PEHP Health & Benefits
560 East 200 South, Salt Lake City, UT 84102
801-366-7555 / 800-765-7347
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**www.pehp.org**

# Tooele City
## Enrollment and Change Form

**Employee Status** ☐ Full time ☐ Part time
**Benefit Eligibility** ☐ Eligible ☐ Ineligible

**Note:** *Changes made on this form are for medical and dental. All other changes can be made online at www.pehp.org.* ***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/yy) | MARITAL STATUS ☐ SINGLE ☐ MARRIED | GENDER ☐ MALE ☐ FEMALE |
|---|---|---|---|---|
| MAILING ADDRESS | CITY/STATE/ZIP | PRIMARY PHONE | | |
| EMPLOYER | EMAIL ADDRESS | ALTERNATE PHONE | HIRE DATE (mm/dd/yy) | |

**Group Medical** (check one) | **Check with your employer to see what options are available to you**

**Summit Network**

☐ The STAR Plan* ☐ Traditional Option **4** ☐ Traditional Option **5**

☐ * I'm eligible for a Health Savings Account (HSA)
☐ * I'm not eligible for an HSA

**Coverage type** (Check one)

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

**GROUP DENTAL** (Check one)

☐ Preferred Choice Dental
☐ No dental coverage at this time

**Coverage type** (Check one)

☐ EMPLOYEE ONLY
☐ Employee plus one dependent
☐ Employee plus two or more dependents

**SECTION B » Dependent Information**

**ADDITIONS** List your eligible dependents. If adding a new spouse, include a copy of marriage certificate. If dependents are stepchildren, natural children not living with both parents, or "other" relationship, provide supporting documentation, e.g., divorce decree, court orders, birth certificate, etc. If you don't have supporting documentation explain in Section D on the back.

| 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; **MD »** Married Dependent; **C »** Child Natural/ Adopted; **SC »** Stepchild; **O »** Other (Describe in Section D) | **S** | | | ☐ **Male** ☐ **Female** | | | ☐**M**edical ☐**D**ental |
| | | | | ☐ **Male** ☐ **Female** | | | ☐**M**edical ☐**D**ental |
| | | | | ☐ **Male** ☐ **Female** | | | ☐**M**edical ☐**D**ental |
| | | | | ☐ **Male** ☐ **Female** | | | ☐**M**edical ☐**D**ental |
| | | | | ☐ **Male** ☐ **Female** | | | ☐**M**edical ☐**D**ental |
| | | | | ☐ **Male** ☐ **Female** | | | ☐**M**edical ☐**D**ental |
| | | | | ☐ **Male** ☐ **Female** | | | ☐**M**edical ☐**D**ental |

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 | | | | | | ☐**M**edical ☐**D**ental |
| **MD »** Married Dependent | | | | | | ☐**M**edical ☐**D**ental |
| **C »** Child Natural/ Adopted | | | | | | ☐**M**edical ☐**D**ental |
| **SC »** Stepchild | | | | | | ☐**M**edical ☐**D**ental |
| **O »** Other (Describe in Section D) | | | | | | ☐**M**edical ☐**D**ental |

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

**Signature required on other side.**

**(HR use only)** **TC-PE** **04-25-23**

Effective Date:_____ Termination Date:_____ HR Approval:_____

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Employee Name: _____ Social Security Number: _____

**CUSTODY OF CHILDREN**

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

Who has physical custody of the children?

☐ Mother ☐ Father

Please provide the names and birth dates of both natural parents

Mother:_____ (Name, Birth date) Father:_____ (Name, Birth date)

Who has physical custody of the stepchildren?

☐ Mother ☐ Father

Please provide the names and birth dates of both natural parents

Mother:_____ (Name, Birth date) Father:_____ (Name, Birth date)

## 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/DEPENDENTS COVERED BY PLAN (Only first name is needed) |
|---|---|---|---|---|---|---|---|
| | | | | ☐ **Health** ☐ **Dental** | ☐ **Employee** ☐ **Retired** | ☐ **A** ☐ **A&B** | |
| | | | | ☐ **Health** ☐ **Dental** | ☐ **Employee** ☐ **Retired** | ☐ **A** ☐ **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 **31 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.

☐ I certify that I am not a party to a divorce proceeding and am not subject to an injunction/order which prevents me from modifying insurance or changing beneficiaries.

| Employee Signature | Date |
|---|---|
| | |

Please make a copy for your records.