



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

<input type="checkbox"/> ACTIVE GROUP HEALTH PROGRAM	GROUP #	BARGAINING UNIT	PERSONNEL #	EMP/ANN PREMIUM	EFFECTIVE DATE
<input type="checkbox"/> ANNUITANT HEALTH CARE PROGRAM					

EMPLOYEE DEMOGRAPHIC INFORMATION (TO BE COMPLETED BY EMPLOYEE)

HEALTH PLAN CHOICES:		MANAGEMENT BENEFITS (DENTAL, VISION, HEARING - not applicable to Faculty)			
<input type="checkbox"/> INDEMNITY (closed to new enrollments)	<input type="checkbox"/> PPO PLAN	<input type="checkbox"/> MANAGEMENT BENEFITS			
<input type="checkbox"/> HEALTH MAINTENANCE ORGANIZATION (HMO)		<input type="checkbox"/> MANAGEMENT BENEFITS <u>ONLY</u>			
<input type="checkbox"/> WAIVE MEDICAL BENEFITS		<input type="checkbox"/> WAIVE MANAGEMENT BENEFITS			

<input type="checkbox"/> FULL-TIME EMPLOYEE	HMO NAME	HMO PRIMARY CARE PHYSICIAN (PCP) PRACTICE NAME	HMO ID#
<input type="checkbox"/> PART-TIME EMPLOYEE			

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

STREET ADDRESS	CITY	STATE	ZIP CODE

COUNTY	RELATIONSHIP STATUS	DATE OF MARRIAGE/ DOM. PARTNERSHIP	DATE OF DIVORCE/ TERM OF DOM. PARTNERSHIP	DAYTIME PHONE #
	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SAME-SEX DOMESTIC PARTNER			

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)
<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	SPOUSE/DOMESTIC PARTNER			
<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	SON <input type="checkbox"/> DAU <input type="checkbox"/> OTHER <input type="checkbox"/> (Explain Relationship)			
<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	SON <input type="checkbox"/> DAU <input type="checkbox"/> OTHER <input type="checkbox"/> (Explain Relationship)			
<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	SON <input type="checkbox"/> DAU <input type="checkbox"/> OTHER <input type="checkbox"/> (Explain Relationship)			
<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	SON <input type="checkbox"/> DAU <input type="checkbox"/> OTHER <input type="checkbox"/> (Explain Relationship)			

OTHER COVERAGE DATA

MEDICARE INFORMATION (IF APPLICABLE)

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	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 #)