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# Utah School Boards Association Medical Enrollment and Change Form

**Note:** Changes made on this form are for medical only. For changes to other plans sponsored by your employer, please contact your employer for information and forms. Please print clearly.

<b>Employee Status</b>	<b>Benefit Eligibility</b>
<input type="checkbox"/> Full time <input type="checkbox"/> Part time	<input type="checkbox"/> Eligible <input type="checkbox"/> Ineligible

## Section A - Employee and Coverage Information

New Enrollment  Status Change (Please specify type): \_\_\_\_\_

Employee Name (last, first, middle initial)	Social Security Number	Birth Date (mm/dd/yy)	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address	City / State / Zip	Home Phone		
Email Address	Employer Garfield School District	Work Phone	Hire Date (mm/dd/yy)	
<b>Group Medical</b> (check one) <input type="checkbox"/> Gold Plan - Preferred <input type="checkbox"/> Silver Plan - Preferred <input type="checkbox"/> Copper HSA - Preferred* <input type="checkbox"/> Gold Plan - Advantage <input type="checkbox"/> Silver Plan - Advantage <input type="checkbox"/> Copper HSA - Advantage*			<b>Coverage Type</b> (check one) <input type="checkbox"/> Employee only <input type="checkbox"/> Employee plus one dependent <input type="checkbox"/> Employee plus two or more dependents	
<input type="checkbox"/> *I am eligible for a Health Savings Account (HSA)			<input type="checkbox"/> *I will not open an HSA at this time	

## Section B - Dependent Information

### Additions

List your eligible dependents. If adding a new spouse, please include date of marriage. If dependents are stepchildren, natural children not living with both parents, or classified as Other Relationship please provide supporting documentation, e.g., divorce decree, court orders, birth certificate, etc. If you don't have supporting documentation please explain in Section D.

Relationship to employee	Full name of dependents to be covered (last, first, middle initial)	Marriage date (mm/dd/yy)	Gender	Birth date			Dependent social security #	Does the dependent have other medical/dental insurance?	Important: If any dependent has other coverage, you must complete Section C.
				Month	Day	Year			
<b>Code Key</b> S - Legal spouse	S		<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>C</b> - Child natural / adopted			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>SC</b> - Stepchild			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>O</b> - Other			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No	

### 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 employee	Dependents to no longer be covered (last, first, middle initial)	Dependent social security No.	Reason for termination (i.e. marriage, divorce, death, age of 26, etc.)	Applicable date*		
				Month	Day	Year
<b>Code Key</b> S - Spouse						
<b>N</b> - Natural Child						
<b>SC</b> - Stepchild						
<b>O</b> - Other (Describe in Section D)						

\*Applicable date could be date of marriage, divorce, birthday, etc.

**Signature required, see Section F on reverse side.**

(HR Use Only)

USBA-E 02-01-17

Effective Date: \_\_\_\_\_ Employment Termination Date: \_\_\_\_\_ Coverage Termination Date: \_\_\_\_\_ HR Approval: \_\_\_\_\_

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Employee Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

## Section C - Multiple Group Coverage

Complete if you, your spouse or dependents are covered by any other health plan, sponsored by an employer or by Medicare.

Insurance company/HMO & phone No.	Name of policy holder	Policy holder SSN or policy No.	Effective date (mm/dd/yy)	Type of policy	Medicare	Employee/dependents covered by plan (Only first name is needed)
				<input type="checkbox"/> Employee <input type="checkbox"/> Retired	<input type="checkbox"/> A <input type="checkbox"/> A&B	
				<input type="checkbox"/> Employee <input type="checkbox"/> Retired	<input type="checkbox"/> A <input type="checkbox"/> A&B	
				<input type="checkbox"/> Employee <input type="checkbox"/> Retired	<input type="checkbox"/> A <input type="checkbox"/> A&B	

## Section D - Explanations

## Section E - Salary Reduction

Monthly Group Flexible Spending Health Insurance Premium \$ \_\_\_\_\_

I hereby authorize my employer to reduce my salary using pre-tax deduction in the amount above to pay for the insurance premium. I understand my Social Security benefits may be reduced since Social Security taxes are not paid on my contributions.

**Sign Here** →

Employee signature	Effective Date
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## Section F - Employee Agreement and Signature

*Before signing, make sure 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 change** affecting coverage 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 insurance 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) certify all dependents listed are eligible for coverage; (3) 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; (4) agree to the terms and conditions in the PEHP Master Policy.

**Sign Here** →

Employee signature	Date
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Please make a copy for your records