

Utah Local Governments Trust

Local Governments Vision Enrollment/ChangeForm

P.O. Box 540610
 North Salt Lake, UT 84054-0610
 Customer Service: (801) 936-6400 / Toll Free (800) 748-4440

Employee and Coverage Information:

Important Note: Changes made on this form will affect your vision coverage only. If you need to make changes to other coverage, please complete the appropriate forms for those plans.

New Enrollment **Change Requested-Please specify type:** _____

Employee Name (last, first, middle initial)	Social Security Number	Birth Date (mm/dd/yy)	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single
Home Address	City/State/Zip	Home Phone	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Employer	Coverage Level <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee plus one dependent <input type="checkbox"/> Employee plus two or more dependents	Work Phone	Hire Date

Dependent Information:

Additions Only

Please complete the section below listing your eligible dependents. If adding a new spouse, please include date of marriage.

Relationship S = Legal Spouse C = Natural/Adopted SC = Stepchild O = Other	Full Name of Dependent to be added to coverage (last, first, middle initial)	Marriage Date (spouse only)	Birth Date (mm/dd/yy)	Dependent Social Security Number

Deletions Only

Complete if terminating coverage for dependents that are no longer eligible (if divorce and children are involved, provide copy of divorce decree)

Relationship S = Legal Spouse C = Natural/Adopted SC = Stepchild O = Other	Name of Dependent to be deleted from coverage (last, first, middle initial)	End Date of Coverage (mm/dd/yy)	Reason for Termination	Dependent Social Security Number

Employee Agreement and Signature:

Before signing, make sure all applicable sections are completed so your enrollment is not delayed. You may be asked to provide additional information and/or documentation. Please note: It is the employee's responsibility to notify the Utah Local Governments Trust Vision Program within 60 days of any change affecting dependent eligibility i. e. birth, marriage, divorce, etc.

I represent that all information is true and correct. I understand and agree that any false information that I provide on this form may, at ULGT's sole discretion, result in a limitation or termination of my coverage. By signing below I hereby: (1) authorize the deduction of vision contributions through the provisions of IRC Section 125 Flexible Benefits; (2) authorize ULGT to release information to vision providers, insurance entities, or other entities necessary to process claims and to administer the Vision Plan; (3) certify all dependents listed are eligible for coverage; (4) understand if ULGT is not notified that a dependent is ineligible and subsequent claims are paid, I will be responsible for reimbursement to ULGT for any claims paid in error.

Employee Signature: _____ Date: _____
 (Please make copy for your records)