



560 East 200 South, Salt Lake City, UT 84102
 801-366-7555 / 800-765-7347
 www.pehp.org

Medicare Supplemental Plan
 Enrollment and Record Card

Note: Both Social Security Number and Medicare ID Number are required for each applicant.

Reason for enrollment change: _____ Effective date: _____

Retiree Information

Spouse Information on Reverse

YOUR NAME (last, first, middle initial) AS IT APPEARS ON YOUR MEDICARE ID CARD		SOCIAL SECURITY NUMBER	BIRTH DATE (mm/dd/yy)
GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED		MEDICARE NUMBER (AS IT APPEARS ON YOUR ID CARD)
HOME ADDRESS		CITY/STATE/ZIP	PRIMARY PHONE
PREVIOUS PUBLIC EMPLOYER		EMAIL ADDRESS	

CURRENT MEDICARE COVERAGE

NOTE: You must be enrolled in Medicare Parts A and B to enroll in any PEHP Medicare Supplement (medical) plan.

Will you have Medicare A and B when this plan takes effect? YES NO

Do you currently have other non-PEHP medical coverage other than Medicare? YES NO

If yes, provide company name: _____ Termination Date: _____

PLAN SELECTION

MEDICAL (all medical plans include discount dental plan)

- PEHP Medicare Supplement Medical Plan 100
- PEHP Medicare Supplement Medical Plan 75
- PEHP Medicare Supplement Medical Plan 50
- No Coverage / Terminate Coverage

You may choose a Medical Plan only, or a Pharmacy Plan only, or a combination of both Medical and Pharmacy.

PHARMACY

- Basic Pharmacy
- Basic Plus Pharmacy
- Enhanced Pharmacy
- No Coverage / Terminate Coverage

DENTAL

- Dental 1500 – \$1,500 Annual Benefit Maximum
- Dental 1000 – \$1,000 Annual Benefit Maximum
- No Coverage / Terminate Coverage

VISION

- Opticare - Full EyeMed - Full (Plan H)
- Opticare - Eyewear only EyeMed - Eyewear only (Plan F)
- No Coverage / Terminate Coverage

I represent that the above 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 PEHP to release information to health/dental providers, insurance entities, or other entities necessary to process claims and to administer the health plan; (2) agree to the terms and conditions in the PEHP Master Policy.

SIGNATURE OF RETIRED EMPLOYEE

DATE

Authorization To Deduct Premiums

Please select one option below and sign.

- Please **deduct** my portion of costs **from my URS pension retirement check**. (New retirees may be billed up to three months prior to pension deduction).
- Please **deduct** from my HRA monthly for my portion of costs. *Authorization form required.*
- Please **bill me** (paper bill or ACH withdrawal) monthly for my portion of costs. *Authorization form required.*

I agree to make payments for benefits by means authorized above. Pension check deductions will be made in accordance with the bylaws of Utah Retirement Systems. I hereby request and authorize you to deduct from my allowance the amount necessary to pay for the benefits for which I have been approved.

Signature

Date

Spouse Information

YOUR NAME (last, first, middle initial) AS IT APPEARS ON YOUR MEDICARE ID CARD		SOCIAL SECURITY NUMBER	BIRTH DATE (mm/dd/yy)
GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED		MEDICARE NUMBER (AS IT APPEARS ON YOUR ID CARD)
HOME ADDRESS		CITY/STATE/ZIP	PRIMARY PHONE
PREVIOUS PUBLIC EMPLOYER		EMAIL ADDRESS	
CURRENT MEDICARE COVERAGE			
NOTE: You must be enrolled in Medicare Parts A and B to enroll in any PEHP Medicare Supplement (medical) plan.			
Will you have Medicare A and B when this plan takes effect? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Do you currently have other non-PEHP medical coverage other than Medicare? <input type="checkbox"/> YES <input type="checkbox"/> NO			
If yes, provide company name: _____ Termination Date: _____			
PLAN SELECTION			
MEDICAL (all medical plans include discount dental plan)		PHARMACY	
<input type="checkbox"/> PEHP Medicare Supplement Medical Plan 100 <input type="checkbox"/> PEHP Medicare Supplement Medical Plan 75 <input type="checkbox"/> PEHP Medicare Supplement Medical Plan 50 <input type="checkbox"/> No Coverage / Terminate Coverage		<input type="checkbox"/> Basic Pharmacy <input type="checkbox"/> Basic Plus Pharmacy <input type="checkbox"/> Enhanced Pharmacy <input type="checkbox"/> No Coverage / Terminate Coverage	
DENTAL <input type="checkbox"/> Dental 1500 – \$1,500 Annual Benefit Maximum <input type="checkbox"/> Dental 1000 – \$1,000 Annual Benefit Maximum <input type="checkbox"/> No Coverage / Terminate Coverage		VISION <input type="checkbox"/> Opticare - Full <input type="checkbox"/> EyeMed - Full (Plan H) <input type="checkbox"/> Opticare - Eyewear only <input type="checkbox"/> EyeMed - Eyewear only (Plan F) <input type="checkbox"/> No Coverage / Terminate Coverage	
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_____ SIGNATURE OF RETIRED EMPLOYEE		_____ DATE	

SIGNATURES ARE REQUIRED FOR EACH ELIGIBLE APPLICANT FOR THIS FORM TO BE PROCESSED.