# PENNSYLVANIA STATE SYSTEM OF HIGHER EDUCATION

## ANNUITANT ENROLLMENT/CHANGE FORM

### TRANSACTION (TO BE COMPLETED BY HUMAN RESOURCES)

☐ ENROLLMENT ☐ ADD SPOUSE/DEPENDENTS - INDICATE REASON IN REMARKS SECTION ☐ CANCEL COVERAGE
☐ OPEN ENROLLMENT ☐ REMOVE SPOUSE/DEPENDENTS - INDICATE REASON IN REMARKS SECTION ☐ CHANGE – INDICATE REASON IN REMARKS SECTION

| GROUP # | BARGAINING UNIT | PERSONNEL # | ANNUITANT PREMIUM | DATE OF RETIREMENT | AHCP EFFECTIVE DATE |
|---|---|---|---|---|---|
| | | | | | |

### ANNUITANT DEMOGRAPHIC INFORMATION (TO BE COMPLETED BY ANNUITANT)

**HEALTH PLAN CHOICES:**

**ANNUITANT NAME**

☐ PPO PLAN ☐ SIGNATURE 65-COVERAGE (SUPPLEMENTS MEDICARE)
☐ INDEMNITY ☐ WAIVE MEDICAL BENEFITS (NEED TO SIGN A WAIVER FORM)

| **SOCIAL SECURITY #** | **PERSONAL EMAIL ADDRESS (after retirement)** | **DATE OF BIRTH (MM,DD,YYYY)** |
|---|---|---|
| | | |

| **STREET ADDRESS** | **CITY** | **STATE** | **ZIP CODE** |
|---|---|---|---|
| | | | |

| **COUNTY** | **RELATIONSHIP STATUS** ☐ **SINGLE** ☐ **MARRIED** ☐ **DIVORCED** | **DATE OF MARRIAGE** | **DATE OF DIVORCE** | **TELEPHONE #** **HOME:** **CELL:** |
|---|---|---|---|---|
| | | | | |

| **IF MEDICARE ELIGIBLE** | **MEDICARE INS #** | **PART A EFF DATE:** | **PART B EFF DATE:** |
|---|---|---|---|
| | | | |

### DEPENDENT DATA (TO BE COMPLETED BY ANNUITANT)

| RELATIONSHIP | **SPOUSE** | SON ☐ DAU ☐ OTHER ☐(Explain Relationship) | SON ☐ DAU ☐ OTHER ☐(Explain Relationship) | SON ☐ DAU ☐ OTHER ☐(Explain Relationship) | SON ☐ DAU ☐ OTHER ☐(Explain Relationship) |
|---|---|---|---|---|---|
| | | **(For dependent child(ren) - If age 19 to 25, must be a full-time student)** | | | |
| NAME (Last, First, MI) | | | | | |
| DATE OF BIRTH (MM,DD,YYYY) | | | | | |
| SOCIAL SECURITY # | | | | | |
| MEDICARE INS # | | | | | |
| MEDICARE DATES (MM, DD, YYYY) (If Medicare eligible) | PART A: PART B: | PART A: PART B: | PART A: PART B: | PART A: PART B: | PART A: PART B: |
| ELIGIBILITY DOC. VERIFIED | | | | | |

### OTHER COVERAGE DATA

Does your spouse have other State System of Higher Education health coverage? ☐ Yes ☐ No
Does your spouse have other fully employer paid coverage? ☐ Yes ☐ No
Do you or your dependents have other health coverage: ☐ Yes ☐ No If yes, provide the following information:

| Full Name of Insured | Name of Health Care Plan/Insurance Co. | Policy/ID Number |
|---|---|---|
| | | |
| | | |

REMARKS:

AUTHORIZATION FOR APPLICATION FOR ENROLLMENT: I request the above enrollment (or change) for insurance coverage and authorize the PA State System to make pre-tax payroll deductions or deductions from my annuity if applicable. I hereby apply for the coverage indicated. ***I understand no changes can be made to this coverage except during Open Enrollment, or when a qualified life event occurs.*** I also understand this application is subject to approval by the Plans, and my coverage will be subject to the terms of the agreement issued to the Pennsylvania State System of Higher Education Health Care Programs. Any person or operation having provided or who may provide health care services to me or any person named on this application either prior to or during this contract is authorized to furnish to the Plans any information or records relating to these services. Any person who knowingly and with intent to defraud any insurance company or other person who files an application for insurance or statement or claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. ***I understand I may be personally liable for any claims paid on behalf of an ineligible dependent.***

SYSTEM HR USE ONLY:

| ANNUITANT SIGNATURE | DATE (MM.DD.YYYY) | _____ ACCESS<br>_____ ANNUITIZED<br>_____ SEPARATED |
|---|---|---|
| | | |

The following categories of individuals may be eligible for coverage under the PASSHE health plan for annuitants:

- Legal Spouse
- Unmarried Dependent child under 19 years of age who meets one of the following requirements:
  - A natural child of your own
  - A legally adopted child (including a child living with you during the probation period)
  - A stepchild living with you
  - A child who is living with and being solely supported by you and for whom you are the legal guardian
  - A foster child, if you were the child's legal guardian, or foster parent prior to the child's 18th birthday (foster children under age 18 are not eligible dependents)
  - A child being supported by you under a court order as a result of a divorce decree
  - A newborn child of yours from the moment of birth to a maximum of 31 days from date of birth. To be covered as a Dependent beyond the 31-day period, the newborn child must be added as a Dependent through the Central Benefits Office (Office of the Chancellor at (717) 720-4153)
  - Unmarried dependent child 19 to 25 years of age who meets all of the following requirements:
    - Enrolled in and attending as a full-time student at a recognized course of study or training;
    - Not employed on a regular full-time basis; and
    - Not covered under any group insurance plan or prepayment plan through the student's employer.
  - Unmarried Dependent child 19 years of age or older who is incapable of self-support because of a physical or mental disability that commenced before the age of 19.

**When Can I Make Changes To My Covered Dependents?**

Outside of open enrollment, if you experience a qualifying life event you may have the opportunity to add or remove dependents from your coverage, or make other changes to your benefit elections. You will need to notify the Central Benefits Office (Office of the Chancellor at (717) 720-4153) within **60 days** of the event occurring. Below are some of the more common examples.

- **Removing Dependents**

  You are required to contact the Central Benefits Office (Office of the Chancellor at (717) 720-4153) and remove a dependent who is no longer eligible for PASSHE coverage under the following situations:
  - Covered child attains age 19 and is not a full-time student (as designated above) (unless disabled)
  - Covered child attains age 25 (unless disabled)
  - Divorce (removal of spouse and stepchildren)
  - Death of a dependent

- **Adding Eligible Dependents**

  You may add a dependent for PASSHE health coverage due to a qualifying life event. You must notify the Central Benefits Office (Office of the Chancellor at (717) 720-4153) and submit the enrollment change within **60 days** of the qualifying life event.
  - You gain a dependent through birth or adoption
  - You get married
  - Your dependent loses coverage under another employer's plan
  - Your dependent loses eligibility for coverage in a Medicare plan, a Medicaid plan or a state children's health insurance program

- **Other Plan Enrollment Changes**

  You must notify the Central Benefits Office (Office of the Chancellor at (717) 720-4153) and submit the enrollment change within **60 days** of the qualifying life event.
  - You lose coverage under your spouse's plan
  - You are enrolled in a plan option that is no longer available, or is substantially reduced

## ENROLLMENT IN MEDICARE PARTS A AND B IS REQUIRED FOR YOU AND YOUR SPOUSE IF YOU RETIRED AFTER JANUARY 1, 1999.