

Public Employees Health Programs

560 East 200 South, Suite 100 / Salt Lake City, Utah 84102-2004

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

Group Term Life Change Form

Section A - Employee Information

Employee Name (First, Middle, Last)	Daytime Phone	Birth Date (mm/dd/yy)	Social Security Number
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Section B - Beneficiary Change

EMPLOYEE TERM LIFE

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

SPOUSE TERM LIFE

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

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

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

Life Coverage Terminations

- | | |
|---|---|
| <input type="checkbox"/> Terminate Employees Basic Coverage | <input type="checkbox"/> Terminate Spouse Coverage |
| <input type="checkbox"/> Terminate Employee Additional Coverage | <input type="checkbox"/> Terminate Dependent Child Coverage |

EMPLOYEE SIGNATURE	DATE
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