



560 East 200 South, Salt Lake City, UT 84102
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www.pehp.org

Vision Coverage Termination

Note: This form is to add one or more dependents to your existing plans with a qualifying event only. If you need to enroll in new plans, or change your coverage in any other way, please download and complete and enrollment/change form from our website or contact PEHP's Enrollment team for assistance. **Please print clearly.**

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

Vision Coverage (check one)

<input type="checkbox"/> Terminate Vision Coverage
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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.

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
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Please make a copy for your records.

(Employer use only)		TVC	12-3-24
Effective Date: _____	Employment Termination Date: _____	Coverage Termination Date: _____	Employer Approval: _____