Public Employees
Health and Dental Programs
560 East 200 South, Suite 100 / Salt Lake City, Utah 84102-2004
Enrollment: 801-366-7555 / Toll Free 800-765-7347 / Fax 801-328-7309

Duplicate Coverage Disclosure for Coordination of Benefits

EMPLOYEE NAME (last, first, middle initial)	SOCIAL SECURITY NUMBER	PRIMARY PHONE	BIRTHDATE (mm/dd/yy)
MAILING ADDRESS	CITY / STATE / ZIP	ALTERNATE PHONE	

Please note: the following section must be completed with all applicable dates, if incomplete, claims may be denied.

INSURANCE COMPANY NAME & PHONE NUMBER	NAME OF POLICY HOLDER	POLICY HOLDERS POLICY NUMBER	EFFECTIVE DATE (mm/dd/yy)	TYPE OF COVERAGE	POLICY TYPE	MEDICARE	INDIVIDUALS COVERED BY PLAN (FIRST NAME ONLY)
				Health Dental Both	☐ Active ☐ Retired	☐ A (ONLY) ☐ A & B	
				☐ Health ☐ Dental ☐ Both	☐ Active ☐ Retired	☐ A (ONLY) ☐ A & B	
				☐ Health ☐ Dental ☐ Both	☐ Active ☐ Retired	☐ A (ONLY) ☐ A & B	

Yes____ **No**____ Have you or your dependents been covered by any other Medical or Dental plan during the time you have been enrolled in the Public Employees' Health/Dental Programs (PEHP/PEDP) and the other coverage has since terminated?
If yes, you must provide PEHP with a termination letter from either the insurance company or the employer this plan was provided through. This letter *must* include the following: name of the group plan, names of dependents covered by the plan, effective dates (of each dependent), termination dates (of each dependent), type of coverage (e.g., medical, dental or both), and the policy type (e.g., active, retired or discount program).

DEPENDENT INFORMATION
Yes____ **No** ____ Are there divorce decree(s), paternity papers, legal guardianship or adoption papers, which apply to your dependents/children?
If yes, please submit a copy of the complete court-signed documents AND complete the following sections.

NAME OF PARENT/ GUARDIAN	DATE OF BIRTH (mm/dd/yy)	DESCRIBE RELATIONSHIP TO CHILDREN (e.g., father of James, step-father of Mike)

Additional Dependent Information and Required Signature Continued on Back

CHILDREN OVER 18

Child's Name	Lives with (Name of parent/guardian, if none, put "none")

EXPLANATIONS

Before signing, make sure you have attached all requested documentation and have completed all applicable sections of this form so your enrollment is not delayed. You may be asked for additional information and or documentation. Please note: It is the employees responsibility to notify PEHP/PEDP within 60 days of any change affecting dependent eligibility (i.e., birth, marriage, divorce, etc.).

I represent that all information is true and correct. I understand and agree the any false information I provide on this form may, at PEHP's sole discretion, result in a limitation or termination of my insurance coverage. By signing below I hereby: (1) authorize PEHP/PEDP to release information to dental providers, insurance entities, or other entities necessary to process claims and administer the Health Plan. (2) certify all dependents listed are eligible for coverage; (3) understand if PEHP/PEDP is not notified that a dependent is ineligible and subsequent claims are paid, I will be responsible for reimbursement to PEHP/PEDP for any claims paid in error; (4) agree to the terms and conditions in the PEHP/PEDP Master Policy.

EMPLOYEE SIGNATURE	**DATE**