150 Social Hall Avenue, Suite 170
P.O. Box 45530
Salt Lake City, Utah 84145
Telephone 1-801-578-5600 • Toll free 1-800-777-3622
Fax 1-801-578-5933 • Website: www.dmba.com

| FOR DESERET MUTUAL USE ONLY |
|---|
| CONTRACT NUMBER |

# EMPLOYEE BENEFIT PROGRAM ENROLLMENT FORM

❑ New Enrollment ❑ Mid-year Change

## A. PERSONAL INFORMATION (REQUIRED)

**PLEASE COMPLETE THIS SECTION IN FULL.**

EMPLOYEE NAME: ______________________

DESERET MUTUAL ID NUMBER: ______________________

EMPLOYER NAME: ______________________ DEPARTMENT: ______________________

EMPLOYEE SOCIAL SECURITY NUMBER: ______________________ BIRTH DATE (MM/DD/YYYY): ______________________

HOME ADDRESS: ______________________

CITY: ______________________ STATE: ______________________ ZIP: ______________

HOME TELEPHONE: ______________________ WORK TELEPHONE: ______________________

SEX: ❑ MALE ❑ FEMALE MARITAL STATUS: ❑ MARRIED ❑ WIDOWED ❑ SINGLE ❑ DIVORCED

SPOUSE NAME AND BIRTH DATE: ______________________

## B. CHOOSING YOUR INSURANCE COVERAGE

❑ EMPLOYEE ONLY ❑ EMPLOYEE & ONE DEPENDENT ❑ EMPLOYEE & TWO OR MORE DEPENDENTS

**CHOOSE YOUR MEDICAL COVERAGE** (All plans include Group Term Life, Occupational Accidental Death & Dismemberment, and Disability insurance)**:**

❑ DESERET CHOICE ❑ DESERET SELECT ❑ HMO (SPECIFY NAME):______________

❑ DESERET PREMIER ❑ DESERET VALUE

❑ WAIVING MEDICAL (GROUP TERM LIFE AND DISABILITY COVERAGE ONLY)

**CHOOSE YOUR VSP (VISION SERVCIE PLAN) COVERAGE:**

❑ ***WITH*** AN ANNUAL EYE EXAM ❑ ***WITHOUT*** AN ANNUAL EYE EXAM ❑ WAIVING VSP COVERAGE

**CHOOSE YOUR DENTAL COVERAGE:**

❑ DESERET DENTAL ❑ DESERET DENTAL *PLUS* ❑ WAIVING DENTAL COVERAGE

## C. PARTICIPANT AUTHORIZATION (REQUIRED)

❑ I WISH TO ENROLL OR MAKE CHANGES AS INDICATED ON THIS FORM.

❑ I WISH TO WAIVE BENEFITS (Medical, Dental, Group Term Life, Occupational Accidental Death & Dismemberment, and Disability insurance).

My signature acknowledges that I have read and agree to the *Terms and Conditions* outlined on the back of this form.

Signature: ______________________ Date: ______________________

## D. EMPLOYER USE ONLY

| Insurance Employment Status | Underwriting Status | Benefit Package | Contract Type | Risk Population | Premium Split Code | Bill To Code |
|---|---|---|---|---|---|---|
| | | | | | | |

| Payroll Code |
|---|
| |

Comments: ______________________

______________________

______________________

| Payroll Number |
|---|
| |

Date: ______________________

Employer Authorization: ______________________

BASIC GTL SALARY LEVEL: ______________________

**ACTION** (CHECK ALL THAT APPLY):

❑ NEW ENROLLMENT (HIRE DATE): ______________

❑ CHANGE OR OTHER: ______________

❑ TERMINATION OF EMPLOYMENT (DATE): ______________

❑ TERMINATION OF COVERAGE (DATE): ______________

❑ DEATH (DATE): ______________

❑ REHIRE (DATE): ______________

❑ SURVIVING SPOUSE: ______________

❑ RETIRED (DATE): ______________

❑ TRANSFER (TO / FROM): ______________

❑ LEAVE OF ABSENCE (SPECIFY TYPE): ______________



YOU MUST COMPLETE THE BACK OF THIS FORM!

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| COMPANY CODE |
|---|
| |

# EMPLOYEE BENEFIT PROGRAM ENROLLMENT FORM

**(THIS FORM IS VALID ONLY IF YOU COMPLETE BOTH SIDES OF THE FORM)**

EMPLOYEE NAME: ___________________________________ SOCIAL SECURITY NUMBER:___________________

## E. EMPLOYEE AND DEPENDENT INFORMATION

I WISH TO: ❑ ADD DEPENDENT(S) ❑ REMOVE DEPENDENT(S) ❑ CHANGE PRIMARY CARE PHYSICIAN

REASON FOR CHANGE: ________________________________________________________________________________

Complete the following information. If you don't list all dependents during initial enrollment, you will forfeit coverage for the omitted person. List yourself, your spouse, and all legal dependents in order of age. Attach another sheet if necessary.

| RELATIONSHIP TO EMPLOYEE | | NAME (FIRST, MIDDLE INITIAL, LAST) | BIRTH DATE (MM/DD/YY) | SEX | SOCIAL SECURITY NUMBER |
|---|---|---|---|---|---|
| E - Employee | E | EMPLOYEE | | M F | |
| S - Legal Spouse | | | | M F | |
| N - Natural or Adopted Child | | | | M F | |
| | | | | M F | |
| SC - Stepchild | | | | M F | |
| GC - Grandchild | | | | M F | |
| O - Other (Specify In Section I) | | | | M F | |
| | | | | M F | |
| | | | | M F | |

*Dependents added above will be enrolled for the coverage currently in effect. This includes the minimum guaranteed amounts only for Group Term Life and Supplemental Group Term Life insurance. You may apply for additional Supplemental Group Term Life insurance coverage when the child is six months old. Also, new dependents will be enrolled for your current level of dependent coverage for 24-Hour Accidental Death & Dismemberment insurance.*

## F. OTHER MEDICAL OR DENTAL COVERAGE

If you or any dependents are covered by any other medical or dental plan(s), please attach a copy of your health insurance card(s). If you no longer have your insurance cards, please contact your other insurance carrier and request a letter verifying your coverage.

Name of Other Insurance Carrier: _____________________________________ Phone Number: ___________________

## G. PRIOR MEDICAL COVERAGE

If you or any of your dependents had medical insurance within 63 days before your hire date, please submit a *Certificate of Creditable Coverage*.

## H. COMMENTS

| |
|---|
| |

CONTRACT NUMBER: ____________________
(FOR DESERET MUTUAL USE ONLY)

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