

# Public Employees Health Program

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 Customer Service: (801) 366-7555 / Toll Free (800) 765-7347

# Local Governments Medical and Dental Enrollment and Change Form

## Section A

### Employee and Coverage Information Please Print Clearly

**Important Note:**

Changes made on this form will affect your medical and dental coverages only. If you need to make changes to other coverages, please complete the appropriate forms for those plans.

New Enrollment     Change Requested (Please specify type):

EMPLOYEE NAME (last, first, middle initial)	SOCIAL SECURITY NUMBER	BIRTH DATE (mm/dd/yy)	MARITAL STATUS	GENDER
MAILING ADDRESS	CITY / STATE / ZIP	HOME PHONE	<input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Male <input type="checkbox"/> Female
EMPLOYER		WORK PHONE	HIRE DATE (mm/dd/yy)	

<p><b>Group Medical</b> (check one)<sup>1</sup></p> <p><b>Benefit Plan Using Contracted &amp; Non-Contracted Providers</b></p> <p><input type="checkbox"/> <b>Preferred Medical Care</b></p> <p><input type="checkbox"/> Option 1  <input type="checkbox"/> Option 2  <input type="checkbox"/> Option 3  <input type="checkbox"/> High Deductible Health Plan 2</p> <p><input type="checkbox"/> <b>Summit Care</b></p> <p><input type="checkbox"/> Option 1  <input type="checkbox"/> Option 2  <input type="checkbox"/> Option 3  <input type="checkbox"/> High Deductible Health Plan 2</p> <p><input type="checkbox"/> <b>Advantage Care *</b></p> <p><input type="checkbox"/> Option 1  <input type="checkbox"/> Option 2  <input type="checkbox"/> Option 3  <input type="checkbox"/> High Deductible Health Plan 2</p> <p><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</p> <p><input type="checkbox"/> No medical coverage at this time  <input type="checkbox"/> I will not be opening a Health Savings Account (HSA) with Utah Retirement Systems (URS) at this time.</p>	<p><b>Benefit Plan Using Contracted Providers Only</b></p> <p><input type="checkbox"/> <b>Preferred Medical Care</b></p> <p><input type="checkbox"/> Option 1  <input type="checkbox"/> Option 2  <input type="checkbox"/> Option 3  <input type="checkbox"/> High Deductible Health Plan 2</p> <p><input type="checkbox"/> <b>Summit Care</b></p> <p><input type="checkbox"/> Option 1  <input type="checkbox"/> Option 2  <input type="checkbox"/> Option 3  <input type="checkbox"/> High Deductible Health Plan 2</p> <p><input type="checkbox"/> <b>Advantage Care *</b></p> <p><input type="checkbox"/> Option 1  <input type="checkbox"/> Option 2  <input type="checkbox"/> Option 3  <input type="checkbox"/> High Deductible Health Plan 2</p>	<p><b>Group Dental</b> (check one)</p> <p><input type="checkbox"/> Preferred Choice Dental Care  <input type="checkbox"/> Traditional Dental  <input type="checkbox"/> No dental coverage at this time</p> <p><b>COVERAGE TYPE</b> (check one)</p> <p><input type="checkbox"/> Employee only  <input type="checkbox"/> Employee plus one dependent  <input type="checkbox"/> Employee plus two or more dependents</p> <p><b>Vision</b> (check one)</p> <p><input type="checkbox"/> Eyemed Vision  <input type="checkbox"/> Opticare Vision</p> <p><b>COVERAGE TYPE</b> (check one)</p> <p><input type="checkbox"/> Employee only  <input type="checkbox"/> Employee plus one dependent  <input type="checkbox"/> Employee plus two or more dependents</p>
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- If you have had previous health coverage within the last 9 months, please attach a Certificate of Creditable Coverage from your former insurance company.
  - If you elect to participate in the URS HSA, you must complete an enrollment form for that program.
- \* This plan is offered in specific geographic areas. Please check the specific plan information before enrolling.

## Section B

### Dependent Information ADDITIONS

Complete the table below listing your eligible dependents. If adding a new spouse, please include date of marriage and marriage certificate. If dependents are stepchildren, natural children not living with both parents, or classified as other relationship please provide supporting documentation, i.e. divorce decree, court orders, birth certificate, etc.

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 NO.	Does the dependent have other Medical/Dental Insurance?	Important: If any dependent has other coverage Section C must be completed.
				Month	Day	Year			
CODE KEY	<b>S</b>		<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No	
S - Legal Spouse			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No	
C - Child Natural / Adopted			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No	
SC - Stepchild			<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No	
O - Other			<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	

**REMOVALS**    Fill out the table below if you are terminating coverage for dependents who are no longer eligible. If termination is a result of a divorce and children are involved, please provide a copy of divorce decree.

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
CODE KEY						
S - Spouse						
C - Natural / Adopted						
SC - Stepchild						
O - Other (Describe in Section D)						

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

Signature required on reverse side.

(HR Use Only)	LG-PE 3-08
Effective Date: _____	HR Approval: _____

