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 www.pehp.org

# Volunteer Emergency Medical Personnel Enrollment and Change Form

New Enrollment    Termination    Change Request (Please Specify Type): \_\_\_\_\_

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		
VOLUNTEERING FOR	EMAIL ADDRESS	ALTERNATE PHONE	START DATE (mm/dd/yy)	

**Group Medical**

**Medical Plans Using In-network & and Out-of-network Providers (Check one)**

Summit Network    Advantage Network

**Medical coverage type (Check one)**

VOLUNTEER ONLY    Volunteer plus two or more dependents  
 Volunteer plus one dependent

**ADDITIONS**

List your eligible dependents. If adding a new spouse, include a copy of marriage certificate. If dependents are stepchildren, natural children not living with both parents, or "other" relationship, provide supporting documentation, e.g., divorce decree, court orders, birth certificate, etc. If you don't have supporting documentation explain in Explanations Section on the back.

RELATIONSHIP TO VOLUNTEER	FULL NAME OF DEPENDENTS (last, first, middle initial)	MARRIAGE DATE (mm/dd/yy)	GENDER	BIRTH DATE (mm/dd/yy)	DEPENDENT SOCIAL SECURITY NO.
<b>CODE KEY:</b> <b>S</b> » Legal Spouse			<input type="checkbox"/> Male <input type="checkbox"/> Female		
<b>C</b> » Child Natural/Adopted			<input type="checkbox"/> Male <input type="checkbox"/> Female		
<b>SC</b> » Stepchild			<input type="checkbox"/> Male <input type="checkbox"/> Female		
<b>O</b> » Other (Describe in Explanations)			<input type="checkbox"/> Male <input type="checkbox"/> Female		

**REMOVALS**

Fill out the table below if you are terminating coverage for dependents who are no longer eligible. For all terminations outside of annual enrollment adequate documentation is required (divorce decree, proof of other coverage, etc.) If you voluntarily drop dental coverage, you will not be able to re-enroll for up to three years.

RELATIONSHIP TO VOLUNTEER	FULL NAME OF DEPENDENTS (last, first, middle initial)	DEPENDENT SOCIAL SECURITY NO.	REASON FOR TERMINATION (e.g., marriage, divorce, death, age of 26)	APPLICABLE DATE (date of marriage, divorce, birthday, etc.)
<b>S</b> » Legal Spouse				
<b>C</b> » Child Natural/Adopted				
<b>SC</b> » Stepchild				
<b>O</b> » Other (Describe in Explanations)				

**Signature required on other side.**

<b>(Employer use only)</b>		<b>VEMP</b>	<b>2-8-23</b>
Effective Date: _____	Volunteer Termination Date: _____	Coverage Termination Date: _____	Employer Approval: _____

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Volunteer Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

## Attest

1. Are you or your spouse currently covered by health insurance?  Yes  No
2. Are you or your spouse currently eligible for coverage through your employer, your spouse' employer, your parents' employer, Medicaid, Medicare or the Veteran's Administration?  Yes  No
3. When was the last time you were covered by insurance?
  - a. Start Date \_\_\_\_\_
  - b. End Date \_\_\_\_\_
  - c. Name of Health Plan \_\_\_\_\_
  - d. Reason for Termination \_\_\_\_\_

## Explanations

## Volunteer 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 volunteer'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 if applicable; (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.

Volunteer Signature	Date
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## EMS Director/Liaison Agreement and Signature

I certify the above volunteer is eligible for coverage under the EMS Volunteer Health Insurance Coverage offered by the state of Utah.

EMS Director/Liaison Signature	Date
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