PENNSYLVANIA STATE SYSTEM OF HIGHER EDUCATION

TRANSACTION (TO BE COMPLETED BY HUMAN RESOURCES)

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

☐ ACTIVE GROUP HEALTH PROGRAM ☐ ANNUITANT HEALTH CARE PROGRAM	GROUP #	BARGAINING UNIT	PERSONNEL #	EMP/ANN PREMIUM	EFFECTIVE DATE

EMPLOYEE DEMOGRAPHIC INFORMATION (TO BE COMPLETED BY EMPLOYEE)

HEALTH PLAN CHOICES:	MANAGEMENT BENEFITS (DENTAL, VISION, HEARING – not applicable to Faculty
☐ INDEMNITY (closed to new enrollments) ☐ PPO PLAN ☐ HEALTH MAINTENANCE ORGANIZATION (HMO) ☐ WAIVE MEDICAL BENEFITS	☐ MANAGEMENT BENEFITS ☐ MANAGEMENT BENEFITS **ONLY** ☐ WAIVE MANAGEMENT BENEFITS

☐ FULL-TIME EMPLOYEE ☐ PART-TIME EMPLOYEE	HMO NAME	HMO PRIMARY CARE PHYSICIAN (PCP) PRACTICE NAME	HMO ID#

SOCIAL SECURITY #	EMPLOYEE NAME	DATE OF BIRTH (MM,DD,YYYY)

STREET ADDRESS	CITY	STATE	ZIP CODE

COUNTY	RELATIONSHIP STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SAME -SEX DOMESTIC PARTNER	DATE OF MARRIAGE/ DOM. PARTNERSHIP	DATE OF DIVORCE/ TERM OF DOM.PARTNERSHIP	DAYTIME PHONE #

DEPENDENT DATA (TO BE COMPLETED BY EMPLOYEE)

ELIGIBILITY DOC. VERIFIED	ADD/REMOVE	DEPENDENT NAME	DATE OF BIRTH (MM,DD,YYYY)	SOCIAL SECURITY #	(HMO) PCP PRACTICE NAME AND ID# (if different than employee)
☐	☐ ☐	SPOUSE/DOMESTIC PARTNER			
☐	☐ ☐	SON ☐ DAU ☐ OTHER ☐ (Explain Relationship)			
☐	☐ ☐	SON ☐ DAU ☐ OTHER ☐ (Explain Relationship)			
☐	☐ ☐	SON ☐ DAU ☐ OTHER ☐ (Explain Relationship)			
☐	☐ ☐	SON ☐ DAU ☐ OTHER ☐ (Explain Relationship)			

OTHER COVERAGE DATA

Does your spouse/Domestic Partner 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

MEDICARE INFORMATION (IF APPLICABLE)

EMPLOYEE	MEDICARE INS. #
PART A EFF. DATE	PART B EFF. DATE
DEPENDENT NAME	MEDICARE INS. #
PART A EFF. DATE	PART B EFF. DATE

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 that I may be personally liable for any claims paid on behalf of an ineligible dependent.***

EMPLOYEE/ANNUITANT SIGNATURE	DATE (MM.DD.YYYY)	HUMAN RESOURCES USE ONLY (FULL CLOCK #)