

**PENNSYLVANIA STATE SYSTEM OF HIGHER EDUCATION**

**ACTIVE GROUP HEALTH PROGRAM**

**ANNUITANT HEALTH CARE PROGRAM**

PLAN

<input type="checkbox"/> <b>INDEMNITY*</b> <small>*closed to new enrollments</small>	<input type="checkbox"/> <b>PPO PLAN</b>	<input type="checkbox"/> <b>HEALTH MAINTENANCE ORGANIZATION (HMO)</b>	<input type="checkbox"/> <b>MANAGEMENT BENEFITS</b>	<input type="checkbox"/> <b>FULL-TIME</b>	<input type="checkbox"/> <b>PART -TIME</b>
GROUP NUMBER _____	HMO NAME _____	BARG. UNIT _____	PERSONNEL # _____	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. _____
ADDRESS (STREET) _____		(CITY) _____		(STATE) _____	(ZIP) _____	(COUNTY) _____	DAYTIME PHONE NUMBER ( ) _____
HMO PRIMARY CARE PHYSICIAN (PCP) PRACTICE NAME AND CODE NUMBER (REFER TO PROVIDER NETWORK DIRECTORY FOR PCP # _____)							

**DEPENDENT DATA**

ELIGIBILITY DOC. VERIFIED	ADD/REMOVE	DEPENDENT NAME (LAST,FIRST,MI)	DATE OF BIRTH (MO,DAY,YR)	SOCIAL SECURITY	IF STUDENT GRAD. DATE	PCP PRACTICE NAME AND CODE #
<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	SPOUSE				
<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	SON <input type="checkbox"/> DAU <input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	SON <input type="checkbox"/> DAU <input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	SON <input type="checkbox"/> DAU <input type="checkbox"/>				
<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 Does your spouse have other fully employer paid coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO Do you or your dependents have other health coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, provide the following information:	Employee/Annuitant 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 _____
	Dependent Name _____	Part A Effective Date _____
	Medicare Health Ins. Claim # _____	Part B Effective Date _____

<b>REMARKS</b>  _____ _____	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.
<b>EMPLOYEE/ANNUITANT SIGNATURE</b> _____	DATE (MO,DAY,YR) _____ PERSONNEL USE ONLY (FULL CLOCK NUMBER) _____