

Public Employees Health Programs

560 East 200 South, Suite 100 / Salt Lake City, Utah 84102-2004

Term Life: (801) 366-7495 / Toll Free (800) 753-7495

Group Term Life Change Form

Section A - Employee Information

Employee Name (First, Middle, Last)	Daytime Phone	Birth Date (mm/dd/yy)	Social Security Number
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Section B - Beneficiary Change

EMPLOYEE TERM LIFE

Revoking any previous nominations of beneficiary(ies), I hereby designate the following individuals to receive all benefits payable upon my death.

Full Given Name of Beneficiary	Designation	Relationship	Birth Date	Mailing Address		
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			Street		
				City	State	Zip
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			Street		
				City	State	Zip
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			Street		
				City	State	Zip
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			Street		
				City	State	Zip

SPOUSE TERM LIFE

Full Given Name of Beneficiary	Designation	Relationship	Birth Date	Mailing Address		
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			Street		
				City	State	Zip
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			Street		
				City	State	Zip

DEPENDENT CHILD TERM LIFE

Full Given Name of Beneficiary	Designation	Relationship	Birth Date	Mailing Address		
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			Street		
				City	State	Zip
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			Street		
				City	State	Zip

Section C - Dependent Addition or Termination

ADDITIONS for existing coverage within 60 days of qualifying event

RELATIONSHIP TO EMPLOYEE	FULL NAME OF DEPENDENTS TO BE COVERED (last, first, middle initial)	GENDER	BIRTH DATE			DEPENDENT SOCIAL SECURITY NO.
CODE KEY		<input type="checkbox"/> M <input type="checkbox"/> F				
C - Child Natural / Adopted		<input type="checkbox"/> M <input type="checkbox"/> F				
SC - Stepchild		<input type="checkbox"/> M <input type="checkbox"/> F				

TERMINATIONS

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 - Child Natural / Adopted						
SC - Stepchild						
O - Other						

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

EMPLOYEE SIGNATURE	DATE
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