PEHP Health & Benefits
560 East 200 South, Salt Lake City, UT 84102
801-366-7555 / 800-765-7347
Fax: 801-366-7599
www.pehp.org

Dependent Addition/Removal Form

Please Print Clearly. Note: *This form is to ADD or REMOVE one or more dependents to your existing plans with a qualifying event only. If you need to enroll in new plans, or change your coverage in another way, please contact PEHP's Enrollment team. To submit completed form, log in to your PEHP account and send form via Message Center.*

YOUR NAME (last, first, middle initial)	SOCIAL SECURITY NUMBER	BIRTH DATE (mm/dd/yy)	MARITAL STATUS ☐ SINGLE ☐ MARRIED	GENDER ☐ MALE ☐ FEMALE
MAILING ADDRESS	CITY/STATE/ZIP	PRIMARY PHONE		
EMPLOYER	EMAIL ADDRESS	ALTERNATE PHONE	HIRE DATE (mm/dd/yy)	

Change Request (check one)

☐ Add Dependent ☐ Remove Dependent

Qualifying Event (check one)

☐ Marriage Date: _____ ☐ Birth/Adoption Date: _____ ☐ Divorce Date: _____ ☐ Lost/Gained other coverage Date: _____ ☐ Other – Please explain: _____ Date: _____

Dependent Information

If dependents are stepchildren, natural children not living with both parents, or "other" relationship, provide supporting documentation, e.g., divorce decree, court orders, birth certificate, etc.

RELATIONSHIP TO EMPLOYEE		FULL NAME OF DEPENDENTS (last, first, middle initial)	GENDER	BIRTH DATE (mm/dd/yy)	DEPENDENT SOCIAL SECURITY NO.	COVERAGE
CODE KEY: **C »** Child Natural/ Adopted **SC »** Stepchild **O »** Other (Describe)			☐ **Male** ☐ **Female**			☐ **M**edical ☐ **D**ental ☐ **V**ision
			☐ **Male** ☐ **Female**			☐ **M**edical ☐ **D**ental ☐ **V**ision
			☐ **Male** ☐ **Female**			☐ **M**edical ☐ **D**ental ☐ **V**ision
			☐ **Male** ☐ **Female**			☐ **M**edical ☐ **D**ental ☐ **V**ision

If your dependents are covered by any other health or dental plan, complete the section below.

Multiple Group Coverage

Complete if you, your spouse, or dependents are covered by any other health or dental plan sponsored by an employer or Medicare.

INSURANCE COMPANY/HMO & PHONE NO.	NAME OF POLICY HOLDER	POLICY HOLDER SSN OR POLICY NO.	EFFECTIVE DATE (mm/dd/yy)	TYPE OF COVERAGE	TYPE OF POLICY	MEDICARE	EMPLOYEE/DEPENDENTS COVERED BY PLAN (Only first name is needed)
				☐ **Health** ☐ **Dental**	☐ **Employee** ☐ **Retired**	☐ **A** ☐ **A&B**	
				☐ **Health** ☐ **Dental**	☐ **Employee** ☐ **Retired**	☐ **A** ☐ **A&B**	

Employee Agreement and Signature

Before signing, make sure that 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 changes** effecting coverage and/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 coverage. By signing below I hereby: (1) authorize the deduction of health/dental contributions through the provisions of IRS Section 125 Flexible Benefits; (2) authorize PEHP to release information to health/dental providers, insurance entities, or other entities necessary to process claims and to administer the health plan; (3) certify all dependents listed are eligible for coverage; (4) 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; (5) agree to the terms and conditions in the PEHP Master Policy.

☐ I certify that I am not a party to a divorce proceeding and am not subject to an injunction/order which prevents me from modifying insurance or changing beneficiaries.
Note: Supporting documentation may be requested to validate the date of this change.

Employee Signature	Date

Please make a copy for your records.

(Employer use only) **DAR 7-2-25**

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