PEHP Health & Benefits
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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 ☐ SINGLE ☐ MARRIED	GENDER ☐ MALE ☐ 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.
CODE KEY: **S »** Legal Spouse **C »** Child Natural/ Adopted **SC »** Stepchild **O »** Other (Describe in Explanations)	**S**			☐ **Male** ☐ **Female**		
				☐ **Male** ☐ **Female**		
				☐ **Male** ☐ **Female**		
				☐ **Male** ☐ **Female**		
				☐ **Male** ☐ **Female**		
				☐ **Male** ☐ **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.)
S » Legal Spouse **C »** Child Natural/ Adopted **SC »** Stepchild **O »** Other (Describe in Explanations)					

Signature required on other side.

(Employer use only) **VEMP** **04-21-22**

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

Please make a copy for your records.