PEHP Health & Benefits
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

NAME (last, first, middle initial) AS APPEARS ON MEDICARE ID CARD		MEDICARE BENEFICIARY IDENTIFIER (MBI), AS APPEARS ON MEDICARE ID CARD	
SOCIAL SECURITY NUMBER	BIRTH DATE (mm/dd/yy)	GENDER ☐ MALE ☐ FEMALE	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED
HOME ADDRESS	CITY/STATE/ZIP	PRIMARY PHONE	ALTERNATE PHONE
MAILING ADDRESS (*if different from Home Address*)			
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
- ☐ Employer-Sponsored Enhanced Plan *(Only available if you receive employer premium contributions)*
- ☐ No Coverage / Terminate Coverage

DENTAL

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

VISION

- ☐ Opticare - Full
- ☐ Opticare - Eyewear only
- ☐ EyeMed - Full (Plan H)
- ☐ 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

Please make a copy for your records.

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 ☐ MALE ☐ FEMALE	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED	MEDICARE BENEFICIARY IDENTIFIER (MBI), AS APPEARS ON MEDICARE ID CARD

HOME ADDRESS CITY/STATE/ZIP	PRIMARY PHONE	ALTERNATE PHONE

MAILING ADDRESS (*if different from Home Address*)

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
- ☐ Basic Dental – $500 Annual Benefit Maximum
- ☐ No Coverage / Terminate Coverage

VISION

- ☐ Opticare - Full
- ☐ Opticare - Eyewear only
- ☐ EyeMed - Full (Plan H)
- ☐ EyeMed - Eyewear only (Plan F)
- ☐ 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.