

# Public Employees Health Program

560 East 200 South, Suite 100 / Salt Lake City, Utah 84102-2004  
 Customer Service: 801-366-7555 / Toll Free 800-765-7347

# Salt Lake County Medical Enrollment and Change Form

**Important Note:**

Changes made on this form may also affect your coverages under other group benefit plans sponsored by your employer. Please contact your employer for information and forms.

**Section A**

**Employee and Coverage Information**

Please Print Clearly

New Enrollment     Status Change (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)	
<b>GROUP MEDICAL</b> <input type="checkbox"/> Preferred Medical Care <input type="checkbox"/> Advantage Care High Deductible Health Plan <input type="checkbox"/> Advantage Medical Care <input type="checkbox"/> Summit Care High Deductible Health Plan <input type="checkbox"/> Summit Medical Care		<b>COVERAGE TYPE (check one)</b> <input type="checkbox"/> Employee plus two or more dependents <input type="checkbox"/> Employee only <input type="checkbox"/> Employee plus one dependent		

**Section B**

**Dependent Information**

**ADDITIONS**

Complete the table below listing your eligible dependents. If adding a new spouse, please include date of marriage and copy of 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. 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 NO.	Does the dependent have other Medical Insurance?
				Month	Day	Year		
CODE KEY S - Legal Spouse C - Child Natural / Adopted SC - Stepchild O - Other (Describe in Section D) AD - Adult Designee ADC - Child of Adult Designee			<input type="checkbox"/> M <input type="checkbox"/> F					<b>Important:</b> If any dependent has other coverage, Section C must be completed.
			<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	
			<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	
			<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, a copy of divorce decree is required.**

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 (Describe in Section D) AD - Adult Designee ADC - Child of Adult Designee						

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

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

(HR Use Only)	C-E Updated: 2-09
Effective Date: _____	HR Approval: _____

