

Section A

Employee and Coverage Information

New Enrollment  Change Requested (Please specify type): \_\_\_\_\_

Important Note:

Changes made on this form will affect your medical and dental coverages only. If you need to make changes to other coverages, please complete the appropriate forms for those plans.

EMPLOYEE NAME (last, first, middle initial)	SOCIAL SECURITY NUMBER	BIRTH DATE (mm/dd/yy)	MARITAL STATUS	GENDER
MAILING ADDRESS	CITY / STATE / ZIP	HOME PHONE	<input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Male <input type="checkbox"/> Female
EMPLOYER		WORK PHONE	HIRE DATE (mm/dd/yy)	

<b>Group Medical</b> (check one) <sup>1</sup>	<b>COVERAGE TYPE</b> (check one)	<b>Group Dental</b> (check one)	<b>COVERAGE TYPE</b> (check one)
<input type="checkbox"/> Preferred Medical Care <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2 <input type="checkbox"/> Option 3 <input type="checkbox"/> High Deductible Health Plan (HDHP) 2	<input type="checkbox"/> Employee only <input type="checkbox"/> Employee plus one dependent <input type="checkbox"/> Employee plus two or more dependents	<input type="checkbox"/> Preferred Choice Dental Care <input type="checkbox"/> Traditional Dental <input type="checkbox"/> No dental coverage at this time	<input type="checkbox"/> Employee only <input type="checkbox"/> Employee plus one dependent <input type="checkbox"/> Employee plus two or more dependents
<input type="checkbox"/> Summit Care <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2 <input type="checkbox"/> Option 3 <input type="checkbox"/> High Deductible Health Plan (HDHP) 2			
<input type="checkbox"/> Advantage Care* <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2 <input type="checkbox"/> Option 3 <input type="checkbox"/> High Deductible Health Plan (HDHP) 2			
<input type="checkbox"/> No medical coverage at this time			
<input type="checkbox"/> I will not be opening a Health Savings Account (HSA) with Utah Retirement Systems (URS) at this time			

1. If you have had previous health coverage within the last 9 months, please attach a Certificate of Creditable Coverage from your former insurance company.  
 \* This plan is offered in specific geographic areas. Please check the specific plan information before enrolling.  
 2. If you elect to participate in the URS HSA, you must complete an enrollment form for that program.

Section B

Dependent Information  
 ADDITIONS

Complete the table below listing your eligible dependents. If adding a new spouse, please include date of marriage, and copy of marriage certificate. If dependents are stepchildren, natural children not living with both parents, or classified as other relationship please provide supporting documentation, i.e. divorce decree, court orders, birth certificate, etc. If you don't have supporting documentation please explain in Section D.

RELATIONSHIP TO EMPLOYEE	FULL NAME OF DEPENDENTS (last, first, middle initial)	MARRIAGE DATE (mm/dd/yy)	GENDER	BIRTH DATE			DEPENDENT SOCIAL SECURITY NO.	COVERAGE DESIRED	
				Month	Day	Year		Medical	Dental
CODE KEY	S		<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Medical <input type="checkbox"/> Dental	
S - Legal Spouse			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Medical <input type="checkbox"/> Dental	
C - Child Natural / Adopted			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Medical <input type="checkbox"/> Dental	
SC - Stepchild			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Medical <input type="checkbox"/> Dental	
O - Other (Describe in Section D)			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Medical <input type="checkbox"/> Dental	
			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Medical <input type="checkbox"/> Dental	

Are you, your spouse or dependents covered by any other health or dental plan or by Medicare?  Yes  No If yes, complete Section C

REMOVALS

Fill out the table below if you are terminating coverage for dependents who are no longer eligible. If termination is a result of a divorce, a copy of your divorce decree is required.

RELATIONSHIP TO EMPLOYEE	DEPENDENTS TO NO LONGER BE COVERED (last, first, middle initial)	DEPENDENT SOCIAL SECURITY NO.	REASON FOR TERMINATION (i.e. marriage, divorce, death, age of 26, etc.)	APPLICABLE DATE*		
				Month	Day	Year
CODE KEY						
S - Spouse						
C - Child Natural / Adopted						
SC - Stepchild						
O - Other (Describe in Section D)						

\*Applicable Date could be date of marriage, divorce, birthday, etc.

