Ivinson MEMORIAL HOSPITAL
AN AFFILIATE OF UCHealth

Medical Dental Vision Enrollment Form

Date of Hire:	Date of Enrollment:	Division: ☐ IMH ☐ MBT ☐ Retiree

Employee Information

Social Security Number	Legal Last Name	Legal First Name	M.I.

Street Address	Home Phone	Work Phone

Apt/Unit #	City	State	Zip	Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated

Benefit Choices

Before completing this section, please review the benefit details and required payroll deductions for each choice.

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

Enrollment Information

Please provide the requested information for yourself and all of your dependents who will be covered by any of the benefits chosen above.
Note: Social Security numbers are required on all members for Federal reporting purposes only.

Mbr	Last Name	First Name	Relation to employee	Sex	Date of Birth (mm/dd/yy)	Social Security Number
Emp			Self	☐ M ☐ F		
SP				☐ M ☐ F		
CH				☐ M ☐ F		
CH				☐ M ☐ F		
CH				☐ M ☐ F		
CH				☐ M ☐ F		
CH				☐ M ☐ F		

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

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

Group/Location	Cov/Class/Plan	Date Completed/By:

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

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