

Appendix Number 27

EMPLOYEE INFORMATION/CHANGE OF STATUS FORM
(Employee must complete within 10 days of any Change of Status)

1. EMPLOYEE'S NAME and ADDRESS: (Please Complete)

	<u>OLD</u>	<u>CURRENT</u>
FULL NAME:	_____	_____
STREET ADDRESS:	_____	_____
CITY, STATE, ZIP CODE:	_____	_____
TELEPHONE NUMBER:	_____	_____

Is the above information releasable to the public? (Please circle one) Yes No

2. EMPLOYEE'S MARITAL STATUS: (Please Circle One)

SINGLE MARRIED SEPARATED DIVORCED WIDOW(ER)

SPOUSE'S NAME, if applicable: _____

CHILDREN'S NAMES and their AGES: _____

_____	_____
_____	_____
_____	_____

3. EDUCATION: _____

4. I understand that it is my responsibility to notify Tremonton City in writing of any, and all, changes to the above information within ten (10) days of the occurrence of such changes.

Employee's Signature

Date

Notes:



REV 02-12.1

A27-2



Notes:



GROUP DENTAL ENROLLMENT FORM

<input type="checkbox"/> New Employee	<input type="checkbox"/> Add Coverage	<input type="checkbox"/> Add/Delete Dependent	<input type="checkbox"/> Address/Name Change	<input type="checkbox"/> Cancel Coverage
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Loss of Other Coverage	<input type="checkbox"/> Transfer From DHMO	<input type="checkbox"/> Transfer From PPO	<input type="checkbox"/> COBRA Enrollment

Name of Employer: (Use Name from Group Billing Notice or Master Application) <div style="text-align: center; font-weight: bold; font-size: 1.2em;">Tremonton City</div>	Group Number: 	Class:
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Plan Types:

TDA - PPO/MAC

<u>Social Security Number</u>	<u>Effective Date</u> Month / Day / Year	<u>Date Employed Fulltime</u> Month / Day / Year	<u>Hours Worked Per Week</u>
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<u>Your Name (Last), (First), (MI)</u>	<u>Date of Birth</u> Month / Day / Year	Sex: Male: <input type="checkbox"/> Female: <input type="checkbox"/>
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Home Address: <hr/> <hr/>	Coverage Requested: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + 1 <input type="checkbox"/> Employee + Family
Home Phone Number: _____ Work Phone Number: _____	
Do you have any other Dental coverage? If so, Carrier: _____	

Complete for Dependent Coverage:			Do any of your dependents have any other dental coverage?	
<u>Spouse Name:</u> (Last), (First), (MI)	<u>Date of Birth:</u>			<u>If so, Name of Carrier:</u>
Sex:	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	
CHILDREN	1.	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	2.	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	3.	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	4.	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	5.	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	6.	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Fraud Warning (Not Applicable in AZ): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I elect the dental coverage selected for which I am eligible. If any contribution from me is necessary to pay part of the cost of insurance. I authorize my employer to deduct the contribution from my wages.

Date _____ **Employee Signature:** _____

Refusal of Group Dental Coverage: I have been offered this insurance coverage and decline to purchase it at this time. I understand that in the event I desire such insurance at a later date, I will be required to furnish evidence of insurability at my own expense, and the company will have the right to refuse any request.

Date _____ **Employee Signature:** _____

Notes:



Benefits Change Form



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Employer		
Employee Last Name	First Name	Social Security Number

Termination of Employment
Effective Date:
Signature (HR Manager or other authorized person):

Name and/or Address Change				
Change Name From:	Last Name	First Name	M.I.	
Change Name To:	Last Name	First Name	M.I.	
New Address:	Street Address	City	State	Zip Code

Cancellation of Coverage <input type="checkbox"/> Open enrollment <input type="checkbox"/> Qualifying Life Change
Effective Date:

Add Dependent(s) (attach additional form if needed) <input type="checkbox"/> Open enrollment <input type="checkbox"/> Life Change				
Dependent's Last Name	First Name	M.I.	Gender	Birth Date
Dependent's Last Name	First Name	M.I.	Gender	Birth Date
Dependent's Last Name	First Name	M.I.	Gender	Birth Date
Dependent's Last Name	First Name	M.I.	Gender	Birth Date

Drop Dependent(s) (attach additional form if needed) <input type="checkbox"/> Open enrollment <input type="checkbox"/> Life Change				
Dependent's Last Name	First Name	M.I.	Gender	Birth Date
Dependent's Last Name	First Name	M.I.	Gender	Birth Date
Dependent's Last Name	First Name	M.I.	Gender	Birth Date
Dependent's Last Name	First Name	M.I.	Gender	Birth Date

Other Changes	Employee Signature
Describe any other requested changes below:	I am requesting the changes documented on this form and authorize any required changes in payroll deductions.
	<hr/> Employee signature _____ Date _____

Notes:

