

**Section A**

**Employee and Coverage Information**

New Enrollment     Status Change (Please specify type): \_\_\_\_\_

**Important Note:**

*Changes made on this form may also affect your coverages under other group benefit plans sponsored by your employer. Please contact your employer for information and forms.*

EMPLOYEE NAME (last, first, middle initial)	SOCIAL SECURITY NUMBER	BIRTH DATE (mm/dd/yy)	MARITAL STATUS	GENDER
HOME ADDRESS	CITY / STATE / ZIP	HOME PHONE	<input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Male <input type="checkbox"/> Female
EMPLOYER		WORK PHONE	HIRE DATE (mm/dd/yy)	

<b>GROUP MEDICAL</b> (check one) <input type="checkbox"/> Platinum Care <input type="checkbox"/> Platinum Care - A* <input type="checkbox"/> Platinum Care - S <input type="checkbox"/> Gold Care <input type="checkbox"/> Gold Care - A* <input type="checkbox"/> Gold Care - S <input type="checkbox"/> Silver Care <input type="checkbox"/> Silver Care - A* <input type="checkbox"/> Silver Care - S <input type="checkbox"/> Bronze Care <input type="checkbox"/> Bronze Care A* <input type="checkbox"/> Bronze Care - S <input type="checkbox"/> Copper Care 1 <input type="checkbox"/> Copper Care 1 - A* <input type="checkbox"/> Copper Care 1 - S <input type="checkbox"/> Copper Care 2 <input type="checkbox"/> Copper Care 2 - A* <input type="checkbox"/> Copper Care 2 - S			<b>COVERAGE TYPE</b> (check one) <input type="checkbox"/> Employee only <input type="checkbox"/> Employee plus one dependent <input type="checkbox"/> Employee plus two or more dependents	
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If you have had previous health coverage within the last 8 months, please attach a Certificate of Creditable Coverage from your former insurance company.  
 \* Available for Employees of Sevier, Garfield and Wasatch County School Districts Only

**Section B**

**Dependent Information**

**ADDITIONS** Complete the table below listing your eligible dependents. If adding a new spouse, please include date of marriage. If dependents are stepchildren, natural children not living with both parents, or classified as Other Relationship please provide supporting documentation, i.e. divorce decree, court orders, birth certificate, etc. If you don't have supporting documentation please explain in Section D.

RELATIONSHIP TO EMPLOYEE	FULL NAME OF DEPENDENTS TO BE COVERED (last, first, middle initial)	MARRIAGE DATE (mm/dd/yy)	GENDER	BIRTH DATE			DEPENDENT SOCIAL SECURITY NO.	Does the dependent have other Medical Insurance?	Important: If any dependent has other coverage, Section C must be completed.
				Month	Day	Year			
CODE KEY	<b>S</b>		<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No	
S - Spouse			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No	
N - Natural Child			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No	
SC - Stepchild			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No	
O - Other (Describe in Section D)			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No	

**CUSTODY OF CHILDREN**

If dependents listed above are not living with **BOTH** natural parents, please complete the following:

Who has physical custody of the natural children? <input type="checkbox"/> Mother <input type="checkbox"/> Father	Please provide names and birth dates of both natural parents. Mother: _____    Father: _____ Name                                      Birth Date                                      Name                                      Birth Date
Who has physical custody of the stepchildren? <input type="checkbox"/> Mother <input type="checkbox"/> Father	Provide names and birth dates of natural parents of stepchildren. Mother: _____    Father: _____ Name                                      Birth Date                                      Name                                      Birth Date

**REMOVALS**

Fill out the table below if you are terminating coverage for dependents who are no longer eligible. If termination is a result of a divorce and children are involved, please provide a copy of divorce decree.

RELATIONSHIP TO EMPLOYEE	DEPENDENTS TO NO LONGER BE COVERED (last, first, middle initial)	DEPENDENT SOCIAL SECURITY NO.	REASON FOR TERMINATION (i.e. marriage, divorce, death, age of 26, etc.)	APPLICABLE DATE*		
				Month	Day	Year
CODE KEY						
S - Spouse						
N - Natural Child						
SC - Stepchild						
O - Other (Describe in Section D)						

\*Applicable Date could be date of marriage, divorce, birthday, etc.

**Signature required, see Section F on reverse side.**

Effective Date: _____ (HR Use Only)	USBA -E Updated: 8-06
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**Medical Enrollment and Change Form (Continued)**

**Utah School Boards Association**

Employee Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**Section C**

**Multiple Group Coverage**

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

INSURANCE COMPANY/HMO & PHONE NO.	NAME OF POLICY HOLDER	POLICY HOLDER SSN OR POLICY NO.	EFFECTIVE DATE (mm/dd/yy)	TYPE OF POLICY	MEDICARE	EMPLOYEE/DEPENDENTS COVERED BY PLAN (Only First Name is Needed)
				<input type="checkbox"/> Employee <input type="checkbox"/> Retired	<input type="checkbox"/> A <input type="checkbox"/> A&B	
				<input type="checkbox"/> Employee <input type="checkbox"/> Retired	<input type="checkbox"/> A <input type="checkbox"/> A&B	
				<input type="checkbox"/> Employee <input type="checkbox"/> Retired	<input type="checkbox"/> A <input type="checkbox"/> A&B	

**Section D**

**Explanations**

Empty box for providing explanations.

**Section E**

Monthly Group Flex Health Insurance Premium \$ \_\_\_\_\_

I hereby authorize my employer to reduce my salary using pre-tax deduction in the amount above to pay for the insurance premium. I understand my Social Security benefits may be reduced since Social Security taxes are not paid on my contributions.

\_\_\_\_\_ Effective \_\_\_\_\_

Signature

**Section F**

**Employee Agreement and Signature**

*Before signing, make sure 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 the Public Employees Health Program within 60 days of any change affecting dependent eligibility (i.e., 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 insurance coverage. By signing below I hereby: (1) authorize PEHP to release information to health/dental providers, insurance entities, or other entities necessary to process claims and to administer the Health Plan; (2) certify all dependents listed are eligible for coverage; (3) 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; (4) 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.