Public Employees Health Programs
560 East 200 South, Suite 100 / Salt Lake City, Utah 84102-2004
Term Life: (801) 366-7495 / Toll Free (800) 753-7495

Group Term Life
Change Form

Section A - *Employee Information*

Employee Name (First, Middle, Last)	Daytime Phone	Birth Date (mm/dd/yy)	Social Security Number

Section B - *Beneficiary Change*

EMPLOYEE TERM LIFE

Revoking any previous nominations of beneficiary(ies), I hereby designate the following individuals to receive all benefits payable upon my death.

Full Given Name of Beneficiary	Designation	Relationship	Birth Date	Mailing Address
	☐ Primary ☐ Contingent			Street City State Zip
	☐ Primary ☐ Contingent			Street City State Zip
	☐ Primary ☐ Contingent			Street City State Zip
	☐ Primary ☐ Contingent			Street City State Zip

SPOUSE TERM LIFE

Full Given Name of Beneficiary	Designation	Relationship	Birth Date	Mailing Address
	☐ Primary ☐ Contingent			Street City State Zip
	☐ Primary ☐ Contingent			Street City State Zip

DEPENDENT CHILD TERM LIFE

Full Given Name of Beneficiary	Designation	Relationship	Birth Date	Mailing Address
	☐ Primary ☐ Contingent			Street City State Zip
	☐ Primary ☐ Contingent			Street City State Zip

EMPLOYEE AD&D

Revoking any previous nominations of beneficiary(ies), I hereby designate the following individuals to receive all benefits payable upon my death.

Full Given Name of Beneficiary	Designation	Relationship	Birth Date	Mailing Address
	☐ Primary ☐ Contingent			Street City State Zip
	☐ Primary ☐ Contingent			Street City State Zip
	☐ Primary ☐ Contingent			Street City State Zip
	☐ Primary ☐ Contingent			Street City State Zip

Life Coverage Terminations

☐ Terminate Employees Basic Coverage
☐ Terminate Employee Additional Coverage
☐ Terminate Spouse Coverage
☐ Terminate Dependent Child Coverage

EMPLOYEE SIGNATURE	DATE