FORM C2

ANNUITANT HEALTH CARE PROGRAM
DELAYED ENROLLMENT FORM FOR SURVIVING SPOUSES

EMPLOYEE / ANNUITANT NAME: _____

SURVIVING SPOUSE NAME: _____

SOCIAL SECURITY NUMBER: _____

- This is to certify that I am the surviving spouse of a Pennsylvania State System of Higher Education (State System) employee / annuitant, and 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.

_____ _____

Signature of Surviving Spouse Date

Updated 1/28/2015