PEHP Health & Benefits
560 East 200 South, Salt Lake City, UT 84102
Retiree Health Counselors: 801-366-7499
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www.pehp.org

Medical, Dental, Vision
Enrollment and Change Form
State of Utah Retiree

Important Note: Changes made on this form will affect your medical, dental, and vision coverages only. If you need to make changes to other coverages, please complete the appropriate forms for those plans. **Please print clearly.**

Need Some Help? Contact a Retiree Health Counselor at **801-366-7499.**

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

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	RETIREMENT DATE (mm/dd/yy)	

Group Medical (check one)

Coverage type (Check one)
- ☐ RETIREE ONLY
- ☐ Spouse only
- ☐ Retiree plus one dependent
- ☐ Retiree plus two or more dependents
- ☐ No medical coverage at this time

Choose your network
- ☐ Summit Network
- ☐ Advantage 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.

Group Dental (check one)

Coverage type (Check one)
- ☐ RETIREE ONLY
- ☐ Spouse only
- ☐ Retiree plus one dependent
- ☐ Retiree plus two or more dependents

Choose your dental plan
- ☐ PEHP Preferred Dental
- ☐ PEHP Traditional Dental
- ☐ EMI Choice Indemnity
- ☐ No dental coverage at this time

Additional options for those on STAR HSA or Consumer Plus Plan Only:
- ☐ Basic HSA Dental
- ☐ Discount HSA Dental

VISION (Check one)
- ☐ Eyemed – Full
- ☐ Eyemed – Eyewear Only
- ☐ No vision coverage at this time

Coverage type (Check one)
- ☐ RETIREE ONLY
- ☐ Spouse only
- ☐ Retiree plus one dependent
- ☐ Retiree plus 2+ dependents

ADDITIONS List your eligible dependents.

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

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

Signature required on other side.

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Retiree Name: _____ Social Security Number: _____

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.) If you voluntarily drop dental coverage, you will not be able to re-enroll for up to three years.

RELATIONSHIP TO Retiree		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*	COVERAGE TERMINATED
S » Legal Spouse						☐**M**edical ☐**D**ental ☐**V**ision
C » Child Natural/ Adopted						☐**M**edical ☐**D**ental ☐**V**ision
SC » Stepchild						☐**M**edical ☐**D**ental ☐**V**ision
O » Other (Describe in Section D)						☐**M**edical ☐**D**ental ☐**V**ision

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

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	RETIREE/DEPENDANTS COVERED BY PLAN (Only first name is needed)
				☐ **Health** ☐ **Dental**	☐ **Employee** ☐ **Retired**	☐ **A** ☐ **A&B**	
				☐ **Health** ☐ **Dental**	☐ **Employee** ☐ **Retired**	☐ **A** ☐ **A&B**	

Explanations

Authorization to Deduct Contributions

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**

Retiree 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 retiree'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/dental contributions through the provisions of IRS Section 125 Flexible Benefits; (2) authorize PEHP to release information to health/dental 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.

Retiree Signature	Date

Please make a copy for your records.