

# Public Employees Health Programs

560 East 200 South, Suite 100 / Salt Lake City, Utah 84102-2004  
 Term Life: 801-366-7495 / Toll Free 800-753-7495

State of Utah

Group Term Life  
 Employee Enrollment Form

## Section A

### Employee Information

<input type="checkbox"/> New Enrollment		<input type="checkbox"/> Application for Additional Coverage		
EMPLOYEE NAME (last, first, middle initial)	SOCIAL SECURITY NUMBER	BIRTH DATE (mm/dd/yy)	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female
HOME ADDRESS	CITY / STATE / ZIP		WORK PHONE	
EMPLOYER / DEPARTMENT	Did you transfer from another Agency/Department? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, which Agency/Department? _____		HIRE DATE (mm/dd/yy)	HOME PHONE

## Section B

### Coverage Information

Select the desired coverage below. See the Term Life Benefits Booklet for coverage and premium amounts. Enter the primary and contingent beneficiaries for Employee Term Life Coverage. If an employee covered by the Plan is also covered as a spouse under dependent coverage, the maximum cumulative coverage for any individual is \$500,000. Coverage amounts are reduced at age 71, see Benefit Booklet for details.

#### EMPLOYEE TERM LIFE

**Basic Group Term Life Coverage** - Provides the following coverage: \$25,000 up to age 70; \$12,500 age 71 to 75; \$6,250 age 76 and over. Basic Term Life is funded by your employer.

**Additional Group Term Life Coverage** - This coverage is in addition to Basic Group Term Life. Up to \$200,000 in additional coverage is guaranteed issue if applying within 60 days of eligibility. After 60 days, or for amounts above \$200,000, you must complete the health statement on the back of this form.

Select the amount of Additional Term Life Coverage you are applying for:  \$50,000  \$75,000  \$100,000  \$150,000  \$200,000  
 \$250,000  \$300,000  \$350,000  \$400,000  \$450,000  \$500,000

Revoking any previous nominations of beneficiary(ies), I hereby designate the following individuals to receive all benefits payable upon my death.

Full Given Name of Beneficiary	Designation	Relationship	Birth Date	Mailing Address		
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			Street	City	State Zip
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			Street	City	State Zip
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			Street	City	State Zip
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			Street	City	State Zip
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			Street	City	State Zip

### Considerations When Naming Beneficiaries

- List ALL beneficiaries. Beneficiary payments are paid from the most recent beneficiary designation on file with PEHP.
- Types of beneficiaries:
  - Primary** - Person to receive the death benefits upon the death of the member.
  - Contingent** - Person to receive the death benefits upon the death of the member if the primary beneficiary is deceased.
- If you name multiple primary beneficiaries, the proceeds will be split equally, unless otherwise instructed on the form.
- If your primary beneficiary(ies) dies before you and you have not named a contingent beneficiary, the proceeds may be subject to Title 75, Chapter 2 of the Utah Uniform Probate Code.
- If you name a trust as beneficiary, be sure to list the name of the trustee and the date the trust agreement became effective.
- Proceeds may not be paid directly to a minor child. In the event a minor child is named a beneficiary, proceeds must be paid to a trust, conservatorship or legal guardian.

EMPLOYEE SIGNATURE	DATE
--------------------	------

FOR PEHP USE ONLY			
Effective Date: _____	Certificate No.: _____	Minimum: _____	
Basic: _____	Additional: _____		
Verified By: _____	Date: _____		

# Group Term Life Enrollment Form (Continued)

Employee Name: _____	Social Security Number: _____
----------------------	-------------------------------

## Section C

### Employee Health Statement

Complete all questions in full for yourself. This information is required if applying for greater than \$150,000 within 60 days of eligibility or for all amounts after 60 days.

Employee Height (Ft., In.): \_\_\_\_\_      Employee Weight: \_\_\_\_\_      Occupation: \_\_\_\_\_

1. Have you <b>ever</b> had symptoms, been diagnosed with, or been treated <table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="width:70%;">a. High blood pressure</td><td style="width:10%;"><input type="checkbox"/> Yes</td><td style="width:10%;"><input type="checkbox"/> No</td></tr> <tr><td>b. Seizures or convulsions</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>c. Mental or nervous conditions</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>d. Lung or respiratory disorders</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>e. Digestive or rectal disorders</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>f. Blood or blood vessel disorders</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>g. Urinary tract disorders</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>h. Skeletal, spine, joint or muscle disorders</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>i. Thyroid, breast or other glandular disorders</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>j. Rheumatic fever or heart disorders</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>k. Chest pain or circulatory disorders</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>l. Reproductive organ disorders</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>m. Substance or alcohol abuse</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>n. Cancer or tumors</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>o. Ulcer</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>p. Colitis</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>q. Diabetes</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> </table>	a. High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	b. Seizures or convulsions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	c. Mental or nervous conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	d. Lung or respiratory disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	e. Digestive or rectal disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	f. Blood or blood vessel disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	g. Urinary tract disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	h. Skeletal, spine, joint or muscle disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	i. Thyroid, breast or other glandular disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	j. Rheumatic fever or heart disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	k. Chest pain or circulatory disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	l. Reproductive organ disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	m. Substance or alcohol abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	n. Cancer or tumors	<input type="checkbox"/> Yes	<input type="checkbox"/> No	o. Ulcer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	p. Colitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	q. Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	4. Have you had or currently have any known physical deformities, or physical or mental impairments, disorders or ill health not mentioned in question #1? <input type="checkbox"/> Yes <input type="checkbox"/> No  5. Have you ever been denied life or health insurance coverage, or received an increased premium rating for health? <input type="checkbox"/> Yes <input type="checkbox"/> No  6. Have you had an electrocardiogram, x-ray, laboratory study, blood study, body scan or diagnostic procedure within the past three years? <input type="checkbox"/> Yes <input type="checkbox"/> No  7. In the past ten years, have you sought or received treatment or advice for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or AIDS related diagnosis or opportunistic diseases, including Pneumocystis Carinii Pneumonia or Kaposi's Sarcoma? <input type="checkbox"/> Yes <input type="checkbox"/> No  8. Have you ever tested HIV positive? <input type="checkbox"/> Yes <input type="checkbox"/> No  9. If female, are you pregnant? If yes, expected date of delivery: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No  10. Tobacco Usage <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:70%;">a. Do you currently smoke cigarettes? If Yes, _____ per day</td> <td style="width:10%;"><input type="checkbox"/> Yes</td> <td style="width:10%;"><input type="checkbox"/> No</td> </tr> <tr> <td>b. Have you ever smoked cigarettes? If Yes, date last smoked? _____</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>c. Have you used any tobacco products in the past 10 years?</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> </table>	a. Do you currently smoke cigarettes? If Yes, _____ per day	<input type="checkbox"/> Yes	<input type="checkbox"/> No	b. Have you ever smoked cigarettes? If Yes, date last smoked? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	c. Have you used any tobacco products in the past 10 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
a. High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																											
b. Seizures or convulsions	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																											
c. Mental or nervous conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																											
d. Lung or respiratory disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																											
e. Digestive or rectal disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																											
f. Blood or blood vessel disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																											
g. Urinary tract disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																											
h. Skeletal, spine, joint or muscle disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																											
i. Thyroid, breast or other glandular disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																											
j. Rheumatic fever or heart disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																											
k. Chest pain or circulatory disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																											
l. Reproductive organ disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																											
m. Substance or alcohol abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																											
n. Cancer or tumors	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																											
o. Ulcer	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																											
p. Colitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																											
q. Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																											
a. Do you currently smoke cigarettes? If Yes, _____ per day	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																											
b. Have you ever smoked cigarettes? If Yes, date last smoked? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																											
c. Have you used any tobacco products in the past 10 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																											
2. Have you <b>ever</b> had a surgical procedure or been advised to have surgery which has not been completed at this time? <input type="checkbox"/> Yes <input type="checkbox"/> No	3. Have you consulted or been attended by a physician or practitioner and/or taken prescription medication(s) within the past five years? <input type="checkbox"/> Yes <input type="checkbox"/> No																																																												

Give complete details below for all "Yes" answers to above questions. Provide complete names and phone numbers for all

Question No.	Disease, Injury or Medical Condition	Treatment / Medication / Dosage (for substance/ alcohol abuse, provide date of last consumption)	Treatment Dates		Hospitalized?		Attending Physician (doctor name and telephone number)	Degree of Recovery
			From	To	Yes	No		

## Section D

### Employee Agreement & Signature

I represent that all information is true and correct. I understand any materially incorrect, incomplete or misstated facts may result in the rescission of coverage issued in reliance on information given to PEHP, and there will be no benefits payable. By signing below I hereby: (1) authorize the deduction of Group Term Life premiums; (2) authorize PEHP to obtain from medically related practitioners or facilities, insurance companies, the Medical Information Bureau, or other organizations, institutions or persons any information necessary to process this application and determine my insurability; (3) understand the coverage applied for replaces any previous Employee, Spouse or Dependent Children Term-Life coverage offered by PEHP; (4) agree to the terms and conditions in the PEHP Group Term Life Master Policy.

EMPLOYEE SIGNATURE	DATE
--------------------	------

Please make a copy for your records.