FORM C

Pennsylvania's
STATE SYSTEM
of Higher Education

ANNUITANT HEALTH CARE PROGRAM
DELAYED ENROLLMENT FORM

EMPLOYEE NAME: _____

SOCIAL SECURITY NUMBER: _____

RETIREMENT DATE: _____

- This is to certify that I am retiring/separating from the Pennsylvania State System of Higher Education (PASSHE), and I am eligible for coverage under the Annuitant Health Care Program (AHCP).
- I understand and agree that I have a one-time election to enroll in the AHCP.
- I am electing to delay enrollment for AHCP coverage at this time due to other health plan coverage.
- It is understood that I can exercise my one-time enrollment at a later date upon loss of other coverage or during an open enrollment period.
- I understand that I must be receiving an annuity from my PASSHE retirement plan in order to enroll in the AHCP.

_____ _____
Signature of Annuitant Date

For PASSHE Use Only—To be completed by the University Benefits Coordinator.

Employee Personnel Number _____

Eligible for Majority Paid Coverage _____ Eligible for Partially Paid Coverage _____

Updated 1/28/15