

**UTAH LOCAL GOVERNMENTS TRUST**

**Enrollment & Change Form**  
Vision and Accidental Dental

55 South Highway 89, North Salt Lake, UT 84054

o 801.936.6400 t 800.748.4440 f 801.936.0300 www.utahtrust.gov

**Important Note:**

Changes made on this form will not affect your Medical coverage. If you need to make changes to your Medical Coverage, or any policies not held with ULGT, please complete the appropriate forms for those plans.

**SECTION A: EMPLOYEE AND COVERAGE INFORMATION**

( ) New Enrollment ( ) Change Requested (please specify type:)

EMPLOYEE NAME: (last, first, middle initial)	SOCIAL SECURITY NUMBER	BIRTHDATE (MM/DD/YYYY)	MARITAL STATUS ( ) Single ( ) Married	GENDER ( ) Male ( ) Female
MAILING ADDRESS	CITY / STATE / ZIP	HOME PHONE		
EMPLOYER		WORK PHONE	HIRE DATE (MM/DD/YYYY)	
<b>ULGT VISION REIMBURSEMENT PLAN</b> (check one): <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + one dependent <input type="checkbox"/> Employee + two or more dependents <input type="checkbox"/> <b>No Vision Coverage at this time</b>		<b>ULGT ACCIDENTAL DENTAL</b> (check one): <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + one dependent <input type="checkbox"/> Employee + two or more dependents <input type="checkbox"/> <b>No Accidental Dental Coverage at this time</b>		

\*\*Enrollment in ULGT policies will only be accepted for those plans which your employer chooses to offer.

**SECTION B: DEPENDENT INFORMATION**

**ADDITIONS:** Complete the table below listing your eligible dependents. If adding a new spouse, please be sure to include date of marriage and 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 certificates, etc.)

RELATIONSHIP TO EMPLOYEE	FULL NAME OF DEPENDENTS TO BE COVERED (last, first, middle initial)	MARRIAGE DATE (MM/DD/YYYY)	Gender M F ( ) ( )	BIRTH DATE (MM/DD/YYYY)	SOCIAL SECURITY NUMBER
CODE KEY: S			M F ( ) ( )		
S Legal Spouse			M F ( ) ( )		
C Child – Natural / Adopted			M F ( ) ( )		
SC Stepchild			M F ( ) ( )		
			M F ( ) ( )		
			M F ( ) ( )		

**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 and children are involved, please provide a copy of a divorce decree.**

RELATIONSHIP TO EMPLOYEE	DEPENDENTS TO BE REMOVED (last, first, middle initial)	DEPENDENT'S SOCIAL SECURITY NUMBER	REASON FOR REMOVAL (i.e. marriage, divorce, death, age 26, etc.)	APPLICABLE DATE (MM/DD/YYYY)
Use above CODE KEY				

\*In order to process enrollment, ULGT must receive this form within 60 days of the Qualifying Event.

(HR use only)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Effective Date: \_\_\_\_\_ HR Approval \_\_\_\_\_

