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Medical Dental, Vision Enrollment and Change Form State of Utah COBRA

Important Note: Changes made on this form will affect your medical, dental, and vision coverages only. If you need to make changes to other coverages, please complete the appropriate forms for those plans. **Please print clearly.**

New Enrollment Termination Change Request (Please Specify Type): _____

SECTION A » Employee and Coverage Information

YOUR NAME (last, first, middle initial)	SOCIAL SECURITY NUMBER	BIRTH DATE (mm/dd/yyyy)	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
MAILING ADDRESS	CITY/STATE/ZIP	PRIMARY PHONE		
EMPLOYER	EMAIL ADDRESS	ALTERNATE PHONE		

Group Medical (check one)

Coverage type (Check one)

- EMPLOYEE ONLY
- Employee plus one dependent
- Employee plus two or more dependents
- No medical coverage at this time

Choose your network

- Summit Network
- Advantage Network
- Preferred Network

Choose your medical plan

- The STAR Plan (complete below for HSA eligibility)*
- Traditional
- Utah Basic Plus (complete below for HSA eligibility)*
Utah Basic Plus is only available to new hires and members previously enrolled in The STAR Plan.

* For The STAR Plan or Utah Basic Plus enrollment, confirm HSA eligibility.

- I am eligible for a health savings account (HSA)
- I will not open an HSA at this time

GROUP DENTAL (Check one)

- Preferred Choice Dental
- Traditional Dental
- Regence Expressions
- No dental coverage at this time

Coverage type (Check one)

- EMPLOYEE ONLY
- Employee plus one dependent
- Employee plus two more dependents

VISION (Check one)

- Eyemed - Full
- Eyemed - Eyewear Only
- Opticare - Full
- Opticare - Eyewear Only
- No vision coverage at this time

Coverage type (Check one)

- EMPLOYEE ONLY
- Employee plus one dependent
- Employee plus 2+ dependents

ADDITIONS List your eligible dependents. For your spouse, include a copy of marriage certificate. For dependent children enrolled, include a copy of birth certificate. PEHP benefits will not be processed until required documentation is received.

SECTION B » Dependent Information

RELATIONSHIP TO EMPLOYEE	FULL NAME OF DEPENDENTS (last, first, middle initial)	MARRIAGE DATE (mm/dd/yy)	GENDER	BIRTH DATE (mm/dd/yy)	DEPENDENT SOCIAL SECURITY NO.	COVERAGE DESIRED
CODE KEY: S » Legal Spouse			<input type="checkbox"/> Male			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
			<input type="checkbox"/> Female			
C » Child Natural/Adopted			<input type="checkbox"/> Male			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
			<input type="checkbox"/> Female			
SC » Stepchild			<input type="checkbox"/> Male			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
O » Other (Describe in Section D)			<input type="checkbox"/> Male			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
			<input type="checkbox"/> Female			
			<input type="checkbox"/> Male			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
			<input type="checkbox"/> Female			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision

Are you, your spouse, or dependents covered by any other health or dental plan or by Medicare? Yes No **If yes, complete Section C on back**

REMOVALS Fill out the table below if you are terminating coverage for dependents who are no longer eligible. For all terminations outside of annual enrollment, adequate documentation is required (divorce decree, proof of other coverage, etc.) If you voluntarily drop dental coverage, you will not be able to re-enroll for up to three years.

RELATIONSHIP TO EMPLOYEE	FULL NAME OF DEPENDENTS (last, first, middle initial)	DEPENDENT SOCIAL SECURITY NO.	REASON FOR TERMINATION (e.g., marriage, divorce, death, age of 26)	APPLICABLE DATE*	COVERAGE TERMINATED
S » Legal Spouse					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
C » Child Natural/Adopted					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
SC » Stepchild					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
O » Other (Describe in Section D)					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision

*Applicable Date is the date of marriage, divorce, birthday, etc.

Signature required on other side.

(HR use only)		ST-C	04-11-16
Effective Date: _____	Termination Date: _____	HR Approval: _____	

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Employee Name: _____ Social Security Number: _____

CUSTODY OF CHILDREN

If dependants listed on first page are not living with both natural parents, please complete the following:

Who has physical custody of the children? <input type="checkbox"/> Mother <input type="checkbox"/> Father	Please provide the names and birth dates of both natural parents Mother: _____ Father: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> Name Birthdate Name Birthdate </div>
Who has physical custody of the stepchildren? <input type="checkbox"/> Mother <input type="checkbox"/> Father	Please provide the names and birth dates of both natural parents Mother: _____ Father: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> Name Birthdate Name Birthdate </div>

SECTION C » Multiple Group Coverage

Complete if you, your spouse, or dependents are covered by any other health or dental plan sponsored by an employer or Medicare.

INSURANCE COMPANY/HMO & PHONE NO.	NAME OF POLICY HOLDER	POLICY HOLDER SSN OR POLICY NO.	Effective Date (mm/dd/yy)	TYPE OF COVERAGE	TYPE OF POLICY	MEDICARE	EMPLOYEE/DEPENDANTS COVERED BY PLAN (Only first name is needed)
				<input type="checkbox"/> Health <input type="checkbox"/> Dental	<input type="checkbox"/> Employee <input type="checkbox"/> Retired	<input type="checkbox"/> A <input type="checkbox"/> A&B	
				<input type="checkbox"/> Health <input type="checkbox"/> Dental	<input type="checkbox"/> Employee <input type="checkbox"/> Retired	<input type="checkbox"/> A <input type="checkbox"/> A&B	

SECTION D » Explanations

SECTION E » Employee Agreement and Signature

Before signing, make sure that all applicable sections are complete so your enrollment is not delayed. You may be asked to provide additional information and or documentation. Please note: It is the employee's responsibility to notify PEHP within **60 days of any changes** effecting coverage and/or dependent eligibility (e.g., birth marriage, divorce, etc.).

I represent that all information is true and correct. I understand and agree that any false information I provide on this form may, at PEHP's sole discretion, result in a limitation or termination of my coverage. By signing below I hereby: (1) authorize the deduction of health/dental contributions through the provisions of IRS Section 125 Flexible Benefits; (2) authorize PEHP to release information to health/dental providers, insurance entities, or other entities necessary to process claims and to administer the health plan; (3) certify all dependents listed are eligible for coverage; (4) understand if PEHP is not notified that a dependent is ineligible and subsequent claims are paid, I will be responsible for reimbursement to PEHP for any claims paid in error; (5) agree to the terms and conditions in the PEHP Master Policy.

Employee Signature	Date
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Please make a copy for your records.