DUAL Medical and Dental Enrollment/Change Form

Employee Name: _____ A-Number:_____

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 Medical Plan, Network Selection, or Dental Plan** (complete PLAN section)
☐ **Update Dependents** (complete DEPENDENTS section)

PERSONAL

Gender	Birthdate	Date of Hire	Employee Social Security Number
Address, City, State, Zip			
Email Address			Phone

PLAN

Select a Medical Plan	
None	_____
Wellness Plan (White Plan)	_____
High Premium Plan (Blue Plan)	_____

Network Selection *(If you do not make a selection you will automatically be enrolled into the Preferred ValueCare network)*	
Preferred ValueCare (PVC) Network	_____
Participating (PAR) Network	_____

Will you or your dependents have other insurance while on the USU plan?	
Yes, Medical insurance	_____
Yes, Dental insurance	_____
No other Medical or Dental insurance	_____

Dental Plan	
None	_____
Employee Only	_____
Employee Plus One	_____
Employee Plus Two or More	_____

DEPENDENTS*

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