

Public Employees Health Programs

560 East 200 South / Salt Lake City, Utah 84102-2004

Enrollment: (801) 366-7495 / Toll Free (800) 753-7495

LOCAL GOVERNMENTS

Group Term Life

Spouse/Dependent Child Enrollment Form

Section A - Employee Information

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

Section B - Coverage Information

Select the desired coverage below. See the term Life Benefits Booklet for coverage and premium amounts. Enter the primary and contingent beneficiaries for Spouse and/or Dependent Child Term Life coverage. Coverage amounts are reduced at age 71, see Benefit Booklet for details. The maximum cumulative coverage for any individual is \$500,000.

SPOUSE TERM LIFE

Select the amount of Spouse Term Life you are applying for: \$25,000 \$50,000 \$75,000 \$100,000 \$150,000 \$200,000
 \$250,000 \$300,000 \$350,000 \$400,000 \$450,000 \$500,000

If applying within 60 days of hire or marriage for \$50,000 or less a health statement is not required, otherwise complete the Spouse Health Statement.

SPOUSE NAME (last, first, middle initial)	BIRTH DATE (mm/dd/yy)	MARRIAGE DATE (mm/dd/yy)
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Full Given Name of Beneficiary	Designation	Relationship	Birth Date	Mailing Address		
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			Street		
				City	State	Zip
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			Street		
				City	State	Zip

DEPENDENT CHILD TERM LIFE

Dependent Group Term Life Coverage is for unmarried children up to age 26. List dependents below. Premium covers all eligible dependent children. A Health Statement is required for each dependent if applying past 60 days from hire, birth of dependent, or event.

Coverage Per Child \$5,000 \$10,000 \$15,000

RELATIONSHIP TO EMPLOYEE	FULL NAME OF DEPENDENTS TO BE COVERED (last, first, middle initial)	GENDER	BIRTH DATE			DEPENDENT SOCIAL SECURITY NO.
			Month	Day	Year	
CODE KEY		<input type="checkbox"/> M <input type="checkbox"/> F				
C-Child		<input type="checkbox"/> M <input type="checkbox"/> F				
Natural/Adopted		<input type="checkbox"/> M <input type="checkbox"/> F				
SC - Stepchild		<input type="checkbox"/> M <input type="checkbox"/> F				
O-Other		<input type="checkbox"/> M <input type="checkbox"/> F				
		<input type="checkbox"/> M <input type="checkbox"/> F				
		<input type="checkbox"/> M <input type="checkbox"/> F				

Full Given Name of Beneficiary	Designation	Relationship	Birth Date	Mailing Address		
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			Street		
				City	State	Zip
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			Street		
				City	State	Zip

EMPLOYEE SIGNATURE	DATE
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FOR PEHP USE ONLY

Effective Date: _____ Certificate No: _____

Spouse: _____ Dependent: _____

GROUP TERM-LIFE SPOUSE/DEPENDENT HEALTH STATEMENT (CONTINUED)

Employee Name: _____ Social Security Number: _____

Section C - Spouse or Dependent Child Health Statement

Complete this form for the spouse or one for each dependent. This information is required if applying for Spouse or Dependent coverage after 60 days from hire date, marriage date, or birth/adoption date. This is also required for Spouse coverage in excess of \$50,000.

Name (Last, First, M. I.) _____ Date of Birth: _____ Height (Ft. In.): _____ Weight _____

Relationship To Employee: _____ Occupation: _____

1. Have you ever had symptoms, been diagnosed with, or been treated for:																		
a. High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	4. Have you had or currently have any known physical deformities, or physical or mental impairments, disorders or ill health not mentioned in question #1?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	5. Have you ever been denied life or health insurance coverage, or received an increased premium rating for health reasons?	<input type="checkbox"/> Yes	<input type="checkbox"/> No										
b. Seizures or convulsions	<input type="checkbox"/> Yes	<input type="checkbox"/> No		6. Have you had an electrocardiogram, x-ray, laboratory study, blood study, body scan or diagnostic procedure within the past three years?	<input type="checkbox"/> Yes		<input type="checkbox"/> No	7. In the past ten years, have you sought or received treatment or advise for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC, or AIDS related diagnosis or opportunistic diseases, including Pneumocystis Carinii Pneumonia or Kaposi's Sarcoma?	<input type="checkbox"/> Yes	<input type="checkbox"/> No								
c. Mental or nervous conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No			8. Have you ever tested HIV positive?		<input type="checkbox"/> Yes		<input type="checkbox"/> No	9. If female, are you pregnant? If yes, expected date of delivery: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No						
d. Lung or respiratory disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No					10. Tobacco Usage				a. Do you currently smoke cigarettes? If yes, _____ per day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
e. Digestive or rectal disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No							b. Have you ever smoked cigarettes? If yes, last date smoked _____			<input type="checkbox"/> Yes	<input type="checkbox"/> No	c. Have you used any tobacco products in the past 10 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
f. Blood or blood vessel disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No																
g. Urinary tract disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No																
h. Skeletal, spine, joint or muscle disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No																
i. Thyroid, breast or other glandular disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No																
j. Rheumatic fever or heart disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No																
k. Chest pain or circulatory disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No																
l. Reproductive organ disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No																
m. Substance or alcohol abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No																
n. Cancer or tumors	<input type="checkbox"/> Yes	<input type="checkbox"/> No																
o. Ulcer	<input type="checkbox"/> Yes	<input type="checkbox"/> No																
p. Colitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No																
q. Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No																
2. Have you ever had a surgical procedure or been advised to have surgery which has not been completed at this time?				<input type="checkbox"/> Yes	<input type="checkbox"/> No													
3. Have you consulted or been attended by a physician or practitioner and/or taken prescription medication(s) within the past five years?				<input type="checkbox"/> Yes	<input type="checkbox"/> No													

Give complete details for all "Yes" answers to above questions. Provide complete names and phone numbers for all physicians.

Question No.	Disease, Injury or Medical Condition	Treatment / Medication / Dosage (for substance/ alcohol abuse, provide date of last consumption)	Treatment Dates		Hospitalized?		Attending Physician (doctor name and phone number)	Degree of Recovery
			From	To	Yes	No		

Section D - Employee Agreement & Signature

I represent that all information is true and correct. I understand any materially incorrect, incomplete or misstated facts may result in the rescission of coverage issued in reliance on information given to PEHP, and there will be no benefits payable. By signing below I hereby: (1) authorize the deduction of Group Term Life premiums; (2) authorize PEHP to obtain from medically related practitioners or facilities, insurance companies, the Medical Information Bureau, or other organizations, institutions or persons any information necessary to process this application and determine my insurability; (3) understand the coverage applied for replaces any previous Employee, Spouse or Dependent Children Term Life coverage offered by PEHP; (4) agree to the terms and conditions in the PEHP Group Term Life Master Policy.

EMPLOYEE SIGNATURE	DATE	DEPENDENT SIGNATURE (Required if applying for Spouse Term-Life Coverage or Dependent Child Coverage if child is age 18 or older)	DATE
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