UTAH LOCAL GOVERNMENTS TRUST
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Enrollment & Change Form

Vision and Accidental Dental

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	GENDER
			( ) Single	( ) Male
MAILING ADDRESS	CITY / STATE / ZIP	HOME PHONE	( ) Married	( ) Female
EMPLOYER		WORK PHONE	HIRE DATE (MM/DD/YYYY)	

ULGT VISION REIMBURSEMENT PLAN (check one):	**ULGT ACCIDENTAL DENTAL** (check one):
( ) Employee Only	( ) Employee Only
( ) Employee + one dependent	( ) Employee + one dependent
( ) Employee + two or more dependents	( ) Employee + two or more dependents
( ) **No Vision Coverage at this time**	(x) **No Accidental Dental Coverage at this time**

Not Available for Tooele City Employees

**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	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 ( ) ( )		
				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)

Effective Date: _____ **HR Approval**_____

Signature:_____ **Date:**_____