COMPLETE BOXES MARKED BY X's

PENNSYLVANIA STATE SYSTEM OF HIGHER EDUCATION

☐ **ACTIVE GROUP HEALTH PROGRAM** ☐ **ANNUITANT HEALTH CARE PROGRAM**

X Medical Plan PLAN

☐ INDEMNITY* ☐ PPO PLAN ☐ HEALTH MAINTENANCE ORGANIZATION (HMO)

*closed to new enrollments

CHECK APPLICABLE Plan

GROUP NUMBER _____ HMO NAME _____

☐ MANAGEMENT BENEFITS ☐ FULL-TIME ☐ PART -TIME

BARG. UNIT	PERSONNEL #	EMP/ANN PREMIUM	EFF.DATE
	XXXX		XXXX

X Transaction Code **TRANSACTIONS**

☐ ENROLLMENT ☐ OPEN ENROLLMENT ☐ CHANGE ** ☐ CANCEL COVERAGE ** ☐ TRANSFER TO AHCP ☐ RETURN FROM LWOP

☐ BEGIN SICK OR PARENTAL LWOP ☐ BEGIN EDUCATIONAL LWOPWOB ☐ ADD SPOUSE/DEPENDENT(S) ☐ REMOVE SPOUSE/DEPENDENT(S)

****INDICATE REASON IN REMARKS SECTION****

EMPLOYEE/ANNUITANT DATA

☐ MR. ☐ MS. NAME (LAST)	(FIRST)	(MI)	DATE OF BIRTH (MO,DAY,YR)	☐ MARRIED ☐ SINGLE	DATE OF MARRIAGE	SOCIAL SECURITY NO.
XXXXXXXXXX	XXXXXX	X	XXXXXXXXX			XXXXXXXXX

ADDRESS (STREET)	(CITY)	(STATE)	(ZIP)	(COUNTY)	DAYTIME PHONE NUMBER
XXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XX	XXXX	XXXXX	( )

HMO PRIMARY CARE PHYSICIAN (PCP) PRACTICE NAME AND CODE NUMBER (REFER TO PROVIDER NETWORK DIRECTORY FOR PCP #

DEPENDENT DATA

ELIGIBILITY DOC. VERIFIED	ADD/REMOVE X ☐	X ☐	DEPENDENT NAME (LAST,FIRST,MI)	DATE OF BIRTH (MO,DAY,YR)	SOCIAL SECURITY	IF STUDENT GRAD. DATE	PCP PRACTICE NAME AND CODE #
☐	☐ ☐	SPOUSE	XXXXXXXXX	XXXXXXX	XXXXXXXX		
☐	☐ ☐	SON ☐ DAU ☐	XXXXXXXXX	XXXXXXX	XXXXXXXX		
☐	☐ ☐	SON ☐ DAU ☐					
☐	☐ ☐	SON ☐ DAU ☐					
☐	☐ ☐	OTHER ☐					

OTHER COVERAGE DATA

Does your spouse have other employee or annuitant State System of Higher Education 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/Annuitant Name	Part A Effective Date
Medicare Health Ins. Claim #	Part B Effective Date
Dependent Name	Part A Effective Date
Medicare Health Ins. Claim #	Part B Effective Date

REMARKS

XXXXX

AUTHORIZATION FOR APPLICATION FOR ENROLLMENT: I request the above enrollment (or change) for health insurance coverage and authorize the State System to make pre-tax payroll deductions or deductions from my annuity if applicable. I hereby apply for the coverage indicated. I 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 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.

EMPLOYEE/ANNUITANT SIGNATURE	DATE (MO,DAY,YR)	PERSONNEL USE ONLY (FULL CLOCK NUMBER)
XXXXXXXXXXX	XXXXXXXX	