LONG-TERM DISABILITY
MEDICAL COVERAGE STIPEND FORM

For PEHP LTD
PO Box 1169
Salt Lake City, UT 84110 801-366-7583 or 800-365-7347

Mark the applicable statement(s):

☐ ***My spouse/family has other employer sponsored medical coverage available to them.***

☐ ***My spouse/family DOES NOT have other employer sponsored medical coverage available to them.***

☐ ***I am Medicare eligible.***

☐ ***I am NOT Medicare eligible.***

☐ ***My spouse is Medicare eligible.***

☐ ***My spouse is NOT Medicare eligible.***

Printed Name: _____

Signature: _____

Date: _____

Phone Number: _____

Mail to PEHP LTD in the envelope provided or email to: pehp.ltd@pehp.org or fax to 801-366-7321.