PEHP Health & Benefits
560 East 200 South, Salt Lake City, UT 84102
801-366-7555 / 800-765-7347
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www.pehp.org

Utah State University
Enrollment and Change Form

Changes made on this form are for medical and vision only. All other changes can be made online at www.pehp.org.
Please print clearly.

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

☐ 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	HIRE DATE (mm/dd/yy)	

Group Medical (check one) | **Check with your employer to see what options are available to you**

Coverage type (Check one)

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

Choose your network

- ☐ Summit Network
- ☐ Advantage Network

Choose your medical plan

- ☐ STAR HSA (complete below for HSA eligibility)*
- ☐ Traditional

* For The STAR HSA Plan enrollment, confirm HSA eligibility.

- ☐ I am eligible for a Health Savings Account (HSA)
- ☐ I will not open an HSA at this time

VISION (Check one)

- ☐ Eyemed – Full
- ☐ Eyemed – Eyewear Only
- ☐ Opticare – Full
- ☐ Opticare – Eyewear Only
- ☐ No vision coverage at this time

Coverage type (Check one)

- ☐ EMPLOYEE ONLY
- ☐ Employee plus one dependent
- ☐ Employee plus 2+ dependents

ADDITIONS List your eligible dependents. For your spouse, include a copy of marriage certificate. For dependent children enrolled, include a copy of birth certificate. If dependents are classified as Other Relationship, please provide supporting documentation, e.g., court orders, birth certificates, etc. 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.	COVERAGE DESIRED
CODE KEY: **S** » Legal Spouse; **C** » Child Natural/ Adopted; **SC** » Stepchild; **O** » Other (Describe in Section D)	**S**			☐ **Male** ☐ **Female**			☐**M**edical ☐**V**ision
				☐ **Male** ☐ **Female**			☐**M**edical ☐**V**ision
				☐ **Male** ☐ **Female**			☐**M**edical ☐**V**ision
				☐ **Male** ☐ **Female**			☐**M**edical ☐**V**ision
				☐ **Male** ☐ **Female**			☐**M**edical ☐**V**ision
				☐ **Male** ☐ **Female**			☐**M**edical ☐**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.

(HR use only) **SRP-USU** 06-30-22

Effective Date:_____ Employment Termination Date:_____ Coverage Termination Date:_____ HR Approval:_____

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Employee 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 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*	COVERAGE TERMINATED
S » Legal Spouse						☐**M**edical ☐**V**ision
C » Child Natural/ Adopted						☐**M**edical ☐**V**ision
SC » Stepchild						☐**M**edical ☐**V**ision
O » Other (Describe in Section D)						☐**M**edical ☐**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	EMPLOYEE/DEPENDENTS COVERED BY PLAN (Only first name is needed)
				☐ **Health** ☐ **Dental**	☐ **Employee** ☐ **Retired**	☐ **A** ☐ **A&B**	
				☐ **Health** ☐ **Dental**	☐ **Employee** ☐ **Retired**	☐ **A** ☐ **A&B**	

Explanations

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/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.

Employee Signature	Date

Please make a copy for your records.