APPLICATION FOR CHANGE AND PAYROLL AUTHORIZATION FOR UT SYSTEM MEDICAL FOUNDATION/TMAIT

Name: _____
Last First MI

Address: _____
Street City State Zip

Social Security Number: _____ _____ _____

ADDITION OF DEPENDENTS (Check One)

❑ New Dependent (Date of Birth, Date of Marriage, etc.) _____/_____/_____
(Complete the Health Statement form if more than 60 days have elapsed.)

❑ New addition to insurance, but not new dependent(s).
(Complete the Health Statement form.)

Spouse: Date of Birth: _____/_____/_____ ❑ Male ❑ Female

Child(ren): Date of Birth: _____/_____/_____ ❑ Male ❑ Female

Date of Birth: _____/_____/_____ ❑ Male ❑ Female

Date of Birth: _____/_____/_____ ❑ Male ❑ Female

Add above to my: Life

Spouse: Date of Birth: _____/_____/_____ ❑ Male ❑ Female

Child(ren): Date of Birth: _____/_____/_____ ❑ Male ❑ Female

Date of Birth: _____/_____/_____ ❑ Male ❑ Female

Date of Birth: _____/_____/_____ ❑ Male ❑ Female

Delete above from my: Life

Termination of Residency: Effective: _____

❑ I do not choose to continue my insurance and understand that it terminates on: _____
❑ I choose to continue my insurance. Contact me at: (_____) _____
Address:_____ City:_____ State: _____ Zip: _____

I understand that once coverage has been deleted, any person(s) so deleted will be required to furnish evidence of insurability satisfactory to the insurance company before they can reenter the Plan(s) and the company reserves the right to refuse to grant such insurance.

Signature: _____ Date: _____