Public Employees Health Programs

560 East 200 South, Suite 100 Salt Lake City, Utah 84102-2004 Enrollment: 801-366-7495 Toll Free 800-753-7495

Accidental Death & Dismemberment Plan Enrollment / Change Form

\$2,500

EMPLOYEE INFORMATION

Home Address		Social Security Number		Birth Date	Birth Date (mm/dd/yy)		
		City / State / Zip					
Employer / Department		Work Phone Hor		Home Ph	me Phone		
Original Hire Date (mm/dd/yy)	Gender	Martial S	Status Single Marrie		dren Under 26		
	Consideratio	ns When Namin	Beneficiaries	 s			
 B. <i>Contingent</i> - Person to receiv. 3. If you name multiple primary beneficiary (ies) dies Chapter 2 of the Utah Uniform Prob 5. If you name a trust as beneficiary, b 6. Proceeds may not be paid directly to conservatorship or legal guardian. 	iciaries, the proceeds will before you and you have bate Code. be sure to list the name o	l be split equally, unle e not named a contin of the trustee and the	ess otherwise instruction gent beneficiary, the date the trust agree	cted on the fo e proceeds m ement became	orm. hay be subject to Title 75 e effective.	5,	
Revoking any previous nominations of beneficiary(ies), I hereby designate the following individuals to receive all benefits payable upon my death.Full Given Name of BeneficiaryDesignationRelationshipBirth DateMailing Action					n my death. Mailing Address		
	Primary Contingent			Street City	State	Zip	
	PrimaryContingent			Street City	State	Zip	
	PrimaryContingent			Street City	State	Zip	
	 Primary Contingent 			Street City	State	Zip	
	PrimaryContingent			Street City	State	Zip	
COVERAGE INFORMATION	(Available to employe	es under age 70)					
*If both you and your spouse		Employee Only loyee" only one may	Family Co	-	AMOUNT OF COVE	RAGE	
Accident Weekly Indemnity (employee only, must be		verage)					
Accident Medical Expense Coverage					* 0 500		

EMPLOYEE AGREEMENT

(employee only, must be enrolled in AD&D coverage)

I represent that all information is true and correct. By signing below I hereby: (1) authorize the deduction of accidental death and dismemberment (AD&D) insurance premiums from my salary; (2) authorize PEHP to release information to the program offeror and /or underwriter necessary to process claims; (3) agree that the information contained on this form replaces all existing coverage and beneficiary designations.

Employee Signature	Date	Effective Date Of Coverage
		Office Use Only

Make and keep a photocopy of completed form for yourself / Return completed form to Human Resources G-3 Updated 10-09