

**Public Employees
Health and Dental Programs**

560 East 200 South, Suite 100 / Salt Lake City, Utah 84102-2004
Customer Service: 801-366-7555 / Toll Free 800-765-7347

**State of Utah
Medical and Dental
Enrollment and Change Form**

Important Note:

Changes made on this form will affect your medical and dental coverages only. If you need to change other PEHP coverages, please complete the appropriate forms for those plans.

Section A

Employee and Coverage Information

New Enrollment Change Requested (Please specify type):

EMPLOYEE NAME (last, first, middle initial)	SOCIAL SECURITY NUMBER	BIRTH DATE (mm/dd/yy)	MARITAL STATUS	GENDER
MAILING ADDRESS	CITY / STATE / ZIP	HOME PHONE	<input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Male <input type="checkbox"/> Female
EMPLOYER / DEPARTMENT	Did you transfer from another department? <input type="checkbox"/> Yes <input type="checkbox"/> No What department?	WORK PHONE	HIRE DATE (mm/dd/yy) ¹	

Group Medical (check one) <input type="checkbox"/> Preferred Care <input type="checkbox"/> Summit Care <input type="checkbox"/> Advantage Care* <input type="checkbox"/> High Deductible Health Plan ^{3, 4} <input type="checkbox"/> No medical coverage at this time <input type="checkbox"/> I will not be opening a Health Savings Account (HSA) with Utah Retirement Systems (URS) at this time.	COVERAGE TYPE (check one) <input type="checkbox"/> Employee only <input type="checkbox"/> Employee plus one dependent <input type="checkbox"/> Employee plus two or more dependents	Group Dental (check one) <input type="checkbox"/> Traditional Dental <input type="checkbox"/> Preferred Choice Dental <input type="checkbox"/> Dental Select ² <input type="checkbox"/> No dental coverage at this time	COVERAGE TYPE (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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Optional Vision	<input type="checkbox"/> EyeMed	<input type="checkbox"/> Opticare E	<input type="checkbox"/> No Vision coverage at this time
	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee plus one dependent	<input type="checkbox"/> Employee plus two or more dependents

1. New enrollees, if you have had previous health coverage within the last 9 months, please attach a Certificate of Creditable Coverage from your former insurance company.
 2. If enrolling in Dental Select, you must complete an enrollment form for that program.
 3. **If you enroll in the HDHP, you agree to be enrolled for at least three Plan Years.**
 4. If you elect to participate in the URS HSA, you must complete an enrollment form for that program.
- * This plan is offered in specific geographic areas. Please check the specific plan information before enrolling.

Section B

**Dependent Information
ADDITIONS**

Complete the table below listing your eligible dependents. If adding a new spouse, please include date of marriage, and copy of marriage certificate. 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 (last, first, middle initial)	MARRIAGE DATE (mm/dd/yy)	GENDER	BIRTH DATE			DEPENDENT SOCIAL SECURITY NO.	COVERAGE DESIRED
				Month	Day	Year		
CODE KEY	S		<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
S - Legal Spouse			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
C - Child Natural / Adopted			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
SC - Stepchild			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
O - Other (Describe in Section D)			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
			<input type="checkbox"/> M <input type="checkbox"/> F					<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

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						
C - Child Natural / Adopted						
SC - Stepchild						
O - Other (Describe in Section D)						

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

Signature required, see Section E.

ST-E

Updated 3-06

