PEHP Health & Benefits
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Utah School Boards Association
Medical Enrollment and Change Form

Note: *Changes made on this form are for medical only. For changes to other plans sponsored by your employer, please contact your employer for information and forms.*
Please print clearly.

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

Section A - Employee and Coverage Information

☐ **New Enrollment** ☐ **Status Change (Please specify type):** _____

Employee Name (last, first, middle initial)	Social Security Number	Birth Date (mm/dd/yy)	Marital Status	Gender
			☐ Single ☐ Married	☐ Male ☐ Female
Mailing Address	**City / State / Zip**	**Home Phone**		
Email Address	**Employer**	**Work Phone**	**Hire Date (mm/dd/yy)**	

Group Medical (check one)

☐ Gold Plan - Preferred	☐ Gold Plan - Advantage	☐ Gold Plan - Summit
☐ Silver Plan - Preferred	☐ Silver Plan - Advantage	☐ Silver Plan - Summit
☐ Bronze Plan - Preferred	☐ Bronze Plan - Advantage	☐ Bronze Plan - Summit
☐ Copper HSA - Preferred*	☐ Copper HSA - Advantage*	☐ Copper HSA - Summit*
☐ Core HSA - Preferred*	☐ Core HSA - Advantage*	☐ Core HSA - Summit*

Coverage Type (check one)

☐ Employee only
☐ Employee plus one dependent
☐ Employee plus two or more dependents

☐ *I am eligible for a Health Savings Account (HSA) ☐ *I will not open an HSA at this time

Section B - Dependent Information

Additions

List 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, e.g., 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 Month	Day	Year	Dependent social security #	Does the dependent have other medical/dental insurance?	
Code Key	**S**			☐M ☐F					☐ Yes ☐ No	**Important:** If any dependent has other coverage, you must complete Section C.
S - Legal spouse				☐M ☐F					☐ Yes ☐ No	
C - Child natural / adopted				☐M ☐F					☐ Yes ☐ No	
				☐M ☐F					☐ Yes ☐ No	
SC - Stepchild				☐M ☐F					☐ Yes ☐ No	
O - Other				☐M ☐F					☐ Yes ☐ No	
				☐M ☐F					☐ Yes ☐ No	

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		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.

(HR Use Only) USBA-E 02-01-17

Effective Date:_____ Employment Termination Date:_____ Coverage Termination Date:_____ HR Approval:_____

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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)
				☐ Employee ☐ Retired	☐ A ☐ A&B	
				☐ Employee ☐ Retired	☐ A ☐ A&B	
				☐ Employee ☐ Retired	☐ A ☐ A&B	

Section D - Explanations

Section E - Salary Reduction

Monthly Group Flexible Spending 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.

Sign Here

Employee signature	**Effective Date**

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 PEHP ***within 60 days of any change*** *affecting coverage 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 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.

Sign Here

Employee signature	**Date**

Please make a copy for your records