



Medical and Dental Enrollment/Change Form

This form needs to be submitted within 30 days of your hire date or life event. The change in insurance will take effect on the day of the life event.

EVENT TYPE: (select one)					LIFE EVENT DATE: _____	
New Hire/Rehire	Marriage	Birth/adoption	Loss/Gain other coverage	Divorce / Term Partnership		

EMPLOYEE INFORMATION		
Name (Last, First)	Employee A#	
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 the DUAL plan please make sure to list your spouse's information in the dependent section below)	<input type="checkbox"/> Yes <input type="checkbox"/> No

MEDICAL COVERAGE			
PLAN SELECTION		NETWORK SELECTION	
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	

PLAN SELECTION		DENTAL COVERAGE	
		Dental Coverage - Level Election	
USU Dental Plan		Employee Only	
WAIVE DENTAL COVERAGE		Employee + 1	
		Employee + 2 or more	

DEPENDENTS							
*Please provide documentation of the relationship between the employee and dependent(s) listed below (e.g. copy of birth certificate, marriage certificate or adoption)							
Name	Dental	Medical	Sex	Birthdate	Social Security Number	A# or F#	Relationship

I understand there is a Summary Plan Document (SPD), which is available to me at <https://hr.usu.edu/benefits/healthcare/index>. The SPD describes the terms and benefits of coverage available through Utah State University.

Employee Signature: _____ Date: _____