

Public Employees Health Programs

560 East 200 South, Suite 100 / Salt Lake City, Utah 84102-2004
 Customer Service: 801-366-7555 / Toll Free 800-765-7347

Accidental Death & Dismemberment Plan

Section A - **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	

Section B - **Coverage Selection**

See pages I-3 through I-6 of your AD&D benefits handbook for coverage, premium amounts, eligibility requirements & age limitations.

<input type="checkbox"/> Basic AD&D Coverage Coverage Type: <input type="checkbox"/> Employee Only <input type="checkbox"/> Family Coverage* *If both you and your spouse are employed by the same employer only one may purchase the Family Plan	AMOUNT OF COVERAGE
<input type="checkbox"/> Optional Accident Weekly Indemnity Coverage (employee only)	
<input type="checkbox"/> Optional Accident Medical Expense Coverage (employee only)	\$2,500

Section C - **Beneficiaries**

Please indicate whether the beneficiary is a primary or secondary (death benefits are first paid to the primary beneficiary, if the primary beneficiary is deceased benefits would be paid to the secondary beneficiary). If more than one primary beneficiary is listed, the benefit will be divided equally among those listed, unless otherwise instructed on the form. If you do not name a beneficiary, the benefit(s) will be paid to your estate, as provided for by the plan.

(Check One)		EMPLOYEE TERM LIFE BENEFICIARIES			
Primary	Secondary	BENEFICIARY NAME (Last, First, Middle Initial)	RELATIONSHIP TO EMPLOYEE	BIRTH DATE	MAILING ADDRESS (Address / City / State / Zip)

Section D - **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.

Employee Signature	Date	Effective Date Of Coverage
		For Office Use Only

Offered by: The Continental Insurance Agency, LLC

Underwritten by: Boston Mutual Life Insurance Company

Make and keep a photocopy of completed form for yourself / return completed original to PEHP.