

Benefits Change Form



(801)886-2020 - (800)363-0950
www.opticareofutah.com

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.
	Employee signature _____ Date _____