<input type="checkbox"/>	<input type="checkbox"/>	M/ F			
		<input type="checkbox"/>	<input type="checkbox"/>	M/ F			
		<input type="checkbox"/>	<input type="checkbox"/>	M/ F			
		<input type="checkbox"/>	<input type="checkbox"/>	M/ F			

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

Signature: _____ Date: _____

*Please Return Form to Human Resources
 In Person: Northwest corner of 1200 E and 700 N, Logan Campus
 Mail: 8800 Old Main Hill, Logan UT 84322-8800
 Fax: 435-797-1816*