

Employee Name:	Department:	Department:		
Email Address:	Job Begin Date:			
Phone:	Position:	Suffix:		
A#: A	Expected Job Hours:			
ACA Full-time Employee Notice Under the Affordable Care Act, you are defined as a fix will be working more than 30 hours per week on avera you will be notified in writing. USU offers medical concess becomes effective with your date of hire. If your plan possible continued coverage. Plan terms as explained in the medical summary plant in the event of conflicting information. I have read and understand this notice, and I conse and related health insurance compliance information notifying the Office of Human Resources. Medical Coverage I acknowledge that I am eligible to enroll in USU Care Act and choose to opt-out. Please sign and Resources, 8800 Old Main Hill, Logan Utah 843 HRBanner@usu.edu. I choose to enroll in USU's ACA medical insural information can be found at hr.usu.edu/benefits. Notice (Page 1) and email to HRBanner@usu.ed pleted and returned to Human Resources, 8800 (435) 797-1816. Do NOT email these forms as the must be submitted within 7 days from job begin NOTE: If you presently have coverage through the Marketplace for health-can Reason for declining medical coverage:	all-time employee. We have a reage each month during the year overage to actively employed A eligibility changes, then the tendescription will control your right to allow for electronic emails on. Electronic consent may be return only the first page of to 22-8800. Send this completed nee plan. Insurance plan optimized. Please complete this AC lu. Medical Enrollment form Old Main Hill, Logan Utah 8 ey contain social security infordate.	easonable expectation that you. If that expectation changes, CA full-time employees that rms of the plan will affect ghts under the plan I communication of PPACA escinded at any time by Inder the Affordable this form to Human document as a PDF to I cons and premium A Full-time Employee (Page 2) must be com-4322-8800 or faxed ormation. Documents		
Signature:	Date: _			



Medical Insurance Enrollment Form									
Affordable Care Act Full-time Employee									
Employee Name			A-Num	A-Number					
Gender	Birthdate	Job Begin Date	9	Employee Social Security Number					
Address, City, State, Zip									
Email Address			Phone						
Select a Medical Plan (check 🕱 one)									
F			Preferred V	Preferred ValueCare (PVC) Network					
Choice High Deductible Health Plan		Participating (PAR) Network							
Wellness Plan		Preferred ValueCare (PVC) Network							
		Participating (PAR) Network							
High Drawing Plan		Preferred ValueCare (PVC) Network							
High Premium Plan			Participating (PAR) Network						
Dependents**									
	Name	Medical	Gender	Birthdate	Social Security Number	Relationship**			
			M/F						
			M/F						
			M/F						
			M/F						
** In order to enroll dependents for medical insurance, you must provide proof of the relationship between the employee and dependent(s)									
listed (e.g. birth certificates, adoption documents or marriage certificate).									
Will you or your dependents have other insurance Yes, I or my dependents have other medical insurance									
while on the USU plan? No, I nor my dependents have other medical insurance					er medical insurance				
 □ I acknowledge that I am eligible for medical insurance under the Affordable Care Act and wish to enroll. I also acknowledge that if I enroll for medical insurance, I agree to pay the medical insurance premiums via payroll deductions. If at any time I do not have sufficient payroll funds to pay for the medical insurance premiums, I will remit to Utah State University the premium amount within 15 days of the last day in the pay period. I further agree that failure to do so may result in my medical coverage being terminated. Return Completed form to Human Resources, 8800 Old Main Hill, Logan Utah 84322, Fax 435-797-1816, or 									
hand deliver to Human Resources building on the corner of 1200 East 700 North									

Date: _____

Signature: