PEHP Health & Benefits
560 East 200 South, Salt Lake City, UT 84102
801-366-7555 / 800-765-7347
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www.pehp.org

Snow College
Enrollment and Change Form

Changes made on this form are for medical, dental, and vision only.
All other changes can be made online at www.pehp.org.
Please print clearly.

Employee Status	**Benefit Eligibility**
☐ Full time ☐ Part time	☐ Eligible ☐ Ineligible

☐ New Enrollment ☐ Termination ☐ Change Request (Please Specify Type):_____

YOUR NAME (last, first, middle initial)	SOCIAL SECURITY NUMBER	BIRTH DATE (mm/dd/yy)	MARITAL STATUS ☐ SINGLE ☐ MARRIED	GENDER ☐ MALE ☐ FEMALE
MAILING ADDRESS	CITY/STATE/ZIP	PRIMARY PHONE		
EMPLOYER	EMAIL ADDRESS	ALTERNATE PHONE	HIRE DATE (mm/dd/yy)	

Group Medical (check one)

Coverage type (Check one)

- ☐ EMPLOYEE ONLY
- ☐ Employee plus one dependent
- ☐ Employee plus two or more dependents
- ☐ No medical coverage at this time

Choose your network

- ☐ Summit Network
- ☐ Advantage Network
- ☐ Preferred Network

Choose your medical plan

- ☐ STAR HSA (complete below for HSA eligibility)*
- ☐ Traditional
- ☐ Consumer Plus (complete below for HSA eligibility)*
  Only available to new hires and members previously enrolled in STAR HSA.
- ☐ Opt-Out of Medical Coverage
  You must have other qualified employer-sponsored coverage to opt-out. See Employee Agreement at bottom of the form.

* For STAR HSA or Consumer Plus enrollment, confirm HSA eligibility.

- ☐ I am eligble for a Health Savings Account (HSA)
- ☐ I am not eligible for a Health Savings Account (HSA). You will be enrolled in a Health Reimbursement Account (HRA).

GROUP DENTAL (Check one)

- ☐ Preferred Choice Dental
- ☐ Traditional Dental
- ☐ Opt-Out of Dental Coverage
  You must have other qualified employer-sponsored coverage to opt-out. See Employee Agreement at bottom of the form.

Coverage type (Check one)

- ☐ EMPLOYEE ONLY
- ☐ Employee plus one dependent
- ☐ Employee plus two or more dependents

VISION (Check one)

- ☐ Eyemed – Full
- ☐ Eyemed – Eyewear Only
- ☐ Opticare – Full
- ☐ Opticare – Eyewear Only
- ☐ No vision coverage at this time

Coverage type (Check one)

- ☐ EMPLOYEE ONLY
- ☐ Employee plus one dependent
- ☐ Employee plus 2+ dependents

ADDITIONS List your eligible dependents. For your spouse, include a copy of marriage certificate. For dependent children enrolled, include a copy of birth certificate. If dependents are classified as Other Relationship, please provide supporting documentation, e.g., court orders, birth certificates, etc. PEHP benefits will not be processed until required documentation is received.

RELATIONSHIP TO EMPLOYEE		FULL NAME OF DEPENDENTS (last, first, middle initial)	MARRIAGE DATE (mm/dd/yy)	GENDER	BIRTH DATE (mm/dd/yy)	DEPENDENT SOCIAL SECURITY NO.	COVERAGE DESIRED
CODE KEY: **S** » Legal Spouse; **C** » Child Natural/ Adopted; **SC** » Stepchild; **O** » Other (Describe in Explanations)	**S**			☐ **Male** ☐ **Female**			☐**M**edical ☐**D**ental ☐**V**ision
				☐ **Male** ☐ **Female**			☐**M**edical ☐**D**ental ☐**V**ision
				☐ **Male** ☐ **Female**			☐**M**edical ☐**D**ental ☐**V**ision
				☐ **Male** ☐ **Female**			☐**M**edical ☐**D**ental ☐**V**ision
				☐ **Male** ☐ **Female**			☐**M**edical ☐**D**ental ☐**V**ision
				☐ **Male** ☐ **Female**			☐**M**edical ☐**D**ental ☐**V**ision

Are you, your spouse, or dependents covered by any other health or dental plan or by Medicare? ☐ **Yes** ☐ **No** **If yes, complete Multiple Group Coverage Section on back.**

Signature required on other side.

(HR use only) **QST-E_SNOW** 4-20-21

Effective Date:_____ Employment Termination Date:_____ Coverage Termination Date:_____ HR Approval:_____

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Employee Name: _____ Social Security Number: _____

REMOVALS Fill out the table below if you are terminating coverage for dependents who are no longer eligible. For all terminations outside of annual enrollment, adequate documentation is required (divorce decree, proof of other coverage, etc.) If you voluntarily drop dental coverage, you will not be able to re-enroll for up to three years.

RELATIONSHIP TO EMPLOYEE		FULL NAME OF DEPENDENTS (last, first, middle initial)	DEPENDENT SOCIAL SECURITY NO.	REASON FOR TERMINATION (e.g., marriage, divorce, death, age of 26)	APPLICABLE DATE*	COVERAGE TERMINATED
S » Legal Spouse						☐**M**edical ☐**D**ental ☐**V**ision
C » Child Natural/ Adopted						☐**M**edical ☐**D**ental ☐**V**ision
SC » Stepchild						☐**M**edical ☐**D**ental ☐**V**ision
O » Other (Describe in Explanations)						☐**M**edical ☐**D**ental ☐**V**ision

*Applicable Date is the date of marriage, divorce, birthday, etc.

Multiple Group Coverage

Complete if you, your spouse, or dependents are covered by any other health or dental plan sponsored by an employer or Medicare.

INSURANCE COMPANY/HMO & PHONE NO.	NAME OF POLICY HOLDER	POLICY HOLDER SSN OR POLICY NO.	EFFECTIVE DATE (mm/dd/yy)	TYPE OF COVERAGE	TYPE OF POLICY	MEDICARE	EMPLOYEE/DEPENDENTS COVERED BY PLAN (Only first name is needed)
				☐ **Health** ☐ **Dental**	☐ **Employee** ☐ **Retired**	☐ **A** ☐ **A&B**	
				☐ **Health** ☐ **Dental**	☐ **Employee** ☐ **Retired**	☐ **A** ☐ **A&B**	

Explanations

Employee Agreement and Signature

Before signing, make sure that all applicable sections are complete so your enrollment is not delayed. You may be asked to provide additional information and or documentation. Please note: It is the employee's responsibility to notify PEHP within **60 days of any changes** effecting coverage and/or dependent eligibility (e.g., birth, marriage, divorce, etc.).

I represent that all information is true and correct. I understand and agree that any false information I provide on this form may, at PEHP's sole discretion, result in a limitation or termination of my coverage. By signing below I hereby: (1) authorize the deduction of health/dental contributions through the provisions of IRS Section 125 Flexible Benefits; (2) authorize PEHP to release information to health/dental providers, insurance entities, or other entities necessary to process claims and to administer the health plan; (3) certify all dependents listed are eligible for coverage; (4) understand if PEHP is not notified that a dependent is ineligible and subsequent claims are paid, I will be responsible for reimbursement to PEHP for any claims paid in error; (5) agree to the terms and conditions in the PEHP Master Policy.

Opting-Out of Coverage to Receive Cash-in-Lieu of Benefits: Employee understands and acknowledges that in order to be eligible to receive a cash-in-lieu-of-benefits option, employee is required to be continuously employed with employer and maintain other employer-sponsored insurance coverage during the next plan year. Employee may not opt out of PEHP coverage to receive cash-in-lieu of benefits if the only coverage they would have left is Medicaid, Medicare, or Individual Coverage through the Federal Marketplace. As part of the below agreement, employee also agrees that if employee elects to waive coverage and instead receive cash-in-lieu-of-benefits: 1) during the open enrollment period, employee shall provide an attestation of other employer-sponsored coverage (or provide PEHP with a certificate of coverage from the other employer-sponsored insurance company); and 2) employee shall inform PEHP immediately upon the loss or termination of other coverage. Failure to meet these obligations will result in forfeiture of cash-in-lieu-of-benefits and may result in the employee having to repay the cash-in-lieu of benefits to your employer and facing penalties for perjury. If an employee elects to waive coverage, but does not provide the attestation or the certificate of coverage during the open enrollment period, employee's coverage will be waived but employee will not receive any cash-in-lieu of benefits. If an employee elects to waive dental coverage, the employee will be eligible to re-enroll in a PEHP dental plan only if the employee has proof of other dental coverage or at least three years have passed since the employee waived PEHP dental coverage.

In order to receive cash-in-lieu of benefits, an employee must waive coverage and complete the following attestation. (1) I am over 18 years of age and I am providing this Attestation to show my eligibility to receive cash-in-lieu of participation in the PEHP medical and/or dental plans (the "Plan"). (2) Under penalty of perjury, I solemnly swear and affirm that the information provided below is true and correct. I understand that if such information is not true and correct, it may constitute insurance fraud, and may result in termination of benefits and criminal penalties. I agree to keep PEHP updated on any changes to my other employer-sponsored insurance coverage at all times. I further understand that adequate documentation of other employer-sponsored insurance coverage may be requested and that if I am unable to produce documentation to verify adequate coverage, my cash-in-lieu of benefits will be terminated retroactively to the time my other coverage ceased, and I will be fully responsible to repay my employer for all amounts I received, including any recovery costs, for any amounts paid by the plan for ineligible cash-in-lieu of benefits payments. (3) I attest that I and all of my dependents eligible for PEHP health and/or dental coverage have previously been and are currently covered under other employer-sponsored health and/or dental insurance which meets the standards for minimum essential coverage. I acknowledge and understand that Medicaid, Medicare, or Individual Coverage through the Federal Marketplace are not considered employer-sponsored insurance coverage and are not employer-sponsored insurance coverage.

☐ I certify that I am not a party to a divorce proceeding and am not subject to an injunction/order which prevents me from modifying insurance or changing beneficiaries.

Employee Signature	Date

Please make a copy for your records.