

Public Employees Health Programs

560 East 200 South, Suite 100
 Salt Lake City, Utah 84102-2004
 Enrollment: 801-366-7555
 Toll Free 800-950-7347

Accidental Death & Dismemberment Plan Enrollment / Change Form

EMPLOYEE INFORMATION

Employee Name (last, first, middle initial)		Social Security Number		Birth Date (mm/dd/yy)	
Home Address		City / State / Zip			
Employer / Department		Work Phone		Home Phone	
Original Hire Date (mm/dd/yy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married		Children Under 26 <input type="checkbox"/> Yes <input type="checkbox"/> No	

Considerations When Naming Beneficiaries

- List ALL beneficiaries. Beneficiary payments are paid from the most recent beneficiary designation on file with PEHP.
- Types of beneficiaries:
 - Primary** - Person to receive the death benefits upon the death of a member.
 - Contingent** - Person to receive the death benefits upon the death of a member if the primary beneficiary is deceased.
- If you name multiple primary beneficiaries, the proceeds will be split equally, unless otherwise instructed on the form.
- If your primary beneficiary(ies) dies before you and you have not named a contingent beneficiary, the proceeds may be subject to Title 75, Chapter 2 of the Utah Uniform Probate Code.
- If you name a trust as beneficiary, be sure to list the name of the trustee and the date the trust agreement became effective.
- Proceeds may not be paid directly to a minor child. In the event a minor child is named a beneficiary, proceeds must be paid to a trust, conservatorship or legal guardian.

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	State	Zip
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			City		
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			Street	State	Zip
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			City		
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			Street	State	Zip
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			City		
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			Street	State	Zip
	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			City		

COVERAGE INFORMATION (Available to employees under age 70)

<input type="checkbox"/> AD&D Coverage	Coverage Type: <input type="checkbox"/> Employee Only <input type="checkbox"/> Family Coverage*	AMOUNT OF COVERAGE
*If both you and your spouse are covered as an "employee" only one may purchase the Family Plan		
<input type="checkbox"/> Accident Weekly Indemnity Coverage (employee only, must be enrolled in AD&D coverage)		
<input type="checkbox"/> Accident Medical Expense Coverage (employee only, must be enrolled in AD&D coverage)		\$2,500

EMPLOYEE AGREEMENT

I represent that all information is true and correct. By signing below I hereby: (1) authorize the deduction of accidental death and dismemberment (AD&D) insurance premiums from my salary; (2) authorize PEHP to release information to the program offeror and /or underwriter necessary to process claims; (3) agree that the information contained on this form replaces all existing coverage and beneficiary designations.

Employee Signature	Date	Effective Date Of Coverage
		Office Use Only

Make and keep a photocopy of completed form for yourself / Return completed form to Human Resources