



60 East South Temple • P.O. Box 45530
Salt Lake City, Utah 84111
Telephone 1-801-578-5600 • Toll Free 1-800-777-3622
Fax Number 1-801-578-5933 • Web site: www.dmba.com

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 (MO, DAY, YR)	SEX	SOCIAL SECURITY NUMBER	FOR DESERET CHOICE HAWAII ONLY
					PCP's NAME & NUMBER
E - Employee	E	EMPLOYEE	M F		
S - Legal Spouse			M F		
N - Natural or Adopted Child			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