560 East 200 South / Salt Lake City, Utah 84102-2004
Enrollment: (801) 366-7495 / Toll Free (800) 753-7495

# LGRP

Group Term Life
Spouse/Dependent Child Enrollment Form

## Section A - *Employee Information*

| ☐ New Enrollment | ☐ Application for Additional Coverage | | MARITAL STATUS ☐ Married ☐ Single |
|---|---|---|---|
| EMPLOYEE NAME (last, first, middle initial) | SOCIAL SECURITY NUMBER | BIRTH DATE (mm/dd/yy) | GENDER ☐ Male ☐ Female |
| HOME ADDRESS | CITY/STATE/ZIP | | WORK PHONE |
| | | | HOME PHONE |
| EMPLOYER / DEPARTMENT | Did you transfer from another Agency/Department? ☐ Yes ☐ No | | HIRE DATE (mm/dd/yy) |

## Section B - *Coverage Information*

***Select the desired coverage below. See the term Life Benefits Booklet for coverage and premium amounts. Enter the primary and contingent beneficiaries for Spouse and/or Dependent Child Term Life coverage. Coverage amounts are reduced at age 71, see Benefit Booklet for details. The maximum cumulative coverage for any individual is $500,000.***

### SPOUSE TERM LIFE

Select the amount of Spouse Term Life you are applying for: ☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000 ☐ $150,000 ☐ $200,000 ☐ $250,000 ☐ $300,000 ☐ $350,000 ☐ $400,000 ☐ $450,000 ☐ $500,000

If applying within 60 days of hire or marriage for $50,000 or less a health statement is not required, otherwise complete the Spouse Health Statement.

| SPOUSE NAME (last, first, middle initial) | BIRTH DATE (mm/dd/yy) | MARRIAGE DATE (mm/dd/yy) |
|---|---|---|
| | | |

| Full Given Name of Beneficiary | Designation | Relationship | Birth Date | Mailing Address |
|---|---|---|---|---|
| | ☐ Primary<br>☐ Contingent | | | Street<br>City State Zip |
| | ☐ Primary<br>☐ Contingent | | | Street<br>City State Zip |

### DEPENDENT CHILD TERM LIFE

**Dependent Group Term Life Coverage is for unmarried children up to age 26. List dependents below. Premium covers all eligible dependent children. A Health Statement is required for each dependent if applying past 60 days from hire, birth of dependent, or event.**

Coverage Per Child ☐ $5,000 ☐ $10,000 ☐ $15,000

| RELATIONSHIP TO EMPLOYEE | FULL NAME OF DEPENDENTS TO BE COVERED (last, first, middle initial) | GENDER | BIRTH DATE Month | Day | Year | DEPENDENT SOCIAL SECURITY NO. |
|---|---|---|---|---|---|---|
| CODE KEY | | ☐ M ☐ F | | | | |
| C-Child Natural/Adopted | | ☐ M ☐ F | | | | |
| | | ☐ M ☐ F | | | | |
| SC - Stepchild | | ☐ M ☐ F | | | | |
| O-Other | | ☐ M ☐ F | | | | |
| | | ☐ M ☐ F | | | | |
| | | ☐ ☐ | | | | |

| Full Given Name of Beneficiary | Designation | Relationship | Birth Date | Mailing Address |
|---|---|---|---|---|
| | ☐ Primary<br>☐ Contingent | | | Street<br>City State Zip |
| | ☐ Primary<br>☐ Contingent | | | Street<br>City State Zip |

| EMPLOYEE SIGNATURE | DATE |
|---|---|
| | |

FOR PEHP USE ONLY
Effective Date: ________ Certificate No: ________
Spouse: ________ Dependent: ________

## GROUP TERM-LIFE SPOUSE/DEPENDENT HEALTH STATEMENT (CONTINUED)

Employee Name: ____________________ Social Security Number: ____________________

### Section C - *Spouse or Dependent Child Health Statement*

*Complete this form for the spouse or one for each dependent. This information is required if applying for Spouse or Dependent coverage after 60 days from hire date, marriage date, or birth/adoption date. This is also required for Spouse coverage in excess of $50,000.*

Name (Last, First, M. I.) ____________________ Date of Birth: __________ Height (Ft. In.): __________ Weight __________

Relationship To Employee: ____________________ Occupation: ____________________

| 1. Have you ever had symptoms, been diagnosed with, or been treated for: | | |
|---|---|---|
| a. High blood pressure | ☐ Yes | ☐ No |
| b. Seizures or convulsions | ☐ Yes | ☐ No |
| c. Mental or nervous conditions | ☐ Yes | ☐ No |
| d. Lung or respiratory disorders | ☐ Yes | ☐ No |
| e. Digestive or rectal disorders | ☐ Yes | ☐ No |
| f. Blood or blood vessel disorders | ☐ Yes | ☐ No |
| g. Urinary tract disorders | ☐ Yes | ☐ No |
| h. Skeletal, spine, joint or muscle disorders | ☐ Yes | ☐ No |
| i. Thyroid, breast or other glandular disorders | ☐ Yes | ☐ No |
| j. Rheumatic fever or heart disorders | ☐ Yes | ☐ No |
| k. Chest pain or circulatory disorders | ☐ Yes | ☐ No |
| l. Reproductive organ disorders | ☐ Yes | ☐ No |
| m. Substance or alcohol abuse | ☐ Yes | ☐ No |
| n. Cancer or tumors | ☐ Yes | ☐ No |
| o. Ulcer | ☐ Yes | ☐ No |
| p. Colitis | ☐ Yes | ☐ No |
| q. Diabetes | ☐ Yes | ☐ No |
| 2. Have you ever had a surgical procedure or been advised to have surgery which has not been completed at this time? | ☐ Yes | ☐ No |
| 3. Have you consulted or been attended by a physician or practitioner and/or taken prescription medication(s) within the past five years? | ☐ Yes | ☐ No |

| Question | | |
|---|---|---|
| 4. Have you had or currently have any known physical deformities,or physical or mental impairments, disorders or ill health not mentioned in question #1? | ☐ Yes | ☐ No |
| 5. Have you ever been denied life or health insurance coverage, or received an increased premium rating for health reasons? | ☐ Yes | ☐ No |
| 6. Have you had an electrocardiogram, x-ray, laboratory study, blood study, body scan or diagnostic procedure within the past three years? | ☐ Yes | ☐ No |
| 7. In the past ten years, have you sought or received treatment or advise for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC, or AIDS related diagnosis or opportunistic diseases, including Pneumocystis Carinii Pneumonia or Kaposi's Sarcoma? | ☐ Yes | ☐ No |
| 8. Have you ever tested HIV positive? | ☐ Yes | ☐ No |
| 9. If female, are you pregnant?<br>If yes, expected date of delivery: __________ | ☐ Yes | ☐ No |
| 10. Tobacco Usage | | |
| a. Do you currently smoke cigarettes?<br>If yes, ______ per day? | ☐ Yes | ☐ No |
| b. Have you ever smoked cigarettes?<br>If yes, last date smoked __________ | ☐ Yes | ☐ No |
| c. Have you used any tobacco products in the past 10 years? | ☐ Yes | ☐ No |

*Give complete details for all "Yes" answers to above questions. Provide complete names and phone numbers for all physicians.*

| Question No. | Disease, Injury or Medical Condition | Treatment / Medication / Dosage (for substance/ alcohol abuse, provide date of last consumption) | Treatment Dates | | Hospitalized? | | Attending Physician (doctor name and phone number) | Degree of Recovery |
|---|---|---|---|---|---|---|---|---|
| | | | From | To | Yes | No | | |
| | | | | | | | | |
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### Section D - *Employee Agreement & Signature*

*I represent that all information is true and correct. I understand any materially incorrect, incomplete or misstated facts may result in the recision of coverage issued in reliance on information given to PEHP, and there will be no benefits payable. By signing below I hereby: (1) authorize the deduction of Group Term Life premiums; (2) authorize PEHP to obtain from medically related practitioners or facilities, insurance companies, the Medical Information Bureau, or other organizations, institutions or persons any information necessary to process this application and determine my insurability; (3) understand the coverage applied for replaces any previous Employee, Spouse or Dependent Children Term Life coverage offered by PEHP; (4) agree to the terms and conditions in the PEHP Group Term Life Master Policy.*

| EMPLOYEE SIGNATURE | DATE | DEPENDENT SIGNATURE (Required if applying for Spouse Term-Life Coverage or Dependent Child Coverage if child is age 18 or older) | DATE |
|---|---|---|---|
| | | | |