

PLEASE COMPLETE BOXES MARKED BY X'S

PENNSYLVANIA STATE SYSTEM OF HIGHER EDUCATION

ACTIVE GROUP HEALTH PROGRAM

ANNUITANT HEALTH CARE PROGRAM

XXXX **INDICATE PLAN CHOICE**

<input type="checkbox"/> INDEMNITY	<input type="checkbox"/> PPO	<input type="checkbox"/> HEALTH MAINTENANCE ORGANIZATION (HMO)	<input type="checkbox"/> MANAGEMENT BENEFITS	<input type="checkbox"/> FULL-TIME	<input type="checkbox"/> PART -TIME
GROUP NUMBER _____ HMO NAME _____			BARG. UNIT	PLAN CODE	COVER.CODE
			EMP/ANN PREMIUM	EFF.DATE	

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

<input type="checkbox"/> MR. <input type="checkbox"/> MS.	NAME (LAST) (FIRST) (MI)	DATE OF BIRTH (MO, DAY, YR)	<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	DATE OF MARRIAGE	SOCIAL SECURITY NO.
XXXXXXXXXX	XXXXX XXX	XXXXXXXXXXXX		XXXXXXX	XXXXXXXXXXXX
ADDRESS (STREET) (CITY) (STATE) (ZIP)		(COUNTY)		DAYTIME PHONE NUMBER	
XXXXXXXXXXXXXXXXXXXXX XXXXXXXX		XXXXXXXXXXXX XXXXXX		() XXXXXXX	
HMO OR POS PRIMARY CARE PHYSICIAN (PCP) PRACTICE NAME AND CODE NUMBER (REFER TO PROVIDER NETWORK DIRECTORY FOR PCP #					

DEPENDENT DATA

ADD/REMOVE	DEPENDENT NAME (LAST, FIRST, MI) XX(LIST ALL DEPENDENTS ON PLAN)XX	DATE OF BIRTH (MO, DAY, YR)	SOCIAL SECURITY	IF STUDENT GRAD. DATE	PCP PRACTICE NAME AND CODE NUMBER
<input type="checkbox"/> <input type="checkbox"/>	SPOUSE	XXXXXXXXXXXX	XXXXXXX		
<input type="checkbox"/> <input type="checkbox"/>	SON <input type="checkbox"/> DAU <input type="checkbox"/>	XXXXXXXXXXXX	XXXXXXX	XXXXXXX	
<input type="checkbox"/> <input type="checkbox"/>	SON <input type="checkbox"/> DAU <input type="checkbox"/>				
<input type="checkbox"/> <input type="checkbox"/>	SON <input type="checkbox"/> DAU <input type="checkbox"/>				
<input type="checkbox"/> <input type="checkbox"/>	SON <input type="checkbox"/> DAU <input type="checkbox"/>				
<input type="checkbox"/> <input type="checkbox"/>	OTHER <input type="checkbox"/>				

OTHER COVERAGE DATA

MEDICARE INFORMATION (IF APPLICABLE)

Does your spouse have other employee or annuitant State System of Higher Education coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO	Employee/Annuitant Name	Part A Effective Date
Does your spouse have other fully employer paid coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO	Medicare Health Ins. Claim #	Part B Effective Date
Do you or your dependents have other health coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, provide the following information:	Dependent Name	Part A Effective Date
Full Name of Insured Name of Health Care Plan/Insurance Co Policy/ID Number	Medicare Health Ins. Claim #	Part B Effective Date

REMARKS
XXXXXXXXXXXXXXXX

AUTHORIZATION FOR APPLICATION FOR ENROLLMENT: I request the above enrollment (or change) for health insurance coverage and authorize the State System to adjust my payroll account or make pre-tax deductions. 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 XXXXXXXXXX	DATE (MO, DAY, YR) XXXXXXX	RX PLAN NUMBER	PERSONNEL USE ONLY (FULL CLOCK NUMBER)
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