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 ___ Open enrollment ___ Qualifying Life Change

Effective Date:

Add Dependent(s) (attach additional form if needed) ___ Open enrollment ___ 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) ___ Open enrollment ___ 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