

**PENNSYLVANIA STATE SYSTEM OF HIGHER EDUCATION**

**ACTIVE GROUP HEALTH PROGRAM**

**ANNUITANT HEALTH CARE PROGRAM**

PLAN

<input type="checkbox"/> INDEMNITY	<input type="checkbox"/> PPO PLAN	<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	PERSONNEL #
			EMP/ANN PREMIUM	EFF.DATE	

**TRANSACTIONS**

<input type="checkbox"/> ENROLLMENT	<input type="checkbox"/> OPEN ENROLLMENT	<input type="checkbox"/> CHANGE **	<input type="checkbox"/> CANCEL COVERAGE **	<input type="checkbox"/> TRANSFER TO AHCP	<input type="checkbox"/> RETURN FROM LWOP
<input type="checkbox"/> BEGIN SICK OR PARENTAL LWOP	<input type="checkbox"/> BEGIN EDUCATIONAL LWOPWOB	<input type="checkbox"/> ADD SPOUSE/DEPENDENT(S)	<input type="checkbox"/> REMOVE SPOUSE/DEPENDENT(S)		

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

**EMPLOYEE/ANNUITANT DATA**

<input type="checkbox"/> MR. NAME (LAST)	(FIRST)	(MI)	DATE OF BIRTH (MO,DAY,YR)	<input type="checkbox"/> MARRIED	DATE OF MARRIAGE	SOCIAL SECURITY NO.
<input type="checkbox"/> MS.				<input type="checkbox"/> SINGLE		
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**

ADD/REMOVE		DEPENDENT NAME (LAST,FIRST,MI)	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				
<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	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)