Public Employees Health Programs
560 East 200 South, Suite 100
Salt Lake City, Utah 84102-2004
Enrollment: 801-366-7495
Toll Free 800-753-7495

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	Martial Status	Children Under 26
	☐ Male ☐ Female	☐ Single ☐ Married	☐ Yes ☐ No

Considerations When Naming Beneficiaries

1. List *ALL* beneficiaries. Beneficiary payments are paid from the most recent beneficiary designation on file with PEHP.
2. Types of beneficiaries:
   A. ***Primary*** - Person to receive the death benefits upon the death of a member.
   B. ***Contingent*** - Person to receive the death benefits upon the death of a member if the primary beneficiary is deceased.
3. If you name multiple primary beneficiaries, the proceeds will be split equally, unless otherwise instructed on the form.
4. 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.
5. If you name a trust as beneficiary, be sure to list the name of the trustee and the date the trust agreement became effective.
6. 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
	☐ Primary ☐ Contingent			Street City State Zip
	☐ Primary ☐ Contingent			Street City State Zip
	☐ Primary ☐ Contingent			Street City State Zip
	☐ Primary ☐ Contingent			Street City State Zip
	☐ Primary ☐ Contingent			Street City State Zip

COVERAGE INFORMATION (Available to employees under age 70)

	AMOUNT OF COVERAGE
☐ AD&D Coverage Coverage Type: ☐ Employee Only ☐ Family Coverage* *If both you and your spouse are covered as an "employee" only one may purchase the Family Plan	
☐ Accident Weekly Indemnity Coverage (employee only, must be enrolled in AD&D coverage)	
☐ 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