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

# Medical ACA
Enrollment Form
**State of Utah**

**Employee Status:** ☐ Full time ☐ Part time
**Benefit Eligibility:** ☐ Eligible ☐ Ineligible

Changes made on this form will affect your medical coverage only. To make changes to other coverages, please complete the appropriate forms for those plans. **Please print clearly.**

☐ New Enrollment ☐ Termination ☐ Change Request (Please Specify Type):________________

## SECTION A » Employee and Coverage Information

| 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) | |

### Group Medical (check one)

**Coverage type** (Check one)

☐ EMPLOYEE ONLY
☐ Employee plus one dependent
☐ Employee plus two more more dependents
☐ No medical coverage at this time

**Choose your network**

☐ Summit Network
☐ Advantage Network
☐ Preferred Network

**Choose your medical plan**

☐ STAR HSA*
☐ Traditional
☐ Consumer Plus*
*Consumer Plus is only available to new hires and members previously enrolled in STAR HSA.*

☐ * I am eligble for a health savings account (HSA)
☐ * I will not open an HSA at this time

* If you participate in an HSA, you must complete an HSA enrollment form. It will be sent to you after enrollment.

## SECTION B » Dependent Information

**ADDITIONS** List your eligible dependents. For your spouse, include a copy of marriage certificate. For dependent children enrolled, include a copy of birth certificate. PEHP benefits will not be processed until required documentation is received.

| RELATIONSHIP TO EMPLOYEE | | FULL NAME OF DEPENDENTS (last, first, middle initial) | MARRIAGE DATE (mm/dd/yy) | GENDER | BIRTH DATE (mm/dd/yy) | DEPENDENT SOCIAL SECURITY NO. |
|---|---|---|---|---|---|---|
| CODE KEY: S » Legal Spouse C » Child Natural/ Adopted SC » Stepchild O » Other (Describe in Section D) | S | | | ☐ Male ☐ Female | | |
| | | | | ☐ Male ☐ Female | | |
| | | | | ☐ Male ☐ Female | | |
| | | | | ☐ Male ☐ Female | | |
| | | | | ☐ Male ☐ Female | | |
| | | | | ☐ Male ☐ Female | | |

Are you, your spouse, or dependents covered by any other health or dental plan or by Medicare? ☐ **Yes** ☐ **No** **If yes, complete Section C on back**

**REMOVALS** Fill out the table below if you are terminating coverage for dependents who are no longer eligible. For all terminations outside of annual enrollment, adequate documentation is required (divorce decree, proof of other coverage, etc.)

| RELATIONSHIP TO EMPLOYEE | | FULL NAME OF DEPENDENTS (last, first, middle initial) | DEPENDENT SOCIAL SECURITY NO. | REASON FOR TERMINATION (e.g., marriage, divorce, death, age of 26) | APPLICABLE DATE* |
|---|---|---|---|---|---|
| S » Legal Spouse C » Child Natural/ Adopted SC » Stepchild O » Other (Describe in Section D) | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

*Applicable Date is the date of marriage, divorce, birthday, etc.

**Signature required on other side.**

**(HR use only)** **ST-E ACA ONLY** 12-13-19

Effective Date:____________ Termination Date:____________ HR Approval:____________

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Employee Name: ______________________________ Social Security Number: ____________________

**CUSTODY OF CHILDREN**

If dependants listed on first page are not living with both natural parents, please complete the following:

Who has physical custody of the children?

☐ Mother ☐ Father

Please provide the names and birth dates of both natural parents

Mother:______________________ Father:______________________

Name Birthdate Name Birthdate

Who has physical custody of the stepchildren?

☐ Mother ☐ Father

Please provide the names and birth dates of both natural parents

Mother:______________________ Father:______________________

Name Birthdate Name Birthdate

## SECTION C » 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/DEPENDANTS COVERED BY PLAN (Only first name is needed) |
|---|---|---|---|---|---|---|---|
| | | | | ☐ **Health**<br>☐ **Dental** | ☐ **Employee**<br>☐ **Retired** | ☐ **A**<br>☐ **A&B** | |
| | | | | ☐ **Health**<br>☐ **Dental** | ☐ **Employee**<br>☐ **Retired** | ☐ **A**<br>☐ **A&B** | |

## SECTION D » Explanations

## SECTION E » 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 contributions through the provisions of IRS Section 125 Flexible Benefits; (2) authorize PEHP to release information to health 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.

| Employee Signature | Date |
|---|---|
| | |

Please make a copy for your records.