

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

BENEFICIARY CHANGE FORM

This form is used to change the primary or secondary beneficiaries of your Employee Group Term Life, Spouse Group Term Life & Accidental Death & Dismemberment (Underwritten by Boston Mutual) plans. This designation only effects the above programs; you may need to file other beneficiary forms with Utah Retirement Systems (801-366- 7765 or 800-688-872). Please type or print clearly in black ink and return this form to PEHP.

Section A - Personal Information

| | | |
|------------------------------------|------------------------|-----------------------|
| NAME (last, first, middle initial) | SOCIAL SECURITY NUMBER | EMPLOYER / DEPARTMENT |
| HOME ADDRESS | CITY / STATE / ZIP | DAYTIME PHONE |

Section B - Plan Designation

If you do not name a beneficiary(ies), the benefit(s) will be paid to your estate, as provided for by the plan. The beneficiary for Dependent Child Term Life coverage is automatically the insured employee.

I WISH MY BENEFICIARY TO RECEIVE PROCEEDS, AS APPLICABLE, FROM THE PLAN(S) INDICATED:
(To designate a different primary beneficiary for each plan, use additional forms to avoid confusion.)

- PEHP Employee Term Life
- PEHP Spouse Term Life
- Accidental Death & Dismemberment (Underwritten by Boston Mutual)

Section C - Beneficiary Designation

Please indicate whether the beneficiary is a primary or secondary beneficiary (death benefits are first paid to the primary beneficiary, if the primary beneficiary is deceased benefits would be paid to the secondary beneficiary). If more than one primary beneficiary is listed, the benefit will be divided equally among those listed, unless otherwise instructed on the form.

More space is provided on the back of this form to list additional primary and secondary beneficiaries.

| | | | |
|--|--------------------|------------|------------|
| <input type="checkbox"/> PRIMARY <input type="checkbox"/> SECONDARY (Check One) | | | |
| BENEFICIARY NAME (last, first, middle initial) | RELATIONSHIP | BIRTH DATE | HOME PHONE |
| MAILING ADDRESS | CITY / STATE / ZIP | | WORK PHONE |
| <input type="checkbox"/> PRIMARY <input type="checkbox"/> SECONDARY (Check One) | | | |
| BENEFICIARY NAME (last, first, middle initial) | RELATIONSHIP | BIRTH DATE | HOME PHONE |
| MAILING ADDRESS | CITY / STATE / ZIP | | WORK PHONE |

Section D - Employee Agreement & Signature

I understand this designation supersedes any prior designation for benefits from any of the plans indicated above. I agree this designation is subject to the terms and conditions in applicable Master Policies.

EMPLOYEE'S SIGNATURE / DATE

RECEIPT ACKNOWLEDGED BY PEHP / DATE

Public Employees Health Program

BENEFICIARY CHANGE FORM (CONTINUED)

| | | | |
|--|--------------------|------------|------------|
| <input type="checkbox"/> PRIMARY <input type="checkbox"/> SECONDARY (Check One) | | | |
| BENEFICIARY NAME (last, first, middle initial) | RELATIONSHIP | BIRTH DATE | HOME PHONE |
| MAILING ADDRESS | CITY / STATE / ZIP | | WORK PHONE |
| <input type="checkbox"/> PRIMARY <input type="checkbox"/> SECONDARY (Check One) | | | |
| BENEFICIARY NAME (last, first, middle initial) | RELATIONSHIP | BIRTH DATE | HOME PHONE |
| MAILING ADDRESS | CITY / STATE / ZIP | | WORK PHONE |
| <input type="checkbox"/> PRIMARY <input type="checkbox"/> SECONDARY (Check One) | | | |
| BENEFICIARY NAME (last, first, middle initial) | RELATIONSHIP | BIRTH DATE | HOME PHONE |
| MAILING ADDRESS | CITY / STATE / ZIP | | WORK PHONE |
| <input type="checkbox"/> PRIMARY <input type="checkbox"/> SECONDARY (Check One) | | | |
| BENEFICIARY NAME (last, first, middle initial) | RELATIONSHIP | BIRTH DATE | HOME PHONE |
| MAILING ADDRESS | CITY / STATE / ZIP | | WORK PHONE |
| <input type="checkbox"/> PRIMARY <input type="checkbox"/> SECONDARY (Check One) | | | |
| BENEFICIARY NAME (last, first, middle initial) | RELATIONSHIP | BIRTH DATE | HOME PHONE |
| MAILING ADDRESS | CITY / STATE / ZIP | | WORK PHONE |
| <input type="checkbox"/> PRIMARY <input type="checkbox"/> SECONDARY (Check One) | | | |
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| MAILING ADDRESS | CITY / STATE / ZIP | | WORK PHONE |
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| MAILING ADDRESS | CITY / STATE / ZIP | | WORK PHONE |
| <input type="checkbox"/> PRIMARY <input type="checkbox"/> SECONDARY (Check One) | | | |
| BENEFICIARY NAME (last, first, middle initial) | RELATIONSHIP | BIRTH DATE | HOME PHONE |
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