PEHP

*Life & Accident*
560 East, 200 South | Salt Lake City, UT 84102-2004
801-366-7495 | 801-753-7495 FAX 801 366-7725

**State of Utah**
*Exempt Employee*
Group Term Life Enrollment Form

## SECTION A » EMPLOYEE INFORMATION

| | | | | |
|---|---|---|---|---|
| ☐ New Enrollment | ☐ Application for Additional Coverage | | Marital Status | ☐ Married ☐ Single |
| Name (last, first, middle initial) | Social Security Number | Birth Date (mm/dd/yy) | Gender | ☐ Male ☐ Female |
| Home Address | City/State/Zip | | Work Phone | |
| | | | Home Phone | |
| Employer/Department | Did you transfer from another agency/department? ☐ Yes ☐ No<br>If yes, which agency/department?_____ | | HIRE DATE (mm/dd/yy) | |

**SECTION B » COVERAGE INFORMATION** Select the amount of coverage you want below. See your benefits summary for costs. Enter your primary and contingent beneficiaries. If you are also covered as a spouse on another plan, the maximum cumulative coverage for any individual is $525,000. Coverage amounts reduced at age 71. See your benefits summary for details.

| EMPLOYEE TERM LIFE | | | | | |
|---|---|---|---|---|---|
| | Employee Salary Level | | | | |
| **Type of Coverage** | **Up to $50,000** | **$50,000 to $60,000** | **Over $60,000** | **Approval Required** | **Premium Paid By** |
| Basic Term Life | ☒ $25,000 | ☒ $25,000 | ☒ $25,000 | No | State |
| Term Life for Exempt Employees | ☐ $125,000 | ☐ $150,000 | ☐ $200,000 | Yes* | State |
| Additional Group Term Life (Select one amount under your salary level) | ☐ $25,000<br>☐ $50,000<br>☐ $100,000<br>☐ $150,000<br>☐ $200,000<br>☐ $250,000<br>☐ $300,000<br>☐ $350,000<br>☐ $375,000 | ☐ $50,000<br>☐ $100,000<br>☐ $150,000<br>☐ $200,000<br>☐ $250,000<br>☐ $300,000<br>☐ $350,000 | ☐ $50,000<br>☐ $100,000<br>☐ $150,000<br>☐ $200,000<br>☐ $250,000<br>☐ $300,000 | Yes* | Employee |

* You must complete the Employee Health Statement on the back of this form. If you are not approved but applied within 60 days of hire, you will get $150,000 Term Life coverage in addition to the $25,000 basic coverage.

| Full Given Name of Beneficiary | Designation | Relationship | Birth Date | Mailing Address |
|---|---|---|---|---|
| | ☐ Primary ☐ Contingent | | | Street:<br>City: State: Zip: |
| | ☐ Primary ☐ Contingent | | | Street:<br>City: State: Zip: |
| | ☐ Primary ☐ Contingent | | | Street:<br>City: State: Zip: |
| | ☐ Primary ☐ Contingent | | | Street:<br>City: State: Zip: |

### CONSIDERATIONS WHEN NAMING BENEFICIARIES

1. List ALL beneficiaries. Beneficiary payments are paid from the most recent beneficiary designation on file with PEHP.
2. Types of beneficiaries:
   - **A. Primary** - Person to get death benefits upon your death.
   - **B. Contingent** - Person to get death benefits upon your dealth if your primary beneficiary is deceased.
3. If you name multiple primary beneficiaries, the proceeds will be split equally, unless otherwise instructed on the form.
4. 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.
5. If you name a trust as beneficiary, be sure to list the name of the trustee(s) and the date the trust agreement became effective.
6. 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 |
|---|---|
| | |

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FOR PEHP USE ONLY
Effective Date_____ Certificate No._____
Basic_____ Additional_____ Exempt_____
Verified by_____ Date_____

**Complete if you applied for coverage more than the guaranteed issue (more than $150,000) or after 60 days of becoming eligible as an employee of the State of Utah.**

## GROUP TERM LIFE EXEMPT ENROLLMENT FORM (Continued)

| Employee Name: | Social Security Number: |
|---|---|

## SECTION C » EMPLOYEE HEALTH STATEMENT

Complete all questions in full for yourself. This information is require if you apply for Additional Term Life or apply for Basic Term Life after 60 days.

Employee Height (ft., in.)_____Employee Weight_____Occupation:_____

| 1. Have you **ever** had symptoms, been diagnosed with, or been treated for: | | |
|---|---|---|
| a. High blood pressure | ☐ Yes | ☐ No |
| b. Seizures or convulsions | ☐ Yes | ☐ No |
| c. Mental or nervous conditions | ☐ Yes | ☐ No |
| d. Lung or respiratory disorders | ☐ Yes | ☐ No |
| e. Digestive or rectal disorders | ☐ Yes | ☐ No |
| f. Blood or blood vessel disorders | ☐ Yes | ☐ No |
| g. Urinary tract disorders | ☐ Yes | ☐ No |
| h. Skeletal, spine, joint, or muscle disorders | ☐ Yes | ☐ No |
| i. Thyroid, breast, or other glandular disorders | ☐ Yes | ☐ No |
| j. Rheumatic fever or heart disorders | ☐ Yes | ☐ No |
| k. Chest pain or circulatory disorders | ☐ Yes | ☐ No |
| l. Reproductive organ disorders | ☐ Yes | ☐ No |
| m. Substance or alcohol abuse | ☐ Yes | ☐ No |
| n. Cancer or tumors | ☐ Yes | ☐ No |
| o. Ulcer | ☐ Yes | ☐ No |
| p. Colitis | ☐ Yes | ☐ No |
| q. Diabetes | ☐ Yes | ☐ No |
| 2. Have you ever had a surgical procedure or been advised to have surgery which has not been completed at this time? | ☐ Yes | ☐ No |
| 3. Have you consulted or been attended by a physician or practitioner and/or taken prescription medications(s) within the past five years? | ☐ Yes | ☐ 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? | ☐ Yes | ☐ No |
| 5. Have you ever been denied life or health insurance coverage, or received an increased premium rating for health reasons? | ☐ Yes | ☐ No |
| 6. Have you had an electrocardiogram, x-ray, laboratory study, blood study, body scan or diagnostic procedure within the past three years? | ☐ Yes | ☐ 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? | ☐ Yes | ☐ No |
| 8. Have you ever tested HIV positive? | ☐ Yes | ☐ No |
| 9. Are you pregnant? If yes, expected date of delivery:_____ | ☐ Yes | ☐ No |
| 10. Tobacco Usage | | |
| a. Do you currently smoke cigarettes? If yes, how many packs per day?_____ | ☐ Yes | ☐ No |
| b. Have you ever smoked cigarettes? If yes, date last smoked_____ | ☐ Yes | ☐ No |
| c. Have you used any tobacco products in the past 10 years? | ☐ Yes | ☐ No |

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

| 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 phone number) | Degree of recovery |
|---|---|---|---|---|---|---|---|---|
| | | | From: | To: | From: | To: | | |
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## SECTION D » EMPLOYEE AGREEMENT AND SIGNATURE

*I represent that all information is true and correct. I understand any materially incorrect, incomplete or misstated facts may result in the recision 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.