

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

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 (MM,DD,YYYY)	<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

ADD/REMOVE	RELATIONSHIP	DEPENDENT NAME (LAST, FIRST, MI)	DATE OF BIRTH (MO, DD, YYYY)	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"/> SON <input type="checkbox"/> DAU					
<input type="checkbox"/>	<input type="checkbox"/> SON <input type="checkbox"/> DAU					
<input type="checkbox"/>	<input type="checkbox"/> SON <input type="checkbox"/> DAU					
<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 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	DATE (MO, DAY, YR)	RX PLAN NUMBER	PERSONNEL USE ONLY (FULL CLOCK NUMBER)