



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.

<input type="checkbox"/> New Hire/Rehire	Life Event (please check one) / Life Event Date:			
	<input type="checkbox"/> Marriage	<input type="checkbox"/> Birth/adoption	<input type="checkbox"/> Divorce	<input type="checkbox"/> Loss/Gain other coverage
	<input type="checkbox"/> 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
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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)	<input type="checkbox"/>	Preferred ValueCare (PVC) Network	<input type="checkbox"/>
Wellness Plan (White Plan)	<input type="checkbox"/>	Participation (PAR) Network	<input type="checkbox"/>
High Premium Plan (Blue Plan)	<input type="checkbox"/>	Medical Coverage - Level Election	
WAIVE MEDICAL COVERAGE	<input type="checkbox"/>	Employee Only	<input type="checkbox"/>
		Employee + 1	<input type="checkbox"/>
		Employee + 2 or more	<input type="checkbox"/>

Coordination of Benefits – Will you or your dependents have other insurance while on the USU plan?

Dental Coverage – Level election

Yes, Medical insurance	<input type="checkbox"/>	Employee Only	<input type="checkbox"/>
Yes, Dental insurance	<input type="checkbox"/>	Employee + 1	<input type="checkbox"/>
No other Medical or Dental insurance	<input type="checkbox"/>	Employee + 2 or more	<input type="checkbox"/>
		WAIVE DENTAL COVERAGE	<input type="checkbox"/>

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*
	<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				

Signature: _____ Date: _____