PEHP Health & Benefits

Weber State University
Enrollment and Change Form

Note: Changes made on this form are for medical only. For changes to other plans sponsored by your employer, please contact your employe
information and forms. Please print clearly.

Section A - Employee Coverage Information

☐ New Enrollment ☐ Status Change (Please specify type): _____

Employee Name (last, rst, middle initial)	Social Security Number	Birth Date (mm/dd/yy)	Marital Status	Gender
			☐ Single ☐ Married	☐ Male ☐ Female
Mailing Address	City / State / Zip	Primary Phone		
Email Address		Alternate Phone	Hire Date (mm/dd/yy)	

Group Medical

The STAR Plan*
- ☐ Summit Network
- ☐ Advantage Network

Traditional Plan
- ☐ Summit Network
- ☐ Advantage Network

☐ No medical coverage at this time

☐ *I am eligible for a Health Savings Account (HSA)

☐ *I will not open an HSA at this time

Coverage Type (check one)
- ☐ Employee only
- ☐ Employee plus one dependent
- ☐ Employee plus two or more dependents

* Complete the WSU Employee Salary Reduction form for pre-tax employee HSA contributions.

Section B - Dependent Information

Additions

			☐ ☐			☐ ☐
			☐ ☐			☐ ☐
			☐ ☐			☐ ☐
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			☐ ☐			☐ ☐
			☐ ☐			☐ ☐
			☐ ☐			☐ ☐

Employee Name: _____ Social Security Number: _____

Section C - Multiple Group Coverage

Complete if you, your spouse or dependents are covered by any other health plan, sponsored by an employer or by Medicare.

Insurance company/HMO & phone No.	Name of policy holder	Policy holder SSN or policy No.		Type of policy	Medicare