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Submit

Ivinson MEMORIAL HOSPITAL
AN AFFILIATE OF UCHealth

Medical Dental Vision Coverage Change Form

Employee Information

Social Security Number	Last Name	First Name	M.I.

Change

Effective Date	Reason for Change		
	☐ Marriage	☐ Divorce/Separation	☐ Death
	☐ Birth	☐ Termination of Coverage	☐ Other _____

Changes to Coverage Options

Medical		Dental	Vision
☐ Waive Medical Coverage	☐ Plan A - Standard	☐ Waive Dental Coverage	☐ Waive Vision Coverage
☐ Employee Only	☐ Plan B - Value	☐ Employee Only	☐ Employee Only
☐ Employee & Spouse		☐ Employee & Spouse	☐ Employee & Spouse
☐ Employee & Child(ren)		☐ Employee & Child(ren)	☐ Employee & Child(ren)
☐ Family		☐ Family	☐ Family

Add Dependent Coverage

Last Name	First Name	Relation to employee	Sex	Date of Birth (mm/dd/yy)	Social Security Number	Coverage Elected
			☐ M ☐ F			☐ Medical (Standard) ☐ Medical (Value) ☐ Dental ☐ Vision
			☐ M ☐ F			☐ Medical (Standard) ☐ Medical (Value) ☐ Dental ☐ Vision
			☐ M ☐ F			☐ Medical (Standard) ☐ Medical (Value) ☐ Dental ☐ Vision

Do you or any of your dependents currently have other coverage, including Medicare? ☐ No ☐ Yes; please provide the following information:

Member Name	Employer Name	Insurance Company Name, Address & Phone #	Policy Number	Medicare A, B or both

Cancel Dependent Coverage

Last Name	First Name	Relation to employee	Date of Birth (mm/dd/yy)	Coverage Dropped	Notes
				☐ Medical ☐ Dental ☐ Vision	
				☐ Medical ☐ Dental ☐ Vision	
				☐ Medical ☐ Dental ☐ Vision	

I certify that, to the best of my knowledge, the information shown on this form is correct. This signature will serve as permission for release of personal medical information or records from any current or previous healthcare provider or facility to UCHealth Plan Administrators, Delta Dental of Wyoming and VSP for the use of my healthcare plan and wellness program administration. I understand that by checking the below box and typing my name into the name field, this document is valid as if I have signed it.

☐ **Employee Signature** (Full Name): **Date:**

For Employer and UCHealth Plan Administrators, Delta Dental of Wyoming and VSP Use Only

☐ Entered in Lawson ☐ Enrolled with UCHPA/DDWY/VSP ☐ Saved in e-File ☐ Premiums Adjusted